Memo

To: SCPD and DDC

From: Disabilities Law Program

Date: 6/13/2023

Re: June 2023 Law and Policy Memo

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

I. PROPOSED REGULATIONS:

PROPOSED DEPARTMENT OF HEALTH AND SOCIAL SERVICES, DIVISION OF MEDICAID AND MEDICAL ASSISTANCE: PROPOSED 2023 QUALITY STRATEGY, 26 Del. Register of Regulations 1014 (June 1, 2023)

The Delaware Department of Health and Social Services (DHSS), Division of Medicaid and Medical Assistance (DMMA), is proposing amendments to the Diamond State Health Plan Medicaid Managed Care Strategy, regarding Quality Strategy for 2023. The stated purpose is "to serve as a roadmap for Delaware on our contracted health plans and assessing the quality of care that beneficiaries receive while setting forth measurable goals and targets for improvement, regarding 2023 Quality Strategy."[1] Federal regulations[2] and the Centers for Medicare and Medicaid Services (CMS) require all states to "draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO [managed care organization] . . . ."[3] This assessment is referred to as the state quality strategy.[4]

In the "Elements of State Quality Strategies" section of the notice, and based on the federal regulations, the state quality strategy must include certain provisions and procedures.[5] Before

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[1] Statement from the Summary of Proposal, *Summary of Proposed Changes* section of the public notice in the Delaware Register of Regulations. https://regulations.delaware.gov/documents/June2023c.pdf; *and see* the Purpose and Rationale section of the proposed regulation: "[T]he Quality Strategy serves as a blueprint or roadmap for Delaware on our contracted health plans and to assessing the quality of care that beneficiaries receive and setting forth measurable goals and targets for improvement." *Id.*

[2] 42 *CFR* §438.340.

[3] *Id.* at §438.340(a). The states must review and update the strategy at lest every three years. *Id.* at §438.340(c)(2). The results must be available on the State's website. *Id.* at §438.340(c)(2)(ii); *see* http://dhss.delaware.gov/dmma/.

[4] *Id.* at §438.340 and (b).

[5] Including, among others: "[p]rocedures that assess the quality and appropriateness of care and services" under the MCO contracts; "[p]rocedures that regularly monitor and evaluate the MCO compliance" with required standards; "[a]rrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO contract"; "[f]for MCOs, appropriate use of intermediate sanctions"; "[a]n information system that supports initial and ongoing operation and review of the State's quality strategy"; and, "[s]tringent standards "for access to care, structure and operations, and quality measurement and improvement." *See* the Elements of State Quality Strategies section of the public notice announcing the change in the Delaware Register of Regulations. https://regulations.delaware.gov/documents/June2023c.pdf; 42 CFR §438.340(b).

submitting the state quality strategy to CMS, DHSS must obtain input of beneficiaries and other stakeholders[6] and to make the strategy available for public comment, which this notice fulfills.[7] [8]

Under its administrative responsibility for the operation of the Medicaid program, DMMA is responsible and accountable for the quality strategy. In theory, and assuming everything goes as planned and orchestrated, the quality strategy will accomplish the following:

- Establish a comprehensive quality improvement system that is consistent with the Triple Aim to achieve better care for patients, better health for communities, and lower costs through improvement in the health care system.
- Provide a framework to implement a coordinated and comprehensive system to proactively drive quality improvement throughout the DSHP and DSHP Plus program. The QS promotes the identification and dissemination of creative initiatives to continuously monitor, assess, and improve access to care, clinical quality of care, and health outcomes of the population served.
- Identify opportunities for improvement in the health outcomes of the enrolled population and improve health and wellness through preventive care services, addressing social determinants of health, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and services and implement improvement strategies to ensure DSHP and DSHP Plus recipients have access to high quality, timely, effective, and culturally appropriate care.
- Identify creative and efficient models of care delivery that are steeped in best practice and make health care more affordable for individuals, families, and the State government.
- Improve recipient satisfaction with care and services.[9]

However, there are some specific recommendations that Councils may wish to consider making to DHSS/DMMA about the 2023 Quality Strategy.

Provider Network Development and Management Plan: the MCOs are required to develop a Provider Network Development and Management Plan (PNDMP) that shows (through development, maintenance, and monitoring) there is an adequate provider network (documented with written agreements with health care agencies) to provide all services to recipients under the contract with DMMA. Nevertheless, there are areas where there is not an adequate provider network.[10] **Councils may wish to recommend that DMMA should more aggressively address these areas and require the MCOs to provide the required services.** DMMA employs a Balanced Quality Model for monitoring of and quality improvement by the MCOs.

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[6] *Id.* at §438.340(c)(1)(i).
[7] *Id.* at §438.340(c)(1). Comments are due by July 3, 2023.
[8] See the Diamond State Health Plan Quality Strategy utilizing the definitions in Appendix A to decipher the myriad acronyms. Https://regulations.delaware.gov/register/june2023/proposed/2023 Quality Strategy draft.pdf.
[9] *Id. a*t 11.
[10] *E.g.*, consider Medicaid's Early and Periodic Screening, Diagnostic and Treatment benefit which provides comprehensive health care services for children under age 21. 42 *U.S.C.* §1905(r). In Delaware, there are neither sufficient heath care agencies nor nurses to provide the private duty nursing services recipients are entitled to.

This model consists of an Early Alert System and a Retrospective Analysis.[11] **Councils comments could include in this recommendation that DMMA should use both prongs of this model and require any MCO that is not in compliance to submit a Corrective Action Plan (CAP) to address the deficiencies.**

Grievances & Appeals: under the reporting requirements, the MCO's are required among other things to keep "Grievance and appeal logs."[12] Although the quality strategy says that "DMMA has a robust set of reporting requirements for it contracted MCOs,"[13] unfortunately, there is no requirement in the quality strategy for the MCOs to provide data on claims for services when they are denied (most commonly because they are not medically necessary). **To ensure that individuals with disabilities are receiving the services they should, councils may wish to recommend that DMMA require the MCOs to provide this data to DMMA, and that they track the claims denials to determine whether the MCOs are providing the required services.**

Accountability related to PROMISE Program: for recipients who are enrolled in the PROMISE (Promoting Optimal Mental Health Through Supports and Empowerment) program, which is a Medicaid program with the Division of Substance Abuse and Mental Health (DSAMH), there are specific performance measures MCO's must achieve. The performance measures also include a measurement method. If the results fall below the 75% threshold, the MCO would need to submit a CAP. This means for accountability and enforcement is important. In the past CLASI (Community Legal Aid Society, Inc.) and NAMI (National Alliance on Mental Illness) of Delaware raised a number of concerns with DHSS about the quality and accessibility of mental health services provided through DSAMH, including PROMISE.[14] These aforementioned performance measures, do not get at all of the observed concerns, but are steps forward.

The quality strategy addresses these potential performance problems by establishing goals in several strategic areas. For the level of care, the performance measures are: "[n]umber and percent of individuals who were referred to PROMISE for evaluation that demonstrated needs-based criteria was used to determine appropriateness for enrollment; [n]umber and percent of PROMISE enrollees who received an evaluation 60 days in advance of expiration date; [n]umber and percent of PROMISE care management files that evidence correct forms and processes were used to determine PROMISE level of need."[15]

For the qualified providers, the performance measures are: "[n]umber and percent of PROMISE providers (licensed and unlicensed) reviewed for who there is documentation that the provider meets minimum qualifications established by the State and met minimum participation criteria prior to delivering waiver services."[16]

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[11] Https://regulations.delaware.gov/register/june2023/proposed/2023 Quality Strategy draft.pdf at 12.
[12] *Id.* at 27.
[13] *Id.*
[14] The concerns included: accountability for case managed clients; lacking grievance and appeals system; accommodating clients with the most challenging behaviors; and deficiencies in the crisis system. This November 30, 2020 letter, which was sent to then-Secretary Molly Magarik (who is stepping down) and Acting DSAMH Director Alexis Teitlebaum, can be provided upon request. The same or analogous problems can occur with MCO's.
[15] *Id.* at 23.
[16] *Id.* at 24.

