

GOVERNOR'S ADVISORY COUNCIL FOR EXCEPTIONAL CITIZENS (GACEC)
GENERAL MEMBERSHIP MEETING
7:00PM, November 16, 2021
ZOOM MEETING

MINUTES

MEMBERS PRESENT: Al Cavalier, Matt Denn, Bill Doolittle, Karen Eller, Ann Fisher, Cory Gilden, Tika Hartsock, Kristina Horton, Terri Hancharick, Jessica Heesh-Mensack, Molly Merrill, Mary Ann Mieczkowski, Beth Mineo, Maria Olivere, Trenee Parker, Erika Powell, Jennifer Pulcinella, Laura Waterland, Erik Warner and Lindsay Williamson

OTHERS PRESENT: Joyce Leatherbury/Delaware Department of Education (DDOE); Jalee Pernol/DDOE; Dale Matusevich/DDOE, Maria Locuniak/DDOE, Cindy Brown/DDOE; Susan Veenema/DDOE; Bruce Orr/Interagency Coordinating Council (ICC), Stephanie Ramirez/Disabilities Law Program (DLP), Barbara Mazza, and Nancy Smith

STAFF PRESENT: Pam Weir/ Executive Director, Kathie Cherry/Office Manager and Lacie Spence/Administrative Coordinator.

MEMBERS ABSENT: Nancy Cordrey, Genesis Johnson, Thomas Keeton, Jill Scannell and Brenné Shepperson.

Chairperson Ann Fisher called the general membership meeting to order at 7:00pm. Ann welcomed everyone to the November general membership meeting. **A motion was made and approved** to accept the November agenda. Ann then asked for **a motion to approve** the October meeting minutes. **The motion was approved.** **A motion was made and approved** to accept the September and October financial reports.

PUBLIC COMMENT

There was no public comment for November.

DOE REPORT

Assisting Mary Ann Mieczkowski were guest speakers, Dale Matusevich, Jalee Pernol, Joyce Leatherbury, Maria Locuniak, Susan Veenema and Cindy Brown, all from DDOE. They presented an overview of Indicators and explained the process for providing input in target setting. Mary Ann expressed that this information is being shared so GACEC members can provide individual feedback and/or as GACEC. The links to the surveys for each Indicator were previously shared with Council members. Mary Ann invited everyone to a one-hour meeting on December 7th to answer questions or provide feedback.

Dale Matusevich presented on Indicator 1- Graduation, Indicator 2- Dropout, Indicator 13- Transition Planning and Indicator 14- Post-School Outcomes. Bill Doolittle stated that he was glad to see that Indicator 1 has moved away from the ESSA standard. Bill believes the new

Dropout measure is much more valuable and more technically accurate. It is more understandable for parents. Bill also agreed that parents need to understand that there is not a change in what is happening, but a change in the way it is being measured. In the chat of the zoom, Maria Olivero asked if those that opted out of state testing were captured in the statistics.

Jalee Pernol presented on Indicator 3- State Assessment and Indicator 17- State Systemic Improvement Plan (SSIP) State Assessment, Regarding Indicator 3, Bill Doolittle is concerned that this is the area where the State has most dramatically failed to make improvements. Bill noted that we need to be aware of how our system is working and why we are not showing improvement. These are some of the core areas that we need to work on to improve the outcome for students with disabilities. Bill thinks there should be a focus on accomplishing the metrics that are being set. Matt Denn stated in the future, it would be helpful to have a discussion with DOE about the Indicators where the State is underperforming. Matt added that it would be helpful to know what other states that are more successful in these Indicators are doing that Delaware is not, so we could learn from that. It would also be valuable to know if there are other variables involved, such as the way data is being collected, to explain the different performances among the states.

