Memo

To: SCPD, GACEC and DDC

From: Disabilities Law Program

Date: May 13, 2022

Re: May 2022 Policy and Law Memo

Please find below per your request analysis of pertinent proposed regulations and legislation identified by councils as being of interest.

Proposed DPH Amendments to 16 DE Admin. Code 4459A, 25 Delaware Register of Regulations 1006 (May 1, 2022)

The Delaware Division of Public Health proposes to make amendments to 16 DE Admin. Code 4459A, which establishes standards for lead testing of young children. The amendments revise standards to correspond with updated guidance on blood lead levels from the Center for Disease Control and Prevention (CDC)[1] and to expand the number of children who will be tested for lead.

Background

Prior to 2012, the CDC utilized the term blood lead "level of concern" in guidance regarding blood lead levels in children. The "level of concern" previously corresponded to 10 or more micrograms per deciliter of lead in blood.

As of 2012, the CDC no longer uses the term "level of concern" and instead now bases guidance using a blood lead "reference value," which is generated by assessing the 97.5th percentile of blood lead values in U.S. children aged 1-5 years. In 2012, this reference value was 5 micrograms per deciliter. In 2021, the CDC revised its reference value to 3.5 micrograms per deciliter.[2] This change in guidance means that the CDC now recommends that children whose blood levels are between 3.5-5 micrograms per deciliter should also be provided with interventions, which an environmental exposure history, an environmental investigation of the home, family education, and monitoring of development, and a variety of possible medical interventions.[3] Prior to the change in CDC guidance, children with blood lead levels less than 5 micrograms may not have received information or interventions for lead exposure. [4]

Revisions

The proposed revisions to 16 DE Admin. Code 4459A will make lead testing nearly universal for all young children in Delaware and lowers the threshold of the reference value of blood lead

---

[1] *Childhood Lead Poisoning Prevention: Blood Lead Reference Value*, CTRS. FOR DISEASE CONTROL & PREVENTION (Oct. 27, 2021), https://www.cdc.gov/nceh/lead/data/blood-lead-reference-value.htm

[2] Id.

[3] Childhood Lead Poisoning Prevention: Recommended Actions Based on Blood Lead Level, CTRS. FOR DISEASE CONTROL & PREVENTION (Apr. 26, 2022), https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm.

[4] CTRS. FOR DISEASE CONTROL & PREVENTION, supra note 1.

levels to 3.5 micrograms per deciliter (the current CDC standard) to include children with lower (but concerning) lead levels to be included in required state reporting.

Previously, Delaware Code required blood lead level testing for if a health care provider determined that a child between 22 and 26 months had a high risk of lead exposure. The revised language states that a primary health care provider "shall administer a blood test for lead when the child is at or around 12 months of age and again at or around 24 months of age." Additionally, primary healthcare providers will also be required to administer a blood test to 12-month visit and again at the 24-month visit…." Further, under the proposed revisions, a primary care official provider shall administer a blood test for lead levels for a child between 24 months and six years if:

> 3.2.1 If the child has not previously received a blood test for lead;
>
> 3.2.2 If the child's parent or guardian fails to provide documentation that the child has previously received a blood test for lead;
>
> 3.2.3 If the health care provider is unable to obtain the results of a previous blood lead analysis; or
>
> 3.2.4 If the child's parent or guardian requests that the child receive a blood test for lead regardless of the child's age or area of residence.

This revised language greatly expands the number of children who must be tested and establishes that every child should at least be tested twice in their first two years of life. The revised language also removes health care provider discretion in determining the risk of lead exposure, and instead makes blood lead levels a routine early childcare screening for all children. (The revised language retains a religious exemption from blood testing, requiring an exemption certificate that is "signed and dated by the child's parent or guardian, notarized, and kept in the child's medical chart.")

Recommendations

Councils should consider supporting this regulation, which will increase the number of children tested for lead, hopefully leading to necessary interventions for more children who have been exposed to lead, and more accurate data about lead exposure in children in the state. However, there are certain elements of the bill that are ambiguous, or do not clearly align with CDC guidance or other state regulations.

Councils may wish to recommend that the terminology used in the proposed revisions be modified to be consistent and correspond to the CDC's terminology. The proposed revisions include three different terms to refer to the same metric of 3.5 micrograms per deciliter of lead. The definitions include:

- "Blood lead level of concern" is defined as "a concentration of lead in whole venous blood greater than or equal to 3.5 micrograms per deciliter in a child younger than six years old. Blood Lead Level of Concern shall be used for surveillance and outreach for children at risk of lead poisoning."