For service plans, and plans of care (including members with identified critical incidents), the performance measures include: [n]umber and percent of PROMISE member:

- "files reviewed that indicate choice was offered for PROMISE service providers;"
- "files reviewed in which the service plan clearly identifies the member's goals, needs, and preferences and files indicate services and supports are delivered consistent with the member's plan of care;"
- "files reviewed which document that the member received education/information at least annually about how to identify and report instances of abuse, neglect, and exploitation;
- "files with a critical incident that demonstrates a prevention plan is in place;"
- "restrictive intervention occurrences with an unauthorized restrictive intervention"

and others[17] If these goals are not achieved through the use of performance measures and measurement methods, there will be a CAP. To make sure the goals are achieved, a Performance improvement Project (PIP) can be employed.[18] **These goals and performance measures, if not met, result in a CAP, and thus may help to protect Delawareans from situations in which critical incidents or restrictive interventions occur, as having an appropriate prevention plan in place should help to reduce such incidents.**

Member Satisfaction: to determine how the Medicaid program is functioning and whether it is improving recipient health and improving the quality of care provided by the providers, DMMA requires the MCO's to survey their members at least once a year. To determine satisfaction of the recipients, the MCO's use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to collect whether the recipients are satisfied.[19] It is unclear whether the MCO's contact individual members to also determine their satisfaction. **Councils may wish to advise DMMA that DMMA should formulate a questionnaire that the MCO's should be required to use to contact individual members to gauge satisfaction with the services and quality of care.** This additional step would help ensure that the goals of the quality strategy are being met.

External Quality Review: to also help assess the quality of the care being provided by the MCO's, DMMA works with the External Quality Review Organization (EQRO) which conducts External Quality Review (EQR) assessment activities for the DMMA. These assessment activities use CMS protocols and allow the EQRO to analyze and evaluate the timeliness of care, the quality of the care, and the access to the services provided by the MCO's to its members.[20] This review is another valuable check on the activities of the MCO's.

Government Transparency: although the 2023 Quality Strategy is available at the DMMA website and although DMMA must also make the results of any review available on its website,[21] **councils may wish to recommend to DMMA that there should be more**

[17] *Id.* at 24-26.
[18] "PIPs are used to assess and improve processes and as a result, improve efficiency, satisfaction, and health outcomes. They embody the continuous quality improvement dynamic. In accordance with 42 CFR §438.330(d) each MCO is required to have at a minimum, one clinical and one nonclinical PIP in progress at all times." *Id.* at 28.
[19] *Id.* at 17.
[20] *Id.* at 31.
[21] *See* footnote 3.

transparency from DMMA. Councils may also want to recommend that DMMA should, at the very least, put on its website the results of the EQRO's assessments and findings for each MCO referred to above. Councils may wish to further comment that DMMA should also post any CAPs on its website for each MCO, so that members can see where there are problems and what steps are being taken to correct those problems, and so members can make informed decisions when choosing their MCO annually.

➔***Conclusion/Recommendations:*** the 2023 Quality Strategy is a roadmap to assess the quality of care and to select areas for improvement. The task is formidable, and the roadmap is detailed. There are important requirements and criteria in the quality strategy. Councils may wish to advocate for the above-mentioned recommendations to be included in the quality strategy, namely that DMMA should:

- more aggressively address areas where there is an insufficient provider network and require the MCO's to provide the required services.
- use both prongs of the Balanced Quality Model and require any MCO that is not in compliance to submit a Corrective Action Plan (CAP) to address the deficiencies.
- require the MCO's to provide claims denial data to DMMA, and that DMMA should track the claims denials to determine whether the MCO's are providing the required services.
- formulate a questionnaire that the MCO's should be required to use to contact individual members to gauge satisfaction with the services and quality of care.
- offer more transparency by putting on its website the results of the EQRO's assessments and findings for each MCO and any CAPs.

PROPOSED DSAMH REGULATIONS – CREDENTIALING MENTAL HEALTH SCREENERS AND PAYMENT FOR VOLUNTARY ADMISSIONS, 26 Del. Register of Regulations 1023 (June 1, 2023)

DSAMH is proposing to amend existing regulations published at 16 Del. Admin. C. § 6002, which governs the credentialing of mental health screeners. Delaware's civil commitment statute, codified at 16 Del. C. § 5000, et seq., requires credentialed mental health screeners to make the underlying determination authorizing the emergency detention of an individual with a mental health condition as part of the civil commitment process. The proposed amendments would strike all existing language and replace it with significantly streamlined and reorganized regulations. The proposed amendments would create a requirement for psychiatrists to register with DSAMH in order to act as a mental health screener; under the existing regulations no credentialing or registration is required for psychiatrists licensed to practice medicine in Delaware. Under the proposed amendments, the Division would then have discretion to deregister a psychiatrist for failure to comply with law, regulation or policy.

With respect to training of screeners, the proposed amendments simply state that to be eligible for credentialing an applicant must complete "the Division-required training," with no further description of what this training entails. The existing regulations are relatively detailed with respect to how many hours of training applicants of various types (depending on whether the applicant was a physician, or a licensed or unlicensed mental health professional) for both initial credentialing and renewal of a credential. The synopsis of the proposed regulations states that

the amendments "[r]emove[] burdensome and unnecessary regulatory requirements mandating the number of hours required for credentialing and renewal." While the previous regulations may have been wordy, it is not clear from the language of the proposed regulations how many hours of training will be required or whether training requirements would be at all different for applicants of various types. Given the nature of the interventions that a screener has the authority to order, it seems essential that screeners be thoroughly trained. **More specific rules and transparency about training for mental health screeners may be warranted.**

Notably the existing regulations contain a provision related to payment to hospitals for voluntary and involuntary admissions, which would require independent review of forms and documentation by a psychiatrist designated by the DHSS to approve state payment. Per the existing regulations, "[t]he review's specific purpose will be to confirm that: the admission represents the most appropriate and least restrictive treatment for the client in crisis; that the duration of stay for the admitted client is reviewed and deemed appropriate, and that the State is the payer of last resort." **This requirement is absent from the proposed amendments and no explanation is provided for why this language is removed.**

➔***Conclusion/recommendations****:* Councils should consider the following,

- Councils could encourage increased oversight of the psychiatrists performing screenings as provided for in the proposed amendments.
- The Councils may wish to question the relative vagueness of the proposed amendments about required training for mental health screeners and recommend that they be solidified.
- Councils may want to recommend that the language in the existing regulations about payment for treatment and related oversight be carried into the revised regulation.

II. PENDING LEGISLATION

SENATE BILL NO. 141 – PROPOSED AMENDMENT TO § 3702-3717, TITLE 24 OF THE DELAWARE CODE RELATING TO THE BOARD OF LANGUAGE PATHOLOGISTS, AUDIOLOGISTS, AND HEARING AID DISPENSERS

Senate Bill No. 141 proposes to amend §§ 3702-3717 of Title 24 of the Delaware Code, establishing updated, detailed standards for hearing aid dispensing. Of note, this amendment adds and defines "over-the-counter hearing aids." The bill defines this term as an aid that does not require implantation surgical intervention and is intended for use by those 18 and older with mild to moderate hearing impairment. Moreover, the definition includes that an over-the-counter hearing aid is available without a prescription, order, or other involvement of a licensed person; it can be made available to consumers through in-person transactions, by mail, or online, provided that the device satisfies certain other requirements. Prescription hearing aids are differentiated, in this bill, from over-the-counter hearing aids.

This bill follows the Federal Drug Administration ("FDA")'s 2022 approval of a rule allowing adults with mild to moderate hearing aids access to over the counter and without a prescription[22].