Susan Veenema presented on Results Indicator-4 Suspension and expulsion of students with disabilities as compared to students without disabilities, Compliance Indicators 9 and 10- disproportionate representation relating to identification of students with disabilities. Bill Doolittle would like to find out which Local Education Agencies (LEAs) were masked from Indicator 4 B, so we can determine if this indicator is meaningful under the federal definition. Bill said that according to his own calculations, this Indicator applies to less than half of our students, which needs to be addressed. This could also have an impact on the target setting. Bruce Orr, from the ICC, asked what the plan is for the repeat offenders. Susan answered that they meet with the districts that are “flagged” and work with them to create an action plan. They are provided with coaching and technical assistance to help them, as well. Because the federal government has never recognized that there is naturally occurring disproportionality due to environmental factors such as trauma, Bill Doolittle believes that if they will not fix their system, then the State needs to adjust our system. Bill thinks that adjusting the State bar to 2.0 would be a reasonable way to improve the disproportionate representation. Al Cavalier wondered if by picking a better threshold level, if there is a basis to improve our sensitivity so that our early warning system is not too early and causing districts to waste time and effort by having false positives identified. Al added that there should be some other indicators or more practical data to help us decide where the bar should be set. Al asked, “what is the basis for picking a new number?” Susan replied that they have created a “what if” scenario of how they came up with the 2.0. The scenario takes all the LEAs from 2018 through 2020 that would be targeted with 1.75 through 2.5 and determined who DDOE would still be working with and how many would drop off. That was the tool that was utilized to determine these numbers. Susan will be happy to share that in further detail at the December 7th meeting. Susan does not believe that districts are being improperly identified. She thinks the effort needs to be focused on the policies, practices and procedures. Al and Bill agreed that there is a flaw in comparing our target setting to other states with similar racial makeup.

Joyce Leatherbury spoke about Indicator 5- Least Restrictive Environments and Indicator 8- Parent Involvement. Bill Doolittle stated that the target for Indicator 5 should be more aggressive. He said Delaware is almost universally failing to follow the federal guidance as to how and what is required before a more restrictive setting is decided upon. DDOE has consistently failed to monitor and train in this area. Bill believes that if we made this change and emphasize what is actually required, this Indicator would improve dramatically. Terri Hancharick commented that we are trying to increase children in the least restrictive environment, yet two schools are being constructed, one of which is on the grounds of an institution. Terri thinks this is a step backward, rather than forward. Al Cavalier is concerned about Delaware building the two new schools. Given the knowledge of best practices and the pride we take in our commitment to them, Al asked how DDOE stood by building these. Mary Ann answered that DDOE is required to have continuum of services. Mary Ann stated that is a complicated process and no one in the Exceptional Children Resources was asked their opinion about this. Jen Pulcinella asked if once those buildings are completed, will that increase the number for setting C. Joyce replied that if more students are sent there, it would increase that number. In reference to Indicator 8, Tika Hartsock asked who mails out the surveys to parents. Joyce answered that the Center for Disabilities Studies at the University of Delaware mails out the surveys. Tika noted that these mailings look similar to junk mail and could easily be overlooked. Tika asked if there has been any thought in changing the way the mailing looks and how people receive it. Joyce stated this is a concern they have heard before.

Cindy Brown is the lead on Indicators 6,7 and 12. Cindy stated that Indicator 12 is a compliance Indicator and would not be discussed tonight. Indicator 6 is the percent of children with Individualized Education Plans (IEPs) who are enrolled in a preschool program and attending: A. Regular early childhood program and receiving the majority of special education services in the regular early childhood program; and B. Separate special education classes, separate school or residential facility. C. Receiving special education services in the home. Indicator 7 is the percent of preschool children age 3 through 5 with IEPs who demonstrate improved: A. Positive social and emotional skills; B. Acquisition and use of knowledge and skills and C. Use of appropriate behavior to meet their needs.

Maria Locuniak presented on Indicator 11- Child Find and Indicator 16- Mediation. Mary Ann thanked everyone for listening and invited everyone to meet via Zoom on December 7 at 6:00pm for further discussion. Each of the presenters encouraged Council members to reach out to them directly with any questions around their Indicators. Pam Weir thanked everyone for their presentations. Pam sent out an email to Council with timelines to complete the surveys and provide feedback. Pam asked that Council provide their feedback to GACEC staff so we can compile that in one comprehensive written package for DDOE.

Questions/Comments in Zoom Chat:

Maria Olivere- are those that opted out of state testing captured?

We are failing right now as well with regards to Covid and the school policies and children with medical complexities and sensory issues. These children are isolated in their classrooms today.

Erik Warner- The GACEC is currently creating a training video for teachers on best practices to increase parent involvement in the IEP process.

Stephanie Ramirez- Is there data on parent response rate? e.g., out of 1000 mailed, 600 were filled out and returned, or how many used the paper form vs electronic?

DIRECTOR'S REPORT

Executive Director, Pam Weir reported that the GACEC had their budget hearing yesterday, which went well.