- "Elevated blood lead level" is defined as “an elevated blood lead level defined by the Division of Public Health to be potentially detrimental to the health, behavioral development, or cognitive potential of a child.
- "Reference level" “is defined as the revised blood lead reference level as determined by the Centers for Disease Control and Prevention.”

As noted above, “level of concern” is the antiquated term no longer used by the CDC. “Reference value” is the current term used by the CDC. As of 2021, the CDC “reference value” is the 3.5 microgram per deciliter level, and the level at which the CDC recommends reporting of test results and additional interventions.[5] Councils may wish to recommend that the proposed revisions only include the term “reference value,” which should correspond with the current CDC definition (and which should be amended if the CDC changes its this value). The definition of “reference value” should include the former terminology now covered by this term.

Councils may wish to recommend that definitions in this section of the Code provide more clarity about the differences between capillary and venous blood testing and clarify when a venous blood test should be administered. According to CDC recommendations:

> *healthcare providers may use a capillary or venous sample for initial BLL screening. If the capillary results are equal to or greater than CDC’s Blood Lead Reference Value (BLRV), providers should collect a venous sample. If a venous sample was taken during the initial screening test, skip to Confirmed Venous Blood Lead Level*.[6]

The current revised language defines “blood test” to include both capillary and venous testing and defines both type of testing. However, the definitions of “capillary” and “venous” testing in the revised language do not include information about the accuracy of testing and do not reflect the CDC’s guidance that the venous test should be used to confirm a finding using a capillary test (although that information is incorporated in the requirements for primary health care providers as noted below).

Councils may also wish to recommend modifying or eliminating other distinctions between primary care and other health care providers in this proposed language. Currently, the proposed requirements about lead testing at different early childhood milestones only apply to primary care providers. The proposed revisions only state that, “a health care provider giving non-primary care to a child may, but is not required to, administer a blood test for lead, even if a blood test for lead is not medically indicated.” This may mean that children who are not be connected with a primary care provider may go longer without getting blood lead level testing. The language could be revised to clarify or identify the circumstances when a non-primary care provider would be required to test a child for lead who previously has not been tested.

Similarly, the proposed revisions only require primary care providers who have administered a capillary blood lead level test to follow up with a venous blood test if initial results indicate blood lead levels at the reference level or higher. If a patient had a capillary blood level test administered by a non-primary care provider, and that test indicated blood lead levels at the

[5] CTRS. FOR DISEASE CONTROL & PREVENTION , supra note 1.
[6] CTRS. FOR DISEASE CONTROL & PREVENTION, supra note 2.

reference level or higher, there would be no required venous blood testing to confirm lead levels as there would be if the test was administered by a primary care provider. Councils may wish to recommend that the proposed language make guidance consistent across healthcare providers or include alternative provisions to ensure all appropriate CDC-recommended testing occurs, regardless of what type of provider administers the initial test.

The proposed revisions include proof of documentation of lead testing requirements prior to childcare or school enrollment (10.0). These requirements are more nuanced and deviate slightly from the corresponding Office of Child Care Licensing (OCCL) regulations regarding the proof of documentation of lead testing.

OCCL's regulations only require that for a child over 12 months of age, there must be a proof of blood lead test within one month of starting care as part of mandatory health appraisal (unless "federal or State laws, such as specified in the McKinney-Vento Homeless Assistance Act, require the center to admit a child without one").[7] OCCL requires health appraisals to be updated every 13 months (although it is unclear if that would require a new blood test).

In contrast, the proposed revisions to the Code in this section specify:

> 10.2 Except in the case of enrollment in kindergarten, the screening may be done within 60 calendar days of the date of enrollment.
> 10.3 A child's parent or guardian must provide one of the following to the administrator of a childcare facility, public or private nursery school, preschool, or kindergarten:
>
> > 10.3.1 A statement from the child's primary health care provider that the child has received a blood test (screening) for lead poisoning;
> > 10.3.2 A certificate signed by the parent or guardian stating that the blood test (screening) is contrary to the parent's or guardian's religious beliefs;
> > or 10.3.3 Certified documentation of the child's blood lead analysis, as specified in this regulation, administered in connection with the 12-month visit and 24-month visit to the child's health care provider not later than:
> >
> > - 10.3.3.1 30 calendar days from the 12-month visit or 24-month visit;
> > - or 10.3.3.2 30 calendar days from first entry into the program or system.