[22] *See*: https://www.fda.gov/news-events/press-announcements/fda-finalizes-historic-rule-enabling-access-over-counter-hearing-aids-millions-americans

Prescription hearing aids can cost upwards of $5,000; Medicare covers only diagnostic tests and not the aid itself. Eliminating exams and hearing aid fittings could reduce the cost of hearing aids by $2,800, increasing the accessibility and affordability of hearing aids to those in need; at the same time, increasing the availability of hearing aids will likely lead to a more competitive and innovative landscape for hearing aid design.[23]

This amendment makes significant additions as to what a hearing aid dispenser may and may not do; hearing aid dispensers are limited to performing non-diagnostic tests solely for the purpose of fitting prescription hearing aids on a client or to make necessary referrals to a medical professional. The amendment makes clear that hearing aid dispensers may not medically treat or diagnose a hearing aid user. Further, the amendment requires hearing aid dispensers to advise hearing aid users to consult with a licensed physician if any notable symptoms associated with hearing loss or other conditions are present and observed by the hearing aid dispenser. These amendments aim to remedy instances where hearing aid dispensers have practiced outside their permissible scope; wax removal and treating tinnitus are examples of impermissible practices by a hearing aid dispenser.[24] The amendment delineates when referral to a physician is required.

Practically, these amendments would help to ensure that individuals who may need the intervention of a medically trained professional receive proper care. Moreover, Delaware hearing aid dispensers frequently use medical diagnosis codes to receive payment from insurance carriers; doing this violates the diagnosis prohibition in the current law.[25] Receipt of a diagnosis from a physician would remedy this issue, as well. While this requirement could impose accessibility issues for individuals who use hearing aids due to high cost and making it to doctors' appointments, those with mild to moderate hearing problems will be able to purchase an over-the-counter hearing aids. Individuals with more significant hearing problems may require a diagnosis from a physician, and this amendment ensures that a hearing aid dispenser cannot provide such a diagnosis. Additionally, the amendment includes that a speech/language pathologist applicant must present a certificate of clinical competence issued by the American Speech-Language-Hearing Association (ASHA), as well as requirements for certification of audiologists and reciprocity standards.

➔***Conclusion/recommendation:*** Councils should consider supporting this amendment as it will expand access to and affordability of hearing aids for many Delawareans.

SENATE BILL NO. 153 – PROPOSED AMENDMENTS TO TITLES 12, 14, 16, AND 29 OF THE DELAWARE CODE RELATING TO BEHAVIORAL HEALTH

This bill's stated purpose is to make changes to code provisions related to behavioral health and DSAMH "to reflect current practices." The bill strikes various provisions that are no longer consistent with today's norms (e.g., provisions around involuntary and voluntary sterilization),

[23]Will Sullivan, *FDA Approves Over-the-Counter Hearing Aids*, SMITHSONIAN MAGAZINE, Aug. 18, 2022, https://www.smithsonianmag.com/smart-news/fda-approves-over-the-counter-hearing-aids-180980603/ (citing Matthew Parrone, Over-the-counter hearing aids expected this fall in US, Associated Press, Aug. 16, 2022, https://apnews.com/article/science-health-government-and-politics-9fba21c0cd4c417e14544e6966b5a298).
[24] *See* bill synopsis.
[25] *See* bill synopsis.

code sections concerning programs that no longer exist (e.g. Governor Bacon Health Center), or provisions that are both defunct and not consistent with today's norms (e.g., mental hygiene clinics that examined individuals who were (not DLP's language) "mentally retarded." **Removal of outdated and prejudicial language and procedures is consistent with Councils' missions, and Councils should consider generally supporting this legislation.**

However, there are several provisions Councils may wish to make specific note of:

- One section of Title 16 being removed is a requirement that each DHSS institution and agency prepare a public report annually (current § 5109). Some specific divisions within DHSS do prepare annual reports, e.g. Health Facilities (16 Del.C. § 9220), Personal Attendant Services (16 Del.C. § 9404), Public Health (16 Del.C. § 2003) and others. DHSS, the department broadly, is required to make annual reports available to the General Assembly and the public, and this provision (29 Del.C. § 7926) is unaffected by this bill. **Councils may wish to encourage the General Assembly to add a provision to this bill requiring all DHSS Divisions and institutions to complete annual public reports specific to their divisions/institutions, if they are not already otherwise required by law to make such reports publicly available.**

- This bill removes all provisions of Title 16, chapter 53, relating to the Governor Bacon Health Center, presumably due to the facility's closure. However, review of these provisions raised a concern that provisions around Delaware Hospital of the Chronically Ill (DHCI) may need updating. Notably, clear clinical admission criteria to DHCI, and appeals procedures, are absent from both statute and regulations[26]. **Councils may want to advocate now, or in the future, that the General Assembly give DHSS the responsibility to develop clinical admission criteria/procedures as well as appeals procedures, subject to public notice and comment.**

- Finally, the bill removes from Title 29 section 7921 provisions concerning "the Governor's Council on Health and Social Services", which appears to no longer exist: https://governor.delaware.gov/boards-commissions/. DHSS may be too large for such a Council. Some DHSS divisions have instead developed their own advisory councils, e.g. the Division of Developmental Disabilities Services[27]. **Councils may wish to advocate for advisory councils for any specific divisions or programs that do not have one, which Councils believe would benefit from such councils.**

➔***Conclusion/recommendations:*** Councils should support this legislation as it removes procedures that are harmful to people with disabilities. However, councils may wish to:

- encourage the general assembly to add a provision to this bill requiring all DHSS Divisions and institutions to complete annual public reports as well, if they are not already otherwise required by law to make such reports publicly available.

[26] 31 Del. C. § 2822 has very broad eligibility requirements that focuses on financial eligibility and §2823 excludes individuals with "a mental condition" and permits discharge if a patient "becomes incorrigible," which may have discriminatory impact.

[27] https://dhss.delaware.gov/dhss/ddds/dac.html; 29 Del. C. § 7910.

- advocate now or in the future, that the General Assembly give DHSS the authority and responsibility to develop clinical admission criteria/procedures as well as appeals procedures, subject to public notice and comment.

SENATE BILL 150, SENATE BILL 151, SENATE BILL 152 – ACTS RELATED TO THE LONG-TERM CARE & MEMORY CARE TASK FORCE

In recent years, Delaware has experienced a demographic shift with the overall population trending older.[28] With this demographic trend comes an increased need for adequate staffing in long term care facilities, particularly for those in need of memory care services. [29] Concerningly, as the average age of Delawareans trend older and the demand for healthcare workers increase, Delaware is concurrently experiencing a workforce shortage, with fewer Delawareans falling into the primary working age. Healthcare work has trended older as well, with the average age of healthcare workers increasing.[30] This trend demonstrates that fewer people are entering the profession, and the average age of healthcare workers is likely to continue to increase.

In response to these concerns, Senator Spiros Mantzavinos introduced Senate Bills 150, 151, and 152 to regulate conduct in both skilled nursing facilities (SNFs) and assisted living facilities (ALFs) that offer memory care services. The bills were drafted in accordance with recommendations made by the Long-Term Care and Memory Care Task Force ("Task Force") created pursuant to House Concurrent Resolution 110. The Task Force was established to "investigate the state's existing policies regarding long-term care facilities, and to develop recommendations to guide future policies and actions to create a robust and well-regulated long-term care system that is able to meet the needs of its residents and promote resident welfare."[31]

The Task Force specifically identified staffing in ALFs as an area of concern. SNFs are largely funded by residents paying through Medicaid and are thus governed by federal regulations, which include requirements for specific nursing staffing ratios.[32] ALFs however often choose not to participate in Medicaid due to low Medicaid reimbursement rates, and in Delaware are instead subject to the regulations of the Delaware Division of Healthcare Quality (DHCQ).[33] As of this writing, DHCQ regulations include no quantifiable staffing ratio requirement, and instead only require staffing to be "sufficient in number and adequately trained," with no further guidance.[34] In addition to staffing, the Task Force identified shortfalls in disclosure and advertising, initial placement and assessment, and orientation and ongoing communication.[35] The following is an

[28] 1 in 5 Delawareans are 65 or older. It is expected to reach 1 in 4 by 2050. *See* Long-Term Care & Memory Care Task Force Final Report (hereinafter "Task Force Final Report"), 4.
[29] "Inadequate staffing levels tend to limit the scope of care delivery to risk management, thus posing a barrier to the delivery of person-centered care." *See* Seetharaman K, Chaudhury H, Kary M, Stewart J, Lindsay B, Hudson M. Best Practices in Dementia Care: A Review of the Grey Literature on Guidelines for Staffing and Physical Environment in Long-Term Care.
[30] only 8.1 % of Delaware LNs are ages of 21-20, while 21 percent are 60 or older. *See* Task Force Final Report, 19.
[31] *Id.* at 1.
[32] *Id.* at 9.
[33] *Id.* at 12.
[34] *Id.* at 16.
[35] *Id.* at 21.

analysis to what extent the proposed legislation comports with Task Force recommendations, and which sections Councils may wish to endorse, or not endorse.