Pam encouraged Council to provide feedback using the links provided by DDOE and stressed the importance of also sending that feedback to GACEC staff so we can compile the information and send it as the State Advisory Panel (SAP). She noted she will draft and share a template with Council members and requested they provide their feedback on the Indicator presentation directly to GACEC via this document and GACEC staff will compile the feedback and share it with the DDOE as official SAP advisement.

CHAIR REPORT

Ann reported absent members for the evening. She thanked our presenters for attending and sharing this useful information. Kathie Cherry asked for two volunteers for the Nomination Committee. Elections for GACEC officers will be held in January. Bill Doolittle and Erika Powell volunteered for the Committee.

COMMITTEE REPORTS

ADULT TRANSITION SERVICES COMMITTEE

Erik Warner reported that the Committee met with Dale Matusевич. Erik and Terri Hancharick will be meeting together to fill out the feedback forms for Indicators 1,2,13 and 14. Terri added that the Committee is in need of new members.

CHILDREN AND YOUTH COMMITTEE

Bill Doolittle said that Maria Locuniak and Mary Ann Mieczkowski joined the group to review Indicators 11,15 and 16. Bill stated the focus was on system improvement. The committee asked questions about the data and expressed concerns about the gap between when a parent requests an evaluation and when the form comes out that triggers the process. A suggestion was made to make a form that combines the parent request and the formal permission to do evaluations into one form to eliminate the unnecessary delay.

INFANT AND EARLY CHILDHOOD COMMITTEE

Jennifer Pulcinella reported that the Committee met with Pam to discuss the development of the Part C Transition Stakeholder Team and the collaboration with the ICC. Both are still in the initial stages. Pam Weir added that she has met with Yvette Sanchez-Fuentes to discuss a Part C transition stakeholder team draft that includes agencies that should be at the table. Yvette has discussed this with her DOE team. Pam submitted a basic strategic plan that would align with

the proposed stakeholder team draft. Pam stated that this has not yet been disseminated widely because it is still in the draft form. Pam will keep GACEC members informed of anything that is solidified in relation to this proposal. In reference to the ICC collaborating with the GACEC, Jennifer added that according to Bruce Orr, the ICC Executive Committee still needs to convene about the structure of a collaboration. The Committee will have Bruce back after they have had their executive meeting.

POLICY AND LAW COMMITTEE

Beth Mineo reported that the Committee reviewed three regulations and is putting forward the adoption of all the recommendations without changes made by the DLP. Beth added that the Committee has some follow up to do to bring some data to the communications regarding the recommendations.

Proposed DDOE Regulation on 14 DE Admin. Code 1564: Physical Education Teacher 25 Del Reg. of Regulations 486 (November 1, 2021)

The Board acting in consultation and cooperation with the Delaware Department of Education (DDOE) has developed amendments to 12 DE Admin. Code 1564 Physical Education Teacher. The proposed changes include adding definitions and striking defined terms in Section 2.0; clarifying the requirements for issuing a Physical Education Teacher Standard Certificate in Section 3.0; specifying the education, knowledge, and skill requirements for obtaining a Physical Education Teacher Standard Certificate in Section 4.0; specifying the application requirements in Section 5.0; adding Section 6.0, which concerns the validity of a Physical Education Teacher Standard Certificate; adding Section 7.0, which concerns disciplinary actions; adding Section 8.0, which concerns requests for the Secretary of Education to review standard certificate applications; and adding Section 9.0, which concerns recognizing past certificates that were issued by the Department.

DDOE makes notable amendments to the education, knowledge, and skill requirements in Section 4.0. The applicant shall have satisfied the following requirements:

Proposed amendments adds that the applicant shall have satisfied one of the following education requirements: (4.1.1.1) Obtained and currently maintain a Physical Education certificate from the National Board for Professional Teaching Standards; or (4.1.1.2) Earned a bachelor's degree from a Regionally Accredited college or university with a minimum of 30 semester hours of coursework in physical education from an educator preparation program approved or recognized by the National Council for the Accreditation of Teacher Education (NCATE), the Council for the Accreditation of Educator Preparation (CAEP), or a state where the state approval body employed the appropriate standards; or (4.1.1.3) Satisfactorily completed an alternative routes for licensure or certification program to teach physical education as provided in 14 Del.C. §§1260-1266; or (4.1.1.4) Satisfactorily completed a Department-approved educator preparation program in physical education; or (4.1.1.5)