These sections could create confusion with OCCL regulations about when lead testing documentation needs to be provided to a daycare center. Section 10.2 of this section (stating that a blood test can occur within 60 days of enrollment) would seem to deviate from OCCL's requirements that documentation of lead testing be provided within a month of enrollment as part of the mandatory health appraisal for children over 12 months. From this proposed language, it is

[7] 14 DE Admin. Code 934 §23, https://regulations.delaware.gov/AdminCode/title14/900/934.shtml.

also unclear what the timeline is for providing proof of documentation of lead testing if it was not taken in connection with a 12-month visit and 24-month visit, which also possibly contradicts OCCL's requirements to provide documentation within a month of enrolling. Further, this proposed language only includes a religious exemption, whereas OCCL's exemption policy is inclusive of any state or federal law which exempt a child from lead testing documentation.

Proposed language in this section also details which testing records need to be provided if multiple tests have been administered. There are no such specifications in OCCL's regulations, apart from the need to update the health appraisal every 13 months (without identifying whether that includes updated lead testing).

Finally, Councils may wish to recommend that the revised language incorporate the CDC's recommended interventions when testing reveals blood lead levels at different metrics. Currently, the revised language does not include any further interventions beyond reporting for medical providers, public health and environmental agency officials, or housing providers. The CDC, meanwhile, outlines various recommended interventions at different blood lead levels (see: https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm). These interventions range from obtaining an environmental exposure history, arranging for an environmental investigation of the home or other sources of lead, providing family education, and providing an spectrum of medical services ranging from monitoring for iron deficiency and development for lower lead blood levels above the reference level to performing an abdominal X-ray, initiating bowel decontamination, admitting to a hospital, and consulting with poison control and/or a medical toxicologist for higher lead blood levels.

Proposed DSS Amendments to 16 DE Admin. Code 11000 Relative In Home Care, 25 Delaware Register of Regulations 1012 (May 1, 2022)

These proposed regulations "define and explain" requirements for a relative to provide in home childcare through the purchase of care program. Of significance to councils, DSS appears to be restating the provisions limiting Relative In Home Care to families with four or more children and eliminating the "last resort" exception to this rule for special needs children when other childcare cannot be found.

In its place, the revised regulation restates the four family member restriction in 3A, by requiring a minimum of four children (and a maximum of five); and in 3C, by requiring that the children be family members of the caregiver and that they all be siblings. The proposed regulation removes the exception for special needs children, and restricts care to non-traditional work hours that are not normally available.

DSS revised these regulations in 2018 in an obvious effort to reduce the use of relative in-home childcare. At the time, councils raised concerns about the need to make reasonable modifications to this and in fact any policy if either the child or the parent has disabilities requiring changes. I have copied below the comment and the response from the last round of these regulations:

Third, Section 3 includes the following limit: "Relative childcare is limited to evening and weekend shift work hours only." This is ill- conceived given the overall shortage of childcare providers. Moreover, "special needs" parents and children are eligible for the State childcare program. See 16 **DE Admin. Code** 11003.7.8. It may be extremely difficult for a parent of a special needs child ages 13-18 to identify a licensed provider to add a 13–18-year-old to their daycare. Moreover, "special needs" parents often rely on relatives for parenting assistance and federal law requires states to accommodate that reliance. See Joint DOJ/HHS LOF to Mass. Dept. Of Children & Families (1/29/15), published at https://www.ada.gov/ma_docf_lof.pdf. See also U.S. DOJ/HHS Joint Guidance, "Protecting the Rights of Parents and Prospective Parents with Disabilities: Technical Assistance for State and Local Child Welfare Agencies and Courts under Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act (8/15)", published at https://www.ada.gov/doj_hhs_ta/child_welfare_ta.pdf. At a minimum, Section 3 should be revised to allow relative childcare for special needs children and adults apart from evening and weekend shifts. It would also be prudent to authorize exceptions for all parents with the approval of DHSS.