SB 150 - AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO DEMENTIA CARE SERVICES IN LONG-TERM CARE FACILITIES.

The purpose of SB 150 is to "define dementia services and activity services" and to "require that all long-term care facilities that offer dementia care services have sufficient staff to meet the needs of each resident." While SB 150 applies to both SNFs and ALFs, SNFs already have codified staffing ratio requirements for nursing services direct caregivers under 16 Del. C. § 1162, while ALFs do not. ALF staffing ratios in facilities offering memory care services would instead be governed under SB 150's provisions, which fail to quantitatively indicate what constitutes "sufficient staff," and gives no guidance into who will be determining what constitutes sufficient staff. In practice, this means that it will likely be the ALFs themselves making these determinations. In light of recent incidents of long-term care facilities failing to comport with existing regulations,[36] elder abuse and neglect,[37] and the fact that long-term care facilities were the state's largest source of COVID deaths in 2020,[38] it is concerning that this bill will essentially allow ALFs to self-regulate. Instead, **Councils should recommend that the State implement the same quantifiable staffing ratios to ALFs for nursing services direct caregivers that are found in 16 Del. C. § 1162 for SNFs.**[39] While the majority of states use similarly vague language and only require staffing in ALFs offering memory care services be "sufficient," experts in long-term care have opined that the ideal ratio for memory care services is five residents to one care staff member.[40] Delaware has an opportunity to become the industry leader by codifying staffing ratios in SNFs and ALFs offering memory care services. Considering our aging population, it is paramount that Delaware is at the forefront of elder care.

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[36] In 2019 Newark Manor nursing home was said to have "persistently failed to provide adequate nursing care including supervision to vulnerable residents of Newark Manor, causing falls, fractures, and other significant injuries" according to a spokesperson for Delaware Attorney General Kathy Jennings. Josh Shannon, *AG: Newark Manor Nursing Home provided 'substandard and worthless care' to residents*, Nov 8, 20019, Newark Post, https://www.newarkpostonline.com/news/ag-newark-manor-nursing-home-provided-substandard-and-worthless-care-to-residents/article_7c8ba5c4-b032-5e9e-9b2e-1ea58b02f79b.html.

[37] *Id.*

[38] Long-term care facilities accounted for 62.3 percent of Delaware covid deaths in 2020. Cris Barrish, Coronavirus-related deaths at Delaware long-term care facilities stubbornly high, July 29, 2020, WHYY, https://whyy.org/articles/covid-19-related-deaths-at-delaware-long-term-care-facilities-stubbornly-high/.

[39]

Day	1:20	1:9
Evening	1:25	1:10
Night	1:40	1:22

[40] Lisa Esposito, *What Nursing Home 'Memory Care' Means*, June 1, 2016, U.S. News, https://health.usnews.com/health-news/patient-advice/articles/2016-06-01/what-nursing-home-memory-care-means

Additionally, Councils should consider advocating that Title 16, Chapter 11's requirement of direct caregivers at a minimum being certified nursing assistants (CNAs), be carried into ALFs. As it stands, ALFs are not required to staff CNAs as direct care staff. Finally, the bill would institute training requirements for all staff working with residents with dementia. SB 150's training requirements falls somewhere in the median amongst states, in both hours of training required and the specificity of such training.[41]

➔***Conclusion/recommendation:*** to support, Councils should consider advocating for quantifiable staffing requirements in ALFs and requirements that direct care staff in ALFs are at least CNAs.

SB 151 - AN ACT TO AMEND TITLE 6 OF THE DELAWARE CODE RELATING TO MANDATORY DISCLOSURE OF INFORMATION IN LONG-TERM CARE FACILITIES OFFERING DEMENTIA CARE SERVICES.

SB 151 would institute requirements that long term care facilities (SNFs and ALFs) promoting or advertising the provision of healthcare services to individuals with dementia complete a written notice form prepared by the DHSS. The Task Force noted that each facility uses their own forms and contracts that are needlessly long, filled with legalize, and incomprehensible to many. In response, they recommended all facilities institute a uniform form. Second, SB 151's section on notice is detailed and includes requirements to disclose facility policies and procedures on subjects such as the pre-admission process, the placement process, the staffing plan, resident activities offered, and physical features of the facility. Subsection (d) promulgates requirements that written notice be disseminated to each facility resident and their agent.

The Task Force recommended requiring long-term care facilities offering memory care services to provide an initial orientation program for both the resident and their family.[42] It was recommended that such a program include tours of the facility, information on resident rights and responsibilities—including right to make decisions about their care—the right to privacy and confidentiality, and the right to be free from abuse or neglect.[43] It appears that these recommendations were taken into consideration, but were altered and inserted into SB 151's written notice section. While requiring disclosure of such information is a net positive, we are concerned that families and particularly residents may not fully comprehend the information they are being provided with, as older residents often face challenges related to literacy[44] and vision.[45]

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[41] 55 Pa. Code § § 2800.69 only requires administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers to undergo at least 4 hours of dementia-specific training, and at least 2 hours of additional dementia-specific training annually. The law does not specify the content required to be in the training. California requirements under Cal. Code Regs. tit. 22 § 87706, require direct care staff to undergo eight hours of in-service training per year, and similarly to PA, does not specify on what the training will consist of. N.J.A.C. 8:37 on the other hand requires all staff employed at facility who have regular direct conduct with clients to undergo a five-day course, administered by an RN, with three entire days dedicated to dementia specific training.

[42] Task Force Final Report, 23

[43] *Id.*

[44] According to a study conducted by the National Center for Educational Statistics, 39 to 47 percent of older adults score in the lowest level of literacy, with such individuals having the hardest time comprehending documents. https://nces.ed.gov/pubs97/97576.pdf.

[45] According to the National Center for Biotechnology Information, 47.4% of Delawareans in nursing homes have moderate to severe vision impairment, and 16.2% are blind.

In person family and resident orientations would provide a clearer line of communication and more certainty that facility policy has been adequately communicated. **Councils may wish to restate the recommendation that individuals who are admitted to SNFs and ALFs for non-emergency reasons have the opportunity to receive an orientation prior to admission.**

In recognition of the reality that individuals are often admitted to SNFs and ALFs for emergency care reasons, Councils could support waiver of these requirement in such circumstances, and instead recommend that both SNFs and ALFs be required to conduct orientations as soon as reasonably possible after an emergency admission, no later than 30 days. Finally, **Councils could support an "out" in the contract forms that would allow the resident or family members after orientation to not stay in the facility if they feel that it is not a good fit.**

➔***Conclusion/Summary:*** Councils may wish to:

- restate the Task Force's recommendation that individuals who are admitted to SNFs and ALFs for non-emergency reasons have the opportunity to receive an orientation prior to admission, and advocate for its inclusion in this legislation, and for those admitted on an emergency basis, within 30 days of admission;
- Recommend an "out" in the contract forms that would allow the resident or family members after orientation to not stay in the facility if they feel that it is not a good fit.

SB 152 - AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO THE RIGHTS OF LONG-TERM CARE FACILITY RESIDENTS.

SB 152's purpose is expanding the rights of long-term care residents by ensuring they receive care that recognizes their cultural differences, and that residents are made aware of their rights in a language and format that is accessible. The bill changes existing language requiring that residents be fully informed in a language in which they understand to one in which they are fluent.[46] This change is of concern, as it implies that the onus is on the resident to understand the information provided, so long as it is accessible and in a language that they are fluent in.

➔***Conclusion/recommendation:*** **Councils should consider recommending that the legislation place an emphasis on resident comprehension and understanding rather than fluency.** This would require inclusion of modalities such as videos with ASL and captioning, options for in person meetings with social workers for residents who are better served by in person communication, audio records, large print, braille, and other modalities as needed.