If the applicant is applying for an Initial License after the applicant completed a minimum of 91 days of successful long-term substitute teaching in a Delaware public school as provided in subsection 4.1.3.1 of 14 DE Admin. Code 1510, earned a bachelor's degree from a Regionally Accredited college or university in any content area and also satisfactorily completed 15 college credits or an equivalent number of hours in professional development with one credit equating to 15 hours taken either as part of a degree program or in addition to a degree program from a Regionally Accredited college or university or a professional development provider approved by the Department related to physical education of which at least six credits focus on pedagogy. (4.1.1.5.1 4.1.1.5.2). The

applicant, in consultation with the applicant's Employing Authority, shall select the 15 credits or the equivalent number of hours in professional development subject to the Department's approval. DDOE clarifies the application requirements for applicants applying for an Initial License, a Standard Certificate must be applied for simultaneously with the application of the Initial License. While the proposed amendments appear to have a significant impact on the Physical Education Teacher's issuance of a standard certificate and the education and skill requirement. The DLP urges Council to recommend adding the education, knowledge, and skill requirements for Adaptive Physical Education (APE) Teachers. APE is an adapted, or modified, physical education program designed to meet the individualized gross motor needs, or other disability-related challenges, of an identified student. The DDOE should encourage APE teachers have additional qualifications such as a degree and/or certification.

Physical Education should be appropriate for a child with a disability as it is a child without a disability. Physical education services, specially designed, if necessary, shall be made available to every child with a disability receiving FAPE unless the public agency enrolls children without disabilities and does not provide physical education to children without disabilities in the same grades.

Delaware law addresses physical education inclusive including APE or accommodation when necessary. The statute explains that each child with a disability shall be afforded the opportunity to participate in the regular physical education program available to non-disabled children unless: (1) the child is enrolled full time in a separate facility; or the child needs specially designed physical education, as prescribed in the child's IEP.² (2) If specially designed physical education is prescribed in the child's IEP, then the public agency responsible for the education of that child shall provide the services directly or make arrangements for those services to be provided through other public or private programs.³ The public agency responsible for the education of a child with a disability who is enrolled in a separate facility shall ensure that the child receives appropriate physical education services in compliance with this section.⁴ An adaptive educationally trained professional would be able to assess individual students and implement specialized physical education programs as needed.

Requiring APE teachers to have the additional qualifications would ensure students in Delaware public schools are receiving an equitable physical education. The DDOE could create incentives such as bonuses or tuition reimbursement to reward teachers that are qualified in Adaptive Physical Education.

Proposed DHSS/DMMA Amendment to the Title XIX Medicaid State Plan Regarding Health Home Services, Assertive Community Integration Support Team (ACIST). 25 Del. Reg. of Regulations 491 (November 1, 2021).

The Delaware Department of Health and Social Services (DHSS) and the Division of Medicaid and Medical Assistance (DMMA) is proposing to amend the Title XIX of the Medicaid State Plan. Specifically, they are proposing to amend the Home Health Services section of the Medicaid State Plan to sunset the Assertive Community Integration Support Team (ACIST) as an option. Delaware's Medicaid State Plan was first amended in October 2018 to expand the option under Home Health Services to include Assertive Community Integration and Support Teams for individuals with severe and persistent mental illness (SPMI) and intellectual and developmental disabilities ((I/DD). Individuals living in the community who had dual diagnosis were often referred to Delaware's mental health system that was ill equipped to address their unique and individualized needs. The purpose of ACIST was to provide comprehensive, holistic team-based approaches to crisis intervention, intensive case management, behavior analysis, psychiatric supports and

monitoring of medical conditions. ACIST used a multi-disciplinary model to provide whole person supports. ACIST was designed to address the unique needs of individuals with chronic SPMI and I/DD, especially those who required additional supports and services to ensure effective interventions.