Agency Response: DSS appreciates the Council's comment regarding the limitations on the Relative Care choice for parents. At this time the Division is not aware of any factual documentation regarding a childcare shortage in our state. We are, however, setting the stage to conduct some research to determine if in fact the childcare demand is greater than the supply, and where services may be lacking. Moreover, the division has seen a significant increase in the request for relative care by providers who are unsuitable for a myriad of reasons. We have had a rash of parents pulling their children from centers to allow relatives to provide care, parents attempting to get people other than relatives to provide care, people other than the authorized relatives actually caring for the children when site visits are conducted (which means they have not been finger printed), relative providers caring for the children at sites other than the authorized sites, relative providers/children who are unable to be located when attempting to conduct site visits, relative care providers allowing other adults who have not been fingerprinted, in the home, around the children, relatives providing care in environments that were not safe for children, etc. In its efforts to, as best it can, ensure the health and safety of children the division has made the decision to restore the integrity of the relative care program by limiting this choice to parents who need care during non-traditional hours such as weekends, and evening shifts. The agency is fully aware that there may be circumstances where exceptions must be made, particularly, for those families who may have a special need. The agency is amenable to addressing these exceptions as they present themselves.[8]

For no good reason, while DSS acknowledged in the response that they were "amenable" to addressing exceptions, they did not revise the regulation. Council should consider reiterating this concern again. Even if DSS is amenable to making exceptions, the fact is they are obligated to, and the regulation should clearly state that individuals can ask for modifications to the policy, especially the ones restricting coverage to non-traditional hours and restricting the use of relative in-home caregivers to families of four. Parents of children with disabilities struggle mightily to find childcare that will accept their child, and childcare providers discriminate on a regular basis against these families. Family size has no bearing on the need for childcare under these circumstances. For clarity and transparency, the regulation should articulate the availability of reasonable modifications to this policy.

[8] https://regulations.delaware.gov/register/february2018/final/21%20DE%20Reg%20639%2002-01-18.htm

DMMA/DDDS Notice of Proposed Amendments to 1915(c) Lifespan Waiver, 25 Delaware Register of Regulations 1033 (May 1, 2022)

The Division of Medicaid and Medical Assistance (DMMA) is proposing an amendment to the existing Lifespan Waiver, a 1915(c) waiver which funds services provided through the Division of Developmental Disabilities Services (DDDS). As many of the proposed changes would likely increase overall payment rates for providers for many of the services provided through the waiver and help with recruitment and retention of direct service providers (DSPs), they are also likely to benefit service recipients.

Notably, for Day Habilitation, Community Participation, and Pre-Vocational services, the waiver amendment would allow providers to bill for transportation as a component part of the services at a separate rate for the days it is provided. The language in the current waiver more generally states that transportation may be considered a component part of the service and may be included in the rate if provided. The proposed change to the billing scheme would likely ensure that providers are able to bill more accurately for the costs they impose in providing individual transportation as they can bill at a separate rate.

Also, for Day Habilitation, Community Participation, Pre-Vocational, Supported Employment, Residential Habilitation, and Medical Residential Habilitation services, the amendments would authorize DDDS to pay a higher rate to providers when services are provided by DSPs who are American Sign Language (ASL) fluent or certified, or by DSPs who are Registered Behavior Technicians (RBTs), when an individual service recipient's need for such specialization is clearly documented in the person-centered plan. Staff who are RBTs would need to be supervised by a Board-Certified Behavior Analyst (BCBA) in order for DDDS to pay the higher rate. While it is not clear why this rate increase wouldn't apply for other waiver services, such as Supported Living, nevertheless increasing the rate for staff who have with ASL fluency or who are RBTs for the specific services proposed would improve the accessibility and individualization of waiver services for people who are deaf or otherwise primarily communicate in ASL, or people with more intensive behavioral support needs.

Additionally, the waiver amendment would increase the combined budget for Respite and Personal Care services from $2700 to $3500 annually. As even with approval for funding, caregivers and their families may struggle to find appropriate providers to provide respite services, having a higher budget may help expand the options available. Similarly, individuals and families may have difficulty finding appropriate providers for Personal Care services. DDDS may also want to explore other incentives for providers of Respite and Personal Care services in light of the nationwide shortages in home health aides and similarly qualified DSPs.

Another change proposed in this waiver amendment would clarify that Assistive Technology covered by the waiver includes hearing aids, and that covered providers could potentially include audiologists. This would potentially increase accessibility of waiver services for individuals who are deaf or hard of hearing.

The waiver amendment would also impose a three-tiered rate structure for both Behavior and Nursing Consultant services. This would enable providers to bill varying amounts for consultant services depending on an individual consultant's credentials and level of experience, which

would incentivize the recruitment and retention of more experienced, skilled providers in these areas.

There are additional changes proposed as part of the amendment that are largely responsive to external rule and policy changes. For example, the eligibility criteria for the Lifespan waiver would be updated to reflect that service recipients can no longer "age out" of eligibility for the Pathways to Employment waiver due to changes to that waiver program. Additionally, DDDS has been removed as a provider for Day Habilitation as there are no longer any state-operated day programs serving DDDS service recipients. The waiver amendment also reflects recent changes to Section 4411 of the Social Security Act, allowing for certain waiver services to be provided in acute care hospital settings if not otherwise available through the hospital or to support transition between the hospital and a community setting.