HB 204 - AN ACT TO AMEND TITLES 16 AND 29 OF THE DELAWARE CODE RELATING TO TEMPORARY STAFFING AGENCIES SERVING LONG-TERM CARE FACILITIES (NOTE: HB 199 WAS STRICKEN).

[46] Senate Bill No. 152, § 1121. Resident's rights. (26) Each resident ~~shall~~ must be fully informed, in plain language and in a language in which the resident ~~can understand~~ is fluent, of the resident's rights and all rules and regulations governing resident conduct and the resident's responsibilities during the stay at the facility. This must be provided in a format that is accessible to the patient and any authorized representative.

In recent years, largely because of the Covid-19 pandemic, long-term care facilities have increasingly relied on temporary staffing agencies to fill vacancies in direct care work.[47] As previously stated, Delaware's aging population has led to an increased demand in healthcare services while the state is concurrently experiencing a decrease in the available workforce. Because of these factors, this trend is expected to continue. Unfortunately, reliance on temporary staffing agencies in long-term care facilities has created various complications, particularly for patients that require memory and dementia care services. The Task Force voiced concerns that temporary staff lack understanding of facility policies and personal relationships with the residents.[48] Additionally, temporary staff provided by an agency is significantly more expensive than those employed directly by the facility.[49]

In response, House Bill 199 was introduced to amend titles 16 and 29 of the Delaware Code relating to temporary nurse staffing agencies serving long-term care facilities. Later, on June 6, 2023, HB 204 was introduced to replace HB 199. HB 204 would grant DHSS authority to regulate temporary staffing agencies in long term care facilities and establishes a maximum rate that they may charge long term care facilities for their services.[50] HB 204 does not specify the basis for calculating the maximum rate or what the maximum rate would be.

Presently, temporary staffing agencies are only required to maintain a business license.[51] Pursuant to HB 204, they will be required to register with the DHSS and renew their registration annually.[52] However, it is unsaid whether registration will require temporary staffing agencies to comply with any sort of guidelines, or if there is anything a temporary staffing agency could do that would cause the DHSS to deny registration. HB 204 additionally requires employees assigned by staffing agencies to long-term care facilities to meet federal and state qualification requirements. **While this requirement is beneficial to individuals with disabilities, significant concerns exist regarding maintaining the prevalence of temporary staff at facilities that offer memory care services, as individuals with dementia greatly benefit from the consistency of staff that temporary direct care workers cannot offer.**[53]

The final provision of HB 204 requires temporary staffing agencies to provide an annual report to the DHSS, which must include details such as total employment numbers, amounts charged to facilities per quarter, wages paid per employee, and documentation providing that employees are

[47] "In January 2022, the median hospital temporary staff accounted for 40% of labor-related expenses compared to 5% in January 2019." *See* Task Force Final Report, 21.
[48] *Id.*
[49] According to the American Hospital Association, in January 2022, temporary staff accounted for 40% of labor expenses at the median hospital. *Id.*
[50] Proposed § 1119C(a)
[51] Long-Term Care & Memory Care Task Force Final, 21.
[52] Proposed § 1119D(a).
[53] "Consistent staff assignments help to promote the quality of the relationships between staff and residents." *See* Dementia Care Practice Recommendations for Assisted Living Facilities, Alzheimer's Association Campaign for Quality Residential Care. "Consistent assignment of direct care staff to residents is necessary to understanding residents' preferences and needs, building trust and relationships, and thereby, ensuring the continuity of care." *See* Seetharaman K, Chaudhury H, Kary M, Stewart J, Lindsay B, Hudson M. Best Practices in Dementia Care: A Review of the Grey Literature on Guidelines for Staffing and Physical Environment in Long-Term Care.

adequately trained and appropriate background checks have been conducted.[54] **Councils should support the requirement that rigorous standards of documentation be implemented.**

Additionally, the staffing concerns addressed by this section are concerning, as well as SBs 150, 151, and 152. **These concerns could be ameliorated by simply putting a pause on the issuance of licenses to new ALFs.** Currently, new facilities are opening while existing facilities still have vacancies. With the existing staffing shortage, an already limited pool of direct care staff is being stretched even thinner. By putting a pause on the issuance of licenses to ALFs until staffing issues are addressed, Delaware could better assure that staffing in ALFs is both qualified and present in sufficient numbers.

➔***Conclusions/recommendations:***

- Councils may wish to support HB 204's proposal that DHSS be granted oversight over temporary staffing agencies but have concerns regarding the prevalence of temporary staff in long term care facilities, particularly for patients requiring memory care services.
- Councils should consider recommending legislation that codifies restrictions on the amount of temporary staff that long-term care facilities may employ, and clearer guidance on the conditions that must be met for temporary staffing agencies to register.
- Councils may wish to encourage DHSS to pause on the issuance of licenses to new ALFs based on existing staff shortages.

HS1 FOR HB 160 – 988 BEHAVIORAL HEALTH CRISIS INTERVENTION SERVICES

HS 1 for HB 160 seeks to create a framework for the administration and funding of the 988 behavioral health crisis line. HB 160 was introduced on May 16, 2023; its substitute was introduced on June 6, 2023 and reported out of the House Health & Human Development Committee on June 7, 2023.

The establishment of 988 as a universal behavioral health crisis number was required by the National Suicide Hotline Designation Act of 2020. While all states were required to implement 988 as of July 16, 2022, only a limited number states have passed related legislation. As of June 14, 2023, fourteen states had passed some form of 988 legislation, with only six having provided for funding through a telecommunications fee as is proposed in HS 1 for HB 160.[55]

HS1 for HB 160 establishes that the Division of Substance Abuse and Mental Health (DSAMH) and the Department of Services for Children, Youth & Their Families (DSCYF) "shall administer the provision of crisis intervention services" in Delaware, which is consistent with current practice and operation. The bill would also require the creation of a Behavioral Health Crisis Intervention Services Board, whose responsibilities would include the development of a "comprehensive statewide crisis services plan," issuing a report every 3 years on the provision of crisis intervention services, and making recommendations related to the budgetary requirements for ongoing administration of crisis intervention services. The membership of the Board would largely consist of state officials and directors of various agencies, in addition to three governor-

[54] Proposed § 1119D(d).
[55] *See* National Alliance on Mental Illness (NAMI), "988 Crisis Response State Legislation Map," available at https://reimaginecrisis.org/map/ (hereinafter 988 Legislation Map).

appointed members (one certified peer recovery specialist, one licensed behavioral health practitioner who provides crisis intervention services, and one representative of a behavioral health treatment program providing crisis intervention services).

The bill also mandates creation of a Behavioral Health Crisis Intervention Fund, to support the operation and maintenance of 988 as well as related crisis intervention services. The primary source of money for the fund would be a monthly surcharge (generally $.60) imposed by telecommunications providers on all service subscribers. Sellers of prepaid wireless service would also be required to impose a surcharge on individual purchases, subject to the terms and limitations further described in the bill. It is worth noting that consumers of "nontraditional communication services" (which are not defined) would also be subject to the fee if the provider is required to or opts to provide 988 service; this begs the question of whether all services utilized by people with disabilities would have access to 988.

The bill further requires the Behavioral Health Crisis Intervention Services Board to develop and recommend a plan for the "establishing, operating and maintaining a behavioral health crisis communications center." The plan must be submitted to the Governor and state legislature within 12 months of enactment of the legislation. This section of the bill outlines specific recommendations that the plan must include as well as capabilities that the technology used by the behavioral health crisis communications center must have.