Goals of ACIST were:

- To lessen or eliminate critical health and safety issues that each individual may experience, with the end result of reducing or preventing signs, symptoms and social issues that could lead to hospitalization or re-hospitalization
- To provide transitional supports post psychiatric hospitalization to assist the individual in ameliorating the symptoms of their mental health condition and to prevent avoidable re-hospitalizations
- To improve the individual's overall medical and physical health
- To meet the individual's basic human needs and enhance quality of life
- To enhance the individual's opportunity to be successful in social activities and employment
- To increase the individual's active participation in their community
- To partner with the individual's family and support systems to support the individual's recovery

The Division of Developmental Disabilities Services (DDDS) in partnership with DMMA administered the ACIST program from the beginning. Psychotherapeutic Services Inc. (PSI) was the DDDS's contracted ACIST provider. PSI provided statewide services to about fifty (50) individuals when the ACIST program was operational. The original intent of ACIST was to evaluate the efficacy of the program after the first contract cycle was complete and to assess whether or not to expand the ACIST program to serve an additional twenty-five (25) individuals. The ACIST program was discontinued abruptly in 2019 with little or no notice to the individuals receiving those services through DDDS.

DHSS and DMMA assert that in 2019, DDDS conducted a thorough evaluation of the services and supports that the Managed Care Organization's (MCO) were providing. This evaluation of the MCO's occurred at about the same time as DDDS amended the 1915(c) Home and Community Based Services Lifespan Waiver. As a result of the evaluation, DDDS determined that the ACIST program was no longer needed because the individuals who were receiving ACIST services could get very similar supports through the MCO carve in. DDDS further asserted that they discontinued the ACIST program so that the individuals could receive these specialized services in the most integrated manner which they felt was through the MCO's and not DDDS. The ACIST Home Health program has been closed since 2019.

The DMMA currently contracts with two Managed Care Organizations, Amerihealth Caritas and Highmark Health Options. Amerihealth Caritas provides the following behavioral health services to its members: addiction services, behavioral health outpatient services to include visits with a doctor, counselor or therapist, individual/family/group therapy, psychological and neuropsychological testing, inpatient hospitalization for mental health and substance use disorders, autism services (applied behavioral analysis, family counseling, parent training, physical therapy, speech therapy and occupational therapy)⁶, psychiatric residential treatment facility services (ages 18-20 years)⁷, crisis intervention and stabilization. Highmark Health Options provides a similar array of behavioral health benefits to its members⁸. While the behavioral health benefits available under the MCO's seem to mostly mirror the services that were offered under the ACIST program, the service delivery model is different in that it is not a multi-disciplinary team managing and addressing the care of the whole

person. The service delivery model of the MCO's is a more ala carte approach which may not address the unique needs of this population with dual diagnosis.

Given that DDDS did not:

1. Evaluate the efficacy of the ACIST program as originally intended; and
2. Adequately manage the ACIST program while it was operational, ensuring it met its stated program goals; and
3. That the ACIST program was abruptly terminated by DDDS in 2019 with inadequate notice to the service recipients and/or transition services for those individuals affected by the closure of the ACIST program.

While Council should consider not opposing the sunset of the ACIST program, Council may also want to consider making other recommendations consistent with ensuring the mental health service and support needs of individuals with SPMI and I/DD receiving services from DDDS are being met. Council may wish to endorse strengthening the coordination of care efforts for individuals being served by both DDDS and DSAMH to better meet the unique needs of this population. Additionally, Council could also recommend that DDDS complete a comprehensive evaluation of the behavioral health needs of their service recipients as compared to what they are receiving from the MCO's.

DSAMH Proposed Regulations – DUI Programs, 25 Del. Reg. Of Regulations 500 (November 1, 2021)

The Division of Substance Abuse and Mental Health (DSAMH) has proposed regulations governing the administration of driving under the influence (DUI) programs. Per legislation passed in 2018 that amended the relevant statute (21 Del. C. § 4177D), authority over DUI programs in Delaware was transferred from the Office of Highway Safety to DSAMH. DSAMH is proposing new regulations governing DUI programs and proposing to repeal the regulations previously promulgated by the Office of Highway Safety, in accordance with that authority. These regulations do not apply to the Court of Common Pleas Driving Under the Influence program, which is separately administered by the Court, however under the law completion of that program is considered equivalent to a program operated under DSAMH's authority for the purposes of driver's license reinstatement.

While the existing regulations to be repealed had more broadly covered other aspects of DUI penalties, the proposed regulations only govern the operations of court-mandated DUI programs that are under the authority of DSAMH. Per the regulations, a program may only provide DUI screening and referral, education, or treatment services to adults if licensed, authorized and contracted by DSAMH. Under the proposed new regulations, all participants must undergo an initial screening and must be referred before participating in an educational or treatment program. A participant's referral to an education or treatment program (with treatment services further classified into Levels 1 through 3) would depend on the nature of the underlying offense, including whether it was the participant's first DUI offense and the participant's blood alcohol content at the time of the offense, as well as other risk factors identified in the screening. DSAMH has preserved the administrative appeal process that currently exists to allow individuals to challenge adverse action by a program such as disqualification or other disciplinary action. DSAMH has updated the fee schedule most recently set by the Office of Highway Safety in 2011 to reflect current program costs, which has resulted in increases in all base program fees.