The Councils should support the proposed amendments to the Lifespan waiver; as discussed above they are likely to improve the availability of providers to meet individual needs for various waiver services. As the disability community has been painfully aware in recent years, DSP shortages and the difficulties that many provider agencies encounter in recruiting and retaining staff with sufficient training and experience inevitably affect the availability and quality of services for people with disabilities. The Councils should encourage efforts to bolster staffing for services offered through the waiver. The changes proposed in the waiver amendment would also make needed services and assistive technology more accessible to DDDS service recipients who are deaf or hard of hearing or otherwise primarily communicate in ASL.

DMMA Notice of Proposed Amendments to 1115 Waiver, 25 Delaware Register of Regulations 1035 (May 1, 2022)

DLP defers comment on the proposed waiver amendment until it has an opportunity to review the proposal in more detail. For information purposes, the waiver amendment proposes to do add the following to the 1115 DSHP Waiver, effective January 1, 2023:

(1) Coverage of two models of evidenced-based home visiting for pregnant women and children;
(2) Permanent coverage for a second home-delivered meal for members receiving home- and community-based services (HCBS) in DSHP Plus;
(3) Coverage of a pediatric respite benefit as an American Rescue Plan Act (ARP) Section 9817 HCBS Spending Plan initiative;
(4) Coverage of a self-directed option for parents on behalf of children receiving state plan personal care services; and
(5) Coverage of Delaware's Nursing Home Transition Program (formerly Money Follows the Person Demonstration) under the DSHP 1115 waiver.

Of particular interest to councils are numbers 4 and 5. First, DMMA is proposing to allow parents to self-direct personal care services for children with disabilities, and importantly to be able to hire relatives, including a legally responsible person (not currently allowed). Number 5 brings the Nursing Home Transition Program (the state's answer to MFP) under the waiver. The are proposing a $2500 cap with some flexibility to make exceptions.

HB 396: AN ACT TO AMEND TITLE 14 OF THE DELAWARE CODE RELATING TO SCHOOL DISCIPLINE.[9]

House Bill 304 ("HB 396") seeks to amend Chapter 16, Title 14 of the Delaware Code relating to school discipline by adding Subchapter II which would codify requirements related to the processing of Attorney General's Reports ("AG Report"). Additionally, the bill seeks to amend Chapter 1, Title 14 of the Delaware Code relating to the powers and duties of the Delaware Department of Education ("DDOE") by amending § 122 which requires DDOE to develop and implement regulations related to uniform procedures for processing AG Reports, as well as procedures and definitions in other areas of school discipline. The bill was introduced in the Delaware House of Representatives on April 28, 2022, sponsored by Rep. Dorsey Walker and Sen. Pinkney.[10]

It was subsequently assigned to the House Education Committee which met on May 11, 2022. At this meeting, the Committee voted to table the bill, at the request of the bill's sponsor.[11] The bill is being tabled to provide additional time for Rep. Dorsey Walker to collaborate with the Delaware Department of Justice ("DOJ"), DDOE, and the Delaware State Educators Association ("DSEA"). Prior to introducing the bill, Rep. Dorsey Walker had not discussed it with DOJ, DSEA, nor local education agencies. DOJ and DDOE indicated they could not support the bill as currently written. Because it is being tabled for a substitute bill or amendment, Councils may wish to take this opportunity to reach out to Rep. Dorsey Walker and express an interest in collaborating on any revisions. Because this bill will not move forward as drafted, this reviewer will be brief in her analysis and touch upon the concerns brought forward at the Committee Hearing.

Specifically, HB 396 does the following:

1. Codifies the AG Report notification process, limiting notifications to violent felonies, crimes that occur on school property or at a school event, or where the alleged victim attends the same school.
2. Requires that when an AG Report is sent, the Attorney General must notify of the case resolution within two (2) business days of the case resolution.
3. Prohibits schools from taking disciplinary action against a child while the charge is pending. Allows schools to take disciplinary action after case resolution only where it is necessary to protect the health and safety of the school community.
4. Allows schools to offer or require counseling or other services for students who are the subject of an AG Report.
5. Allows the school to take safety measures, as appropriate, where an alleged victim attends the same school as the student who is the subject of an AG report.