While the Councils should otherwise support the expansion of dedicated funding for behavioral health crisis services, there are a number of concerns worth noting about this bill. First, there is little to no mention of how the State will ensure that 988 and behavioral health crisis services are accessible and meaningfully available to people with disabilities. While the capability for text and chat were required as part of 988 implementation and are referenced in the bill, there is no specific mention of integrating other technologies that hearing-impaired individuals may use to communicate such as TTY or video relay. Additionally, existing behavioral health crisis response services are often ineffective or not meaningfully available to people with have co-occurring disabilities, such as intellectual or developmental disabilities. There is no discussion in the bill of how to ensure that mobile crisis teams or other crisis intervention services have adequate training and resources to respond to people with these disabilities who are experiencing a mental health crisis. While there may be further elaboration on these issues in policies to be developed by DSAMH or DSCYF or potentially the comprehensive plan developed by the Board, there are no specific mentions of accessibility or disabilities in the bill, which is concerning. **The Councils should consider suggesting the bill be amended to add a specific commitment to make behavioral health crisis assistance accessible to people with disabilities, and that this be added to the list of recommendations the Board be required to make for the behavioral health crisis communications center.**

Second, this bill does not really discuss safeguards for the safety and confidentiality of callers or how the operation of 988 would interact with law enforcement response and potentially involuntary treatment. The preamble to the bill recognizes that "a 2023 Pew study showed that 2 in 5 adults expressed concern that calling for help for a behavioral health crisis might result in law enforcement involvement, being forced to go to a hospital, being charged for services they could not afford, or other people finding out that they called," yet the bill does not otherwise

address these specific concerns. While these issues may be further addressed in the policies and plans developed in accordance with the provisions of the bill, it is concerning that they are not specifically required. The bill also does not directly address privacy concerns such as the confidentiality of calls or how geolocation might be used to track individual callers.[56] Recent data from Delaware indicates that a relatively small number of calls to 988 resulted in activation of 911/police/EMS services, although this may not capture when calls transferred to one of the state-operated mobile crisis hotlines ultimately result in police or 911 response.[57] It remains crucial, however, to ensure that ongoing planning for the implementation of 988 and any expansion of behavioral health crisis services includes a commitment to minimizing police involvement and is focused on providing a response that the individual in crisis is comfortable with, and consents to whenever possible. **Councils should recommend that the Board be required to track data related to law enforcement response, involuntary hospitalizations, or civil commitments resulting from 988 calls, and to consider how to best safeguard privacy.**

Further, the Board itself contains minimal representation of people with lived experience of mental illness who would be in the position of utilizing 988 or crisis intervention services, or potentially having a third party attempting such access on their behalf. **The Councils should encourage increased representation of people with lived experience with mental illness and/or substance use disorders as well as adding the protection and advocacy system to the list of organizations whose participation on the Board is required.** Finally, the bill does not address how 988 and related crisis intervention services will interact with health insurance. Some states have included specific provisions in passed or pending legislation that address insurance coverage or waiver of prior authorization requirements for crisis response and related services.[58] **The Councils may wish to suggest that this be specifically addressed in the legislation.**

➔***Conclusion/recommendations:*** Councils' support of this bill is consistent with the goal of getting individuals experiencing crisis the services they need. However, Councils may wish to advocate for the following amendments to the bill, or via future legislation:

- add a specific commitment to make behavioral health crisis assistance accessible to people with disabilities, and that the Board be required to make recommendations for the behavioral health crisis communications center to that end.
- that the Board be required to track data related to law enforcement response and involuntary hospitalizations or civil commitments resulting from calls to 988, and to consider how to best safeguard privacy.
- encourage increasing the representation of people with lived experience with mental illness and/or substance use disorders as well as adding the protection and advocacy system to the list of organizations whose participation on the Board is required.
- Adding how 988 interfaces with insurance in the legislation.

HB 167: AN ACT TO AMEND TITLE 14 OF THE DELAWARE CODE RELATING TO SCHOOL RESOURCE OFFICER FUNDING.[59]

[56] While it references that this global positioning technology would be used to track mobile crisis teams.
[57] *See* DSAMH 988 Spring E-Newsletter, available at https://dhss.delaware.gov/dhss/files/april2023enewsletter.pdf (indicating that 17 of 980+ calls resulted in activation of 911 response during the first quarter of 2023)
[58] *See* 988 Legislation Map.
[59] https://legis.delaware.gov/BillDetail?legislationId=140420.

House Bill 167 ("HB 167") seeks to amend Chapter 17, Title 14 of the Delaware Code relating to state appropriation for public education by adding § 1716H, which would add a new school resource officer ("SRO") unit for the employment of SROs.[60] HB 167 does the following:

1. Establishes SRO units to fund school resource officers in all Delaware public schools;
2. Funds one SRO in each school in every district and charter school;
3. Funds an additional SRO for schools with over 1,000 students, including a fractional unit for the percentage of students above 1,000 that are insufficient to meet the threshold for an additional unit; and
4. Allows a school district to refuse the funding.

The bill was assigned to the House Education Committee which met on May 7, 2023.[61] Despite strong objections from Representative Morrison and an indication from the bill's sponsor that HB 167 would be amended, it was voted out of committee. Rep. Shupe, HB 167's sponsor, indicated that the purpose of the bill was to reduce the burden on local school districts and charter schools (collectively, "LEAs") for funding SROs – instead, HB 167 would allow those LEAs to use the local funds currently paying for SROs for other services for students. Other concerning alternatives were discussed at committee meeting.[62]

Funding for the SRO units would be shared between state and local funds with the state paying a maximum of 70% of the annual salary rate and other employment costs. The remaining 30% would be paid with local funds. This bill would generate approximately 239 full-time SRO units with an average personnel cost to the state of $111,465 and $40,766 from local funds for each unit. This does not include the annual per unit equipment and maintenance cost of approximately $25,000 or one-time vehicle and equipment costs per unit of $110,000.[63] To implement this bill, the total cost is approximately $69 million in FY 2024,[64] $45 million in FY 2025, and $46 million in FY 2026. Because this year's budget is tight and Joint Finance Committee is already over, HB 167 will likely not get out of appropriations this year with the 70/30 split; however, it may move forward next year. Rep. Shupe shared that he spoke with Governor Carney, and he supports the bill but would not include in the recommended budget.

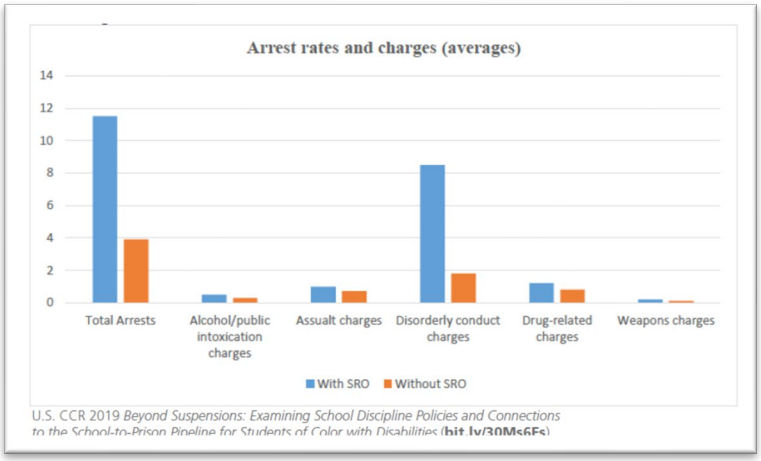
For the reasons discussed below, **Councils may wish to oppose, in its entirety, this bill and any effort to expand the use of police in schools.** Of concern, according to a 2022 opinion

[60] Sponsors: Reps. Shupe & K. Williams and Sens. Lawson & Walsh; co-sponsors: Reps. Bush, Collins, Gray, Parker Selby, Ramone, Michael Smith, & Yearick and Sens. Buckson, Hocker, Pettyjohn, & Wilson.
[61] https://legis.delaware.gov/MeetingNotice/33114.
[62] Rep. Shupe stated during the committee meeting that he would be amending HB 167 to include constables. Rep. Shupe stated that substituting constables for SROs would reduce the fiscal note from $44 million to $19 million. Rep. K. Williams then questioned why the funding provided by the state could not be at the level of funding needed for constables, with the LEAs making up the difference. She noted that this would lower the fiscal note attached; however, Rep. Shupe expressed concerns with this approach and that it may lead to LEAs choosing between constables or SROs. According to the fiscal note attached to the bill, the September 2022 unit count showed that Delaware had approximately 195 schools with less than 1,000 students, 25 schools with 1,000-1,999 students, 4 schools with 2,000-2,999 students, and 1 school with more than 3,000 students.
[63] Equipment and maintenance costs are assumed to be fully funded through state funds.
[64] Includes state one-time cost of approximately $26 million.

piece in the Hechinger Report,[65] "[r]esearch has shown that policing in schools disproportionally affects children of color, LGBTQ+ youth and students with disabilities. Black and Latinx students, who are already overrepresented among students suspended and expelled, make up more than 70 percent of all students referred to law enforcement. While LGBTQ+ youth comprise only 6 percent of the total youth population, they represent about 15 percent of the young people in juvenile detention. In some states, students with disabilities were arrested nearly three times as frequently as their peers."