Concerningly, the new regulations and fee schedule are not on a sliding scale based on income, nor do they allow for any other sort of fee waiver or financial aid, even though the proposed maximum fee for a treatment program is up to \$1000 per person for a 16-hour treatment program and \$1700 per person for a 27-hour program. These fees do not include a separate fee of up to \$150 for screening and referral, and fees of up to \$35 for each urine drug screen performed, which is a required element of treatment plans for participants receiving Level 2 or Level 3 treatment. They also do not include added fees that may be imposed under the regulations for absences (up to \$50 per absence), late payments (up to \$30 per late payment) and additional fees for other various administrative costs, including program materials. Program fees are separate from any fine imposed as a criminal penalty for a DUI offense, although the statute prohibits DUI programs for charging program fees that are greater than the maximum fine under state law for a related offense. Individuals participating in DUI programs may also incur additional expenses resulting from their DUI offense, including but not limited to the need to pay for alternative transportation while a driver's license is revoked or related increases in car insurance premiums. DSAMH states in the summary of the proposed regulations that while the Division is "supportive" of a sliding scale based on ability to pay, a sliding scale or other option for waiver of fees is not included in the proposed regulations because the agency lacks the financial resources to offset program costs for providers, and because of the administrative burdens of verifying individual income for purposes of determining financial eligibility.

The maximum program fees under the proposed regulations exceed what many low-income individuals can reasonably pay. In fact, the maximum fees far exceed what many low-income households pay per month for subsidized housing. They also exceed what many individuals with disabilities receive per month in Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits through the Social Security Administration. Imposing fees without any option for a waiver based on the ability to pay essentially shuts certain populations out of participating in required programming or significantly delays their ability to do so, resulting in prolonged periods of ineligibility to drive. It is also worth noting that individuals with disabilities, particularly if unable to utilize their personal vehicles, may incur additional costs in participating in such programs, or if exacerbation of their disability causes unanticipated absences or inability to complete other program requirements, which could result in additional fees (although presumably in some such circumstances an individual with disabilities may have the option to request a reasonable accommodation or reasonable modification of program rules under applicable state or federal law).

Many low-income individuals and families are often dependent on vehicles to access needed services, education, or health care, as well as employment, particularly those who live in rural communities or high-poverty urban neighborhoods where access to reliable public transportation is generally more limited. In fact, some research has linked vehicle ownership with the greater economic opportunity for low-income households (see, e.g., the Urban Institute's 2014 report *Driving to Opportunity: Understanding the Links among Transportation Access, Residential Outcomes, and Economic Opportunity for Housing Voucher Recipients*, available at <https://www.urban.org/research/publication/driving-opportunity-understanding-links-among-transportation-access-residential-outcomes-and-economic-opportunity-housing-voucher-recipients>). Inability to restore a driver's license for a prolonged period could have catastrophic financial consequences for these households and could also potentially incentivize driving without a license out of desperation to continue to access needed services or sustain income from employment. The public costs of those outcomes could potentially be greater than the costs of administering a sliding scale or other financial support for DUI program costs.

Some states such as Oregon and New Jersey have dedicated funding to support low-income individuals' participation in DUI programs. Notably Oregon's program, under state law, also allows for the funding of "special services required to enable a person with a disability, or a person whose proficiency in the use of English is limited because of the person's national origin, to participate in treatment programs that are used for diversion agreements" regardless of the program participant's income (see Oregon Revised Statute 813.270, available at https://oregon.public.law/statutes/ors_813.270). While establishment of such a program in Delaware may require a statutory change and/or specific allocation of funds through the state budgeting process, such measures would be worth considering.

Driving under the influence can have devastating consequences, and while it is understandable that for purposes of public safety the State would want to deter individuals by imposing severe penalties and keep certain higher-risk drivers off the road until it has been deemed safe for them to resume driving, the proposed fee framework for this program will in fact make it very difficult for a segment of Delaware's population to get their licenses back regardless of their willingness to complete program requirements. While the proposed regulations allow for contracted providers to charge less than the maximum fees and would not prevent contracted providers from implementing their own sliding scales for fees, there would be little incentive for them to do so if the contracting entity (DSAMH) is paying a set rate for the provided services and is not offering to help offset costs.