[9] https://legis.delaware.gov/BillDetail/109400.
[10] HB 396 is co-sponsored by Sen. Sokola and Reps Baumbach, Chukwuocha, Lambert, Morrison, and Wilson-Anton.
[11] A bill is tabled in Committee when a majority of the members decide it should not be released from Committee. The bill is subject to being petitioned out of committee. https://legis.delaware.gov/Resources/GlossaryOfTerms.

6. Requires that when a child has an Individualized Education Program ("IEP") or Section 504 Plan, the school must consider their disability / disabilities when considering disciplinary proceedings.
7. Requires AG Reports be handled confidentially and retained past the case resolution only in specified circumstances.

As background, an AG Report is defined as the DOJ's "report of: 1) an enrolled student's alleged criminal conduct, regardless of jurisdiction, which shows disregard for the health, safety and welfare of others, including, but not limited to acts of violence, weapons offenses, and drug offenses; 2) wanted persons enrolled in a school; and 3) missing persons enrolled in a school." When an AG report is sent to the Superintendent (or designee), the Superintendent has the discretion of whether to provide that report to the school principal for disciplinary action. The current procedures require no follow up from DOJ after the initial report is sent, which can lead to disciplinary actions in school for arrests or charges for students that end up being dropped or for which the student is found not guilty or not delinquent.

The way HB 396 is currently written would address the latter concern – where students are being punished at school for behaviors outside of school for which the student is ultimately held not responsible. The current HB 396 language would prevent school disciplinary action until there is a case resolution related to the conduct outside of school.

As noted above, an AG Report is currently sent when there is "criminal conduct" which shows disregard for the health, safety, and welfare of others such as acts of violence, weapons offenses, and drug offenses. The way HB 396 is currently written would change this and limit the number and types of offenses for which AG Reports are sent. What initially prompted Rep. Dorsey Walker to want to table the bill was the purported list of offenses which the Policy Director for DOJ said would be removed. She explained that the following offenses would no longer generate an AG Report:

1. Offensive touching
2. Reckless endangering
3. Assault Third
4. Abuse of a sports official
5. Terroristic threatening
6. Indecent exposure
7. Incest
8. Unlawful sexual contact Third
9. Unlawful imprisonment
10. Coercion
11. Reckless burning or exploding
12. Cross or religious symbol burning
13. Hate crimes
14. Harassment
15. Cruelty to animals
16. Offenses involving deadly weapons, including carrying a concealed deadly instrument

The Policy Director added that "deadly instrument" would include firearms and knives; this was followed up by the Delaware House of Representative's attorney who mistakenly read the definition for "deadly weapon" rather than "deadly instrument."[12] This latter definition is what prompted Rep. Dorsey Walker to seek tabling of the bill. One of the problems with this list is that it is inaccurate, including the extraneous note related to deadly instruments including firearms.

The way HB 396 is written would allow AG Reports to be sent to the school district if it involves a violent felony. Title 11 of the Delaware Code includes an exhaustive list of what offenses constitute a violent felony.[13] One of the violent felonies listed is "Carrying a Concealed Deadly Weapon" which includes a firearm.[14] A firearm would not be considered a "dangerous instrument" but rather would be considered a "dangerous weapon." In addition to this inconsistency, the following offenses identified as would be removed are considered violent felonies and would remain:

1. Abuse of a sports official
2. Unlawful imprisonment First
3. Hate Crimes (in certain situations)
4. Although reckless burning or exploding is not considered a violent felony, any use of explosive devices such as Molotov cocktails, bombs, or incendiary devices *is* a violent felony.

Brian Moore, Director for School Climate and Discipline at DDOE, was available to speak and answer questions. He said that there were 980 AG reports generated last year, and only twelve (12) of them resulted in a school removal such as alternative placement or expulsion. He said he had not pulled data for other consequences. Therefore, it is unclear what the true impact is of AG Reports on students. He further noted that when he was in the Red Clay Consolidated School District, he would use the AG Report as a restorative tool rather than for discipline. And he finds this is generally what schools do now. Brian noted that these reports are just a piece of the larger puzzle in the lives of students. He said they provide information to the school about something that happened in the community and allows the school to determine whether something could possibly spill over into the school environment.

Rep. Collins expressed his concern with the section requiring schools to consider the disability or disabilities of a student with disabilities. He said there he hears from teachers who complain because they have students with disabilities who act out but who they cannot do anything about because they have disabilities and therefore "nothing can be done." Brian Moore clarified that this is already a requirement under the Individuals with Disabilities Education Act.