This is consistent with the data collected in the 2017-18 Civil Rights Data Collection ("CRDC") which found that Delaware was not only among the top 10 in referrals to law enforcement but was the **first** in the nation for disproportionately suspending minority students and students with disabilities.[66] Delaware's own data reporting (the School Discipline Improvement Program Statewide Summary Report) mirrors the CRDC data in showing that students of color and students with disabilities are suspended or otherwise subject to discipline at much higher rates than their white and non-disabled peers.[67]

One of the concerning aspects of these numbers is that one of the most common reasons for school-based arrests of students is for disorderly conduct.[68] This infraction is so broad and subjective which has historically led to it being disproportionately imposed upon students of color. In referring these students to law enforcement or otherwise imposing school-based discipline, schools are criminalizing normal youth disruptive behavior. These subjective discipline policies, which divert students away from school-based discipline and toward law enforcement, are major contributors to the school-to-prison pipeline. Moreover, despite a decrease in crime generally, arrest rates at schools with SROs are 3.5 times the rate of arrests at schools without SROs – and in some states the rate is as high as 8 times.[69]



U.S. CCR 2019 *Beyond Suspensions: Examining School Discipline Policies and Connections to the School-to-Prison Pipeline for Students of Color with Disabilities* (**bit.ly/30Ms6Fs**)

[65] https://hechingerreport.org/opinion-more-police-in-schools-are-not-the-answer-its-up-to-educators-to-make-schools-safe/.
[66] https://ocrdata.ed.gov/estimations/2017-2018.
[67] https://education.delaware.gov/wp-content/uploads/2021/11/20.21_discipline_improvement_report.pdf. *See also* https://data.delaware.gov/Education/Student-Discipline/yr4w-jdi4.
[68] https://www.usccr.gov/files/pubs/2019/07-23-Beyond-Suspensions.pdf.
[69] https://www.aclu.org/report/cops-and-no-counselors.

Table pulled from the Education Civil Rights Alliance and American Federation of Teachers' report *Police in Schools: A Background Paper.*[70]

Instead, state funding could and should be used for strategies that actually decrease discipline infractions in school or may otherwise lead to an increase in academic gains for students. These strategies could include:

1. funding for at least one social worker at each school, to increase the number of student wellness centers, to expand facilities or otherwise increase staffing to reduce teacher-to-student ratios;
2. removing subjective discipline from the Delaware code and regulations (including infractions such as disorderly conduct, disrupting the educational process, disrespect to staff or student);
3. requiring restorative justice and positive behavior intervention supports to be used at each LEA;
4. removing SROs from elementary and middle schools;
5. developing specific guidelines for when it is appropriate to involve an SRO in a disciplinary issue on school grounds.

➔***Conclusion/recommendation:*** Because of the disastrous impact that SROs have on the school climate and environment, especially with respect to those students of color and students with disabilities, Councils may wish to oppose HB 167 in its entirety.

HB 188: AN ACT TO AMEND TITLE 14 OF THE DELAWARE CODE RELATING TO THE PUBLIC EDUCATION EQUITY OMBUDSPERSON PROGRAM AND THE EDUCATION EQUITY COUNCIL

This bill codifies portions of the Equity Ombudsman program, established as a result of a settlement order in the school funding lawsuit, currently operating as the Delaware Public Education Ombudsperson Program through the Parent Information Center of Delaware.[71] This program provides students and families with advocates to assist them when encountering inequity within the school system, such as disparate discipline and denial of educational opportunities. This bill also establishes an Educational Equity Council, for the purpose of providing input and oversight to the Education Ombudsman Program and to "study and recommend solutions to ongoing or systemic equity."

Education equity advocacy is sorely needed in Delaware. According to Delaware's Every Student Succeeds Act ("ESSA") Plan[72], 64% of low income students, 85% of English language learners and 86% of students with disabilities did not meet the state standards in grades three through eight for English Language Arts established by the state; similarly 74% of low income students, 81% of English language learners and 89% of students with disabilities did not meet the state's math standards in those grades. Statistics based on race and ethnicity are similarly concerning - data compiled by Propublica shows significant racial disparities in our state's education: Black students are 3.5 times as likely to be suspended than white students and

[70] https://edrights.org/wp-content/uploads/2020/08/PoliceInSchools-by-ECRA-and-AFT.pdf.
[71] *See* bill synopsis *and* https://picofdel.org/public-education-ombudsperson-program-dpeop/
[72] *Available at* https://education.delaware.gov/community/funding-contracts/federal-and-state-programs/essa/.

Hispanic 1.5 times as likely as White students, whereas white students are 2.1 times more likely to be enrolled in at least one or more AP class and 2.5 times more likely than Hispanic students.[73] In Delaware, where 31% of our students are Black and 46% are white, 57% of our out-of-school suspensions are for Black students, compared to 24% for White Students; expulsion rates are similar (56% vs. 30%).[74] In at least one Delaware district discipline rates were reported as 5.1times higher for Black students, compared to white students, coupled with an achievement gap of as much as 2.8 grades (Brandywine School District).[75]

This bill would continue a program intended to combat those disparities. That said, there are some problems with the bill. Terminology is not consistent – in some places the program is called the Equity Ombudsman program and in others the Education Equity Ombudsperson Program. **This inconsistent terminology should be corrected.** With this bill, the Education Equity Council (EEC) would have a minimum of 17 voting members and 9 non-voting members, which may be unworkably large and difficult to maintain. The EEC responsibilities may overlap some with the GACEC, specifically relating to making recommendations to the legislature and Department of Education to improve equity in public education, and also requesting data from the Department of Education. **Councils may wish to advocate that one of the voting member seats be reserved for a member of the GACEC, to ensure that the GACEC and ECC are not duplicating effort. At the very least, GACEC may wish to participate with the ECC or otherwise collaborate in some fashion.**

The last concerns we will note here are two differences between the Equity Ombudsperson's capacity under the settlement order and the capacity it would have pursuant to the proposed legislation. First, unlike the settlement order, the legislation would most likely not enable the Ombudsperson non-lawyer employees to represent students at hearings. Second, that while the bill allows the Equity Ombudsman to refer matters for legal services organizations or pro bono programs where that is important for protecting a student's rights, the bill would disallow program funds from being used to pay for litigation or other proceedings asserted against the State or its agencies, employees or officials, otherwise than in appeals on the record from administrative proceedings. What this could mean in practice is that legal services could only assist after a student's issue already goes to an administrative hearing, such as a due process hearing, severely limiting what such legal services can do because they could not ensure the facts and evidence necessary for successful resolution of the students' case are part of the record. Indeed, this provision even prohibits funds from being used so that the non-attorney advocates can consult with attorneys, to make sure they are preserving students' legal rights, making the proper claims, and effectively advocating for student through proceedings the non-attorney advocates are bringing on behalf of students. In other words, the non-attorney advocates cannot benefit from the counsel of attorneys, nor can the students directly be represented at hearings, significantly restricting the students' ability to achieve education equity, the very goal of this program. **Councils may wish to advocate for these restrictions to be removed through an amendment to the pending legislation or through future legislation.**

[73] https://projects.propublica.org/miseducation/state/DE
[74] *Id.*
[75] *Id.*

➔***Conclusion/recommendation:*** Because the settlement of the lawsuit did not result in the education ombudsperson program being established for an extended duration, notwithstanding the above flaws, Councils should not oppose this bill as the legislation would ensure the continued existence of the education ombudsperson program, without interruption. Considering the significant educational inequity Delaware students presently encounter, it is important for Delaware students, and consistent with Councils' missions, to safeguard Delaware students with disabilities' access to advocates who can help ensure they receive education equity now and in the future. The above noted concerns can be fixed by an amendment to the pending legislation or by future legislation.