It is recommended that the Council not support the proposed regulations unless DSAMH is willing to make allowances for a sliding scale or other option for possible waiver of fees for qualifying individuals.

FINAL REGULATIONS

1. DDOE Regulation 1203 Scholarship Program, 25 Del. Reg. of Regulations 508 (November 1, 2021).

The Councils had suggested individuals who are unable to use the online portal either due to disability or lack of access to the internet be given alternative means to apply. DDOE rejected this comment, because 1. There has been an online component to the program for 6 years; 2. People can ask for assistance; and 3. A paper application can be requested.

2. DHSS DHQC Home Health Aide – Aide Only, 25 Del. Reg. of Regulations 521 (November 1, 2021).

The Councils made fairly extensive comments on these regulations, and while DHCQ reviewed each of them, they did not make any changes. They also didn't modify these based on provider comments. It is important to note that, based on the provider comments, DHCQ had meetings with the provider community while doing these revisions. It may be worth asking whether DHCQ solicited or considered any comments from the consumer community.

Regarding specific comments, first, regarding requiring more than one year of home health experience for Clinical Directors, DHCQ appreciated the comment but said that the regulations needed to take into account the difficult job market. They rejected the provider request to eliminate the requirement altogether.

Second, this is what they said in response to Council request that the regulations allow delegation by a consumer to a home health aide to participate in medication administration:

The regulations at 6.4.1 address circumstances where a competent patient who does not reside in a medical facility or a facility regulated pursuant to 16 Del.C. Ch. 11 may delegate personal care services to home health aides *provided: the nature of the service/task is not excluded by law or other state or federal regulation*, the services/tasks are those competent patients could normally perform themselves but for functional limitation; and the delegation decision is entirely voluntary. (Emphasis added).

It is unclear to DLP what DHCQ means by this. Are they suggesting that a home health aide can participate in medication administration if directed by a competent adult not in a licensed facility? DLP suggests that perhaps Councils with an interest in this issue reach out directly to DHCQ to bring some clarity to this issue. Home health agencies are very clearly of the opinion that a home health aide can't touch medication with a ten-foot pole (which is what this regulation reiterates).

Third, regarding the request that DCHQ clarify the regulation regarding traveling beyond one county, DCHQ indicates there is no need to change the regulation because this is how home health agencies interpret it anyway. Councils may want to reiterate that if that is the intent, why not put in the regulation. You can't enforce a practice.

Fourth, DHCQ rejected the concern about only requiring serious injuries to be reported, the argument being that if they didn't add the qualifier "serious" that the word injury could be "subject to interpretation." However, by adding "serious" DHCQ is limiting reporting to ONLY serious injuries.

Fifth, DHCQ rejected the suggestion that home health agencies notify case workers if discharge is imminent to avoid disruptions and address involuntary discharges. While DHCQ seems to recognize that most individuals have a case manager, they seem to be saying in response that these case managers "generally know." Why not put it in as a requirement to help ensure continuity of care? DHCQ suggests that they don't regulate insurance companies, which is completely beside the point. DHCQ does regulate home health agencies, and councils were requesting that they notify case managers, not the other way around.

A motion was made and approved to accept the Policy and Law Memo.

MEMBERSHIP COMMITTEE

Al Cavalier reported that there was a meeting with Lori James, the Director of Boards and Commissions. Lori is in a more positive mindset to collaborate with us and allow a more open and timely process for appointing new members. Al explained that we are working out a vetting process to approve applications from perspective members before they are presented to the Governor. The Committee is updating the member handbook for new members and as a resource for current members. Al will keep us informed of when that document is ready to be shared. Meedra Surratte of the Parent Information Center (PIC) was recently appointed as a new member.

Jennifer Pulcinella **made a motion** for the Board to convene in Executive Session. The **motion was approved**.

There were no Outside Committee Updates or Ad Hoc Committee reports this month.

Ann reminded members to contact GACEC staff if you would like copies of any feedback or GACEC letters. She reminded Council that we are still in need of self-advocates. Ann thanked all members and guests for attending. **A motion was made and approved** to adjourn the meeting at 9:08pm.