Rep. Kowalko expressed his support for the bill, noting that it goes a long way to addressing the disparate impact on certain students in "circumstances beyond their control." He noted that the way schools typically use AG Reports amounts to profiling, because individuals are taking an incident and extrapolating from that to determine whether they believe a student will have a

[12] These inaccuracies were, unfortunately, reprinted in at least one place. https://delawarelive.com/house-debates-whether-student-crimes-should-be-reported-to-school/.
[13] 11 Del. C. § 4201(c).
[14] The specific offense elements are listed at 11 Del. C. § 1442.

problem. In the educational context, this sort of "profiling" can be considered a mini form of a threat assessment, which can lead to drastic consequences for students, especially those with disabilities.[15]

Delaware students with disabilities, males, and students who are Black and Latinx are disproportionately represented in statistics related to school discipline. They are removed from school, face exclusionary discipline, and are likely to face justice involvement all at higher-than-average rates.[16] The way AG reports are currently handled only exacerbates these numbers. This bill, as currently written, can help to alleviate these statistics.

Because this bill will not move forward as currently written, Councils should not feel the need to provide comment on the bill. However, as recommended earlier, Councils may wish to contact the bill's sponsor to express interest in collaborating on revisions.

SB 270, To Amend Title 14 Related to Air Quality And Environmental Safety In Public Schools

The Synopsis for SB 270 indicates that: "This Act establishes an evaluation and assessment system created by the Department of Education to determine whether a school facility is in good repair to assure that school facilities are clean, safe, and functional for staff and students. This Act also requires the Division of Public Health to establish a routine indoor air quality monitoring program and temperature and humidity standards for schools that are published on the Department of Health and Social Services website via an information portal. It further requires the Division of Public Health to create a contractor certification program for indoor air quality services that will allow schools to contract with properly trained and certified contractors when indoor air quality remediation is necessary for a school facility, and it provides procedures for receiving and reporting indoor air quality complaints in schools."

The Act directs DOE and DPH to develop school facility evaluation tools by January 1, 2024; DOE is required to develop standards for, among other things, water quality, mold, and mildew, and DPH is required to establish an indoor air quality monitoring program and mandatory temperature and humidity ranges for all public schools. School districts would be required to institute the air quality monitoring programs by Jan. 1, 2025.

Sen. Stephanie Hansen, primary Senate sponsor, on the bill:

> "Nearly 140,000 children and 15,000 educators spend much of each day in our school buildings, yet there are no meaningful statewide standards for evaluating the safety, functionality, and cleanliness of those facilities, which makes prioritizing the need for specific repairs and maintenance nearly impossible. As a result, we fall further behind on the repairs that are necessary to upkeep our school facilities every year while the costs of those repairs have ballooned to over $1 billion. The legislation I filed today will provide a pathway to developing a common standard and provide a healthy indoor

[15] https://www.ndrn.org/wp-content/uploads/2022/02/K-12-Threat-Assessment-Processes-Civil-Rights-Impacts-1.pdf.
[16] https://ocrdata.ed.gov/estimations/2017-2018 and https://www.doe.k12.de.us/Page/3927.

environment in our school buildings throughout our state to better direct funding where it's needed most."[17]

Rep. Debra Heffernan, House prime sponsor on the bill:

> "Physical learning environments play an important role in a child's overall education, with significant cognitive, behavioral, and health consequences for students of all ages. We need to prioritize funding to ensure school buildings are able to meet the needs of staff and students and are free from hazardous indoor pollutants and mold. By creating statewide standards for evaluating the infrastructure and air quality of our educational facilities, we're affirming what we know to be true; students and educators deserve to learn, grow, and work in a safe and healthy environment."[18]

In recent years, comparative risk studies performed by EPA's Science Advisory Board (SAB) have consistently ranked indoor air pollution among the top five environmental risks to public health. "Good indoor air quality is an important component of a healthy indoor environment and can help schools reach their primary goal of educating children."[19] Moreover, the pandemic has highlighted the need for good ventilation and air quality to prevent the spread of disease. [20] Councils should consider supporting this bill establishing an indoor air quality program in all free public schools, given the strong links between improved environmental conditions and overall health and well-being.

SB 272: An Act to Amend Title 24 To Allow Delaware to Join The Audiology And Speech Language Pathology Interstate Compact.

By this Act, Delaware would join the Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC). Under the compact, audiologists and speech-language pathologists who are licensed and in good standing in a member state may practice in any other member state via a "compact privilege." The privilege extends both to in-person practice and, significantly, to telepractice. The compact, according to the official synopsis, "is the same in form and function as other occupational licensure compacts," such as those for nurses, and physical therapists, and physicians.