HB 175- ACCESSIBLE PARKING

HB 175 amends Titles 21 and 9 to do the following:

- incorporates federal standards for accessible parking spaces found in the Americans with Disabilities Act and applicable regulations
- adds a requirement for a van only space in large parking lots
- increases the penalty associated with violating the statute that prohibits individuals who do not possess a parking placard or special license plate from parking in accessible parking spaces, or in the access aisles located next to accessible parking spaces.
- adds provisions in Titles 9 and 22 to require county and municipal governments to adopt regulations and ordinances incorporating these requirements for accessible parking spaces, including the requirement that local governments require property owners to have a permit and to develop a process to ensure compliance for new or modified accessible parking spaces, in order to increase compliance and uniformity statewide.

People with disabilities find that many locations have non-compliant accessible parking. This may include not having any spots at all, spots in the wrong places or in insufficient numbers or types, or that are not properly marked by signage and paint. In addition, people are often frustrated by poor enforcement of existing parking laws limiting access to these spaces to people with appropriately issued placards and tags. One reason sometimes given by law enforcement for refusing to enforce parking rules for accessible spaces is that they spaces do not comply with legal standards.

Another frustration is that ADA enforcement requires filing a federal complaint or lawsuit, and that many times the United States Department of Justice will reject parking complaints because of their capacity, and their priorities. This leaves individuals with almost no recourse, either against the violator who parks illegally, or the business or other location that has not provided parking consistent with either ADA standards or local building codes.

HB 175 attempts to address these concerns in a number of ways. First, it amends 21 Del Code §4183 to define an "accessible parking space". It then greatly simplifies §4183's parking violation section by making it illegal for any vehicle "other than a vehicle being used by a person with a disability" to park in an accessible parking space. It authorizes towing for private property owners and for publicly- controlled spaces. It clarifies that it is illegal to park in access aisles. It increases the fines to $300 and $500. Importantly it states that minor variations in parking space

features, including the lack of a sign, are not a defense to a charge of parking illegally in an accessible parking space.

New Section §4183A(b) states that parking spaces must comply with ADA standards.[76] There is specific language in (c)1-7 regarding signage and markings. Almost all spaces must have a sign that clearly marks the space as an accessible space, and that lists the fine. Van accessible spaces must be marked as such. Access aisles must be painted blue with lines. It clearly states that access aisles cannot be blocked. Section 4183A(d) incorporates ADA standards for required numbers of spaces, but adds the requirement that for every 5 required accessible spaces,[77] the lot must include, in addition to any required spaces, one van accessible space that is marked as reserved for wheelchair and scooter users only. This goes beyond what is required under ADA and building codes. Finally, this section requires maintenance of spaces including removal of ice and snow. Section 4183A (e)(1) requires compliance for all new spaces as of the effective date and to any existing spaces whenever they are restriped, repainted, resurfaced or altered, or within 5 years of effective date, whichever is sooner. There is an exception to the five-year rule for national register or historic sites and for lots of less than 25 spaces.

The most significant changes are found in §§4183A(f) which require local authorities to issue a permit or require a certification from a licensed engineer or surveyor that a parking plan meets the requirements of the statute. There is the possibility of a fine of up to $50,000 for a person who restripes, repaints or otherwise alters a parking lot without following the permit/certification process. Once a permit has been issued, the issuer must verify compliance by use of documentation and photographic evidence, provided that evidence is sufficient to confirm compliance. Another new element is found in §4183A(h) which requires each parking space to have a clearly marked contact number for the appropriate enforcement agency as well as a unique identifier that will allow enforcement agency to locate each space.

Lack of accessible parking is a constant frustration for people with disabilities and impedes community life and access. Hb 175 attempts to clarify and strengthen the requirements regarding the features of these spaces, and then creates a new mechanism to enforce them and hopefully stop compliance issues before they start by requiring permitting. **As such, councils should consider endorsing this piece of legislation.** The bill is currently out of committee and is on the ready list for the House.

➔***Conclusion/recommendation:*** Councils should consider endorsing this piece of legislation.

HS1 FOR HB 114 – RECOVERY HOUSING

DLP analyzed HB 114 in the April Policy and Law Memo.[78] On 6/1/23, HS1 for HB 114 was introduced. The bill is currently in the Appropriations Committee. The newer version does

[76] https://www.ada.gov/topics/parking/;
https://adata.org/sites/adata.org/files/files/Accessible_Parking_final2017(2).pdf
[77] This would be in lots of at least 150 spaces. https://www.ada.gov/topics/parking/
[78] That analysis was as follows:
HB 114 seeks to require certification for Recovery Houses in Delaware that wish to receive referrals from state agencies and who receive state funds. Recovery Houses are residential "sober" houses where individuals in various stages of treatment and recovery reside. Sometimes services are provided in addition to housing. Oxford Houses

eliminate the reference to MAT. However, the bill continues to attempt to exempt certified recovery houses (Oxford Houses are excluded from this definition) from the Landlord Tenant Code. The only protections for residents in the bill are that they are notified of the rules of the house, and whatever protections are ultimately part of the "nationally recognized standards" that DSAMH in theory will be adopting.

➔***Conclusion/recommendation:*** Councils should consider whether they may wish to endorse the concept of regulating recovery houses but object to the exemption from the landlord tenant code. Despite what the bill's synopsis says, there are no protections for residents in this bill.

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are a particular type of Recovery House. While stable housing in a substance free environment can be crucial element in substance use disorder treatment, these houses are ripe for abuse and there have certainly been instances of financial exploitation, neglect and abuse of residents who seek out these facilities. Like every other treatment milieu, especially ones that are funded by state or federal dollars, Recovery Houses must be regulated to avoid these abuses. However, this bill does not set up a licensing system, nor does it require all sober living houses to be certified. Entities that choose not to undergo this process can continue to operate with private funds. There is nothing to stop unqualified and sometimes unscrupulous individuals from setting up flop houses under the guise of calling them "sober-living" or recovery houses. Such entities could be fined if they hold themselves out as being a certified recovery house, and state agencies are forbidden from referring people to these locations.

The bill sets up a voluntary certification system and authorizes DSAMH to 1. Contract out the certification process and 2. Develop regulations. The contracted certification organization is responsible for developing and implementing standards. DSAMH's role is markedly minimal in this process. DSAMH is charged with adopting "nationally recognized standards" for the certifying organization and for the operation of recovery homes. These standards are not delineated but one would assume they are contemplating the National Association for Recovery Residences (NARR) standards. DSAMH must approve the processes and requirements that the certifying entity establishes. However, NARR standards are not subject to federal review and have been developed by private entities who engage in running recovery houses. In a brief review, the author noted that there is no requirement in the NARR standards that these homes provide physical accessibility. It is worth noting that Pennsylvania issues licenses recovery houses and has developed its own regulations It does not contract this process out.
There are some other concerning aspects of the bill. The bill requires that houses publish in the required online registry (2204A(a)(4)) "whether residents can participate in Medication Assistant Treatment." MAT is a widely used and supported short term and long term treatment modality. United States Department of Health and Human Services has made it clear that it is a violation of the ADA (and very likely a violation of the Fair Housing Act) to prohibit or exclude individuals who are engaged in MAT. This bill is basically sanctioning illegal discrimination.

Second, the bill explicitly exempts Recovery Houses from the Landlord Tenant Code. The resident has no protection from being literally put on the curb, without notice or warning. The House is authorized to establish rules about behavior and termination from the program. The only obligation to the resident is to make a "reasonable effort to connect the resident with appropriate services." There is no due process, no appeal process, no obligation to refund the resident's rent or other payments, no obligation to protect the person's property, and no obligation to consider the person's safety when terminating services.

While maintaining a sober environment is obviously of key importance, creating these environments should not be done in a vacuum without recognition of the frequency of relapse and also the devastating impact of being rendered homeless and penniless. There is a middle ground where a residence could use the emergency eviction process. There should be written notice, the ability to challenge a decision to terminate someone from the program, and firm guidelines that protect a resident's resources.

Councils should consider expressing support for the concept, in fact the necessity, of regulating recovery houses while insisting that the bill address protection of all residents in these settings.