The compact has been adopted by 18 states–Alabama, Colorado, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maryland, Mississippi, Nebraska, New Hampshire, North Carolina, Ohio, Oklahoma, Utah, West Virginia, and Wyoming–and is pending approval in 8 others (Illinois, Iowa, Minnesota, Missouri, South Carolina, Vermont, and Washington). [21]

The American Speech-Language-Hearing Association (ASHA) plays a lead role in advocacy for the compact. The American Academy of Audiology, meanwhile, "supports state adoption of the ASLP-IC to facilitate mobility of audiologists, to support telehealth services, and to expand patient

[17] http://www.desenatedems.com/april-28---release.html
[18] http://www.desenatedems.com/april-28---release.html
[19] https://www.epa.gov/iaq-schools/why-indoor-air-quality-important-schools;
[20] https://www.ed.gov/improving-ventilation-schools-colleges-and-universities-prevent-covid-19;
[21] https://aslpcompact.com/compact-map/?

access to audiology services."[22]

The National Council of State Boards of Examiners for Speech-Language Pathology and Audiology also supports the compact.[23]

Although there is widespread support for the compact among professional and industry groups, [24]DLP could find no evidence either of support or opposition among consumer groups or disability advocates. Dr. Beth Mineo, Director of the University of Delaware's Center for Disabilities Studies, expressed concern about the licensing requirements in some states and reported that a person at ASHA confirmed to her that a Certificate of Clinical Competence is *not* required for licensure by all states in the compact. At this writing, she is waiting for an assessment from the president of the Delaware Speech-Language-Hearing Association. "My concern is growing," she concludes, "that consumer groups may not be aware of the implications of this bill, as on the surface it appears to benefit consumers."

Given the uncertainties identified by Dr. Mineo, the DLP should recommend that Councils express concern about the licensing requirements.

SB 277, A Bill to Amend Titles 14 And 16 Related To Dentistry

SB 277 is an important initiative attempting to address an acute problem recruiting dentists to work in federally qualified health centers and other government-funded dental clinics. Delaware has particularly restrictive licensing requirements for dentists. Delaware does not provide reciprocity for dentists licensed in other states. Every dentist who wants to practice under a Delaware license has to pass Delaware specific written and practical exams. In addition, there is a yearlong internship requirement. While this is good for business for dentists who have been through the process, it discourages dentists from neighboring states and elsewhere in coming to Delaware. This has led to a very low ratio of dentists per capita, and Delaware has a dentist shortage. [25] [26] It is extremely difficult to find a dentist in Delaware who has specialized training to treat individuals with disabilities, especially those with ID/DD. [27]

FQHCs have had to close down dental clinics in some areas because these rules make it very difficult to recruit and retain dentists willing to work there. SB 277 now provides that dentists working in FQHCs and government clinics treating "underserved populations" can acquire a "community health license" and after working 3600 hours over two-year period can acquire a full license. Toobtain a community license, the person has some alternatives to the Delaware practice

[22] https://www.asha.org/advocacy/state/audiology-and-speech-language-pathology-interstate-compact;
[23] https://www.audiology.org/advocacy/legislative-and-regulatory-activities/state-affairs/audiology-speech-language-pathology-interstate-compact-aslp-ic/
[24] https://www.ncsb.info/Advocacy/10699537. A complete list of supporting organizations can be found at: https://aslpcompact.com/supporting-organizations/
[25] https://www.delawareonline.com/story/life/2018/01/23/delaware-dentists-oppose-states-suggestion-dentists-working-mandatory-del-residency-oppose-suggestio/1013056001/
[26] https://www.ruralhealthinfo.org/charts/9?state=DE
[27] https://delawaretoday.com/life-style/health/dentistry-with-a-difference/

examination and does not have to participate in the one-year internship. The hope is that these changes will allow the community dental clinics to adequately staff their clinics.

The bill also creates a Dental Care Access Task Force, which has a cast of thousands including the director of SCPD, and which will examine the following:

a. Dental care access, including for underserved populations and communities.
b. Dental licensure practices and requirements.
c. Dental provider type and scope of practice.
d. Dental provider recruitment and retention strategies.
e. Dental insurance networks and coverage, including for the uninsured and underinsured.

Given that dentist shortages directly impact many vulnerable people in the state, and especially in light of the expanded Medicaid dental benefit, councils should consider endorsement and encourage the Task Force to take a meaningful look at the supply of dentists for special populations.