Adult Protective Services

Delaware Health Information Network

2020 Holdover Meeting

JOINT LEGISLATIVE OVERSIGHT & SUNSET COMMITTEE

Tuesday, February 12, 2020
6:00 p.m.
JFC Hearing Room
Ground Floor, Legislative Hall

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STATE OF DELAWARE

JOINT LEGISLATIVE OVERSIGHT AND SUNSET COMMITTEE

Joint Legislative Oversight and Sunset Committee Meeting

JFC Hearing Room
Ground Floor, Legislative Hall

Wednesday, February 12, 2020
6:00 p.m.

Agenda

1. Welcome
2. Approve Minutes
3. Adult Protective Services
4. Delaware Health Information Network
5. Adjournment

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	Joint Legislative Oversight and Sunset Review Committee **Adult Protective Services 2.12.2020 Talking Points**

As an agency, the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) has taken the Joint Legislative Oversight and Sunset Review Committee (JLOSC) recommendations seriously and has worked diligently to implement them.

Some of APS' progress has included:

- Comprehensive training plan – Reflected in the October and December Progress Reports, the DSAAPD Training and Staff Development department has hired a trainer/educator that is dedicated to APS and training on APS related topics. Since taking on this position, a comprehensive annual training plan has been developed and 100% of APS staff members have had critical trainings on important topics, including financial exploitation, self-neglect, and dangerous conditions. All staff have either completed or are working towards National Adult Protective Services Association (NAPSA) certification. All APS staff members will have completed the necessary modules for certification by March 31st.

- DSAAPD website updates – DSAAPD immediately worked to modernize and update abuse, neglect and exploitation information on its website. This is part of a larger website modernization that will make it easier for Delawareans to find the most sought-after information on the DSAAPD site.

- Grant opportunities – DSAAPD is always looking for grant opportunities to improve the service delivery system. This includes finding grants that will sustain APS special projects, like the Financial Exploitation Advocate program. This grant has continued into FY 2020 through the Criminal Justice Council. In addition, DSAAPD is collaborating with the Department of Justice and the Delaware Center for Justice on grant opportunities that will expand

supportive victim services to Kent and Sussex County and develop a multi-disciplinary response to elder justice.

- Fully staffed – As of December, APS was fully staffed after an extensive hiring process. This includes family service specialists and APS nurses.

- Exploration of afterhours – DSAAPD leadership continue to explore the need for expanding APS services past 4:30 pm. After examining call data, as well as the need for APS workers to flex their schedules to enable them to better investigate cases outside of normal business hours, DSAAPD leadership did not identify a need to expand service hours. DSAAPD leadership will continue to explore the call data and work to develop protocols that will facilitate investigations past 4:30 pm.

- Planning to take on self-neglect – working with a national expert, ADvancing States, DSAAPD is planning for APS to take self-neglect cases. This planning includes bringing on many more nurses in all DSAAPD office locations that will be trained in working with people who may be self-harming. With the help of ADvancing States, this service delivery transition will be judicious and well-thought out to ensure DSAAPD is developing a system that is not only responsive, but proactive.

- Advisory Council – The APS Advisory Council has been informed of all recommendations, including the recommendation to disband this group and merge them with DSAAPD's Council on Services for Aging and Adults with Physical Disabilities. Draft legislation to codify this change has been given to JLOSC. Two positions will be added to the Council dedicated to victim serving agencies.

- Multi-Disciplinary Team (MDT) – Along with the recommendation related to the APS Advisory Council was an option to develop a Multi-Disciplinary Team. Draft legislation has been given to JLOSC that would create the Vulnerable Adult Populations Commission and includes organizations and agencies that work with adults every day in Delaware. Modelled after several other MDT's in Delaware,

like the Child Protection Accountability Commission and the Domestic Violence Coordinating Council, DSAAPD feels that this type of MDT will bring Delaware in line with national standards around collaboration and policy development. DSAAPD worked with our sister agencies and the Delaware Department of Justice in drafting this legislation.

- Other Suggested Changes to the Code – DSAAPD has submitted draft language for other suggested code changes, including adding self-neglect as a harm that APS will respond to, investigative time frames, and training requirements for APS staff.

DSAAPD continues to look for ways to improve its work. This includes:

- The Perception of APS in the Community – DSAAPD will continue to educate partner agencies and the community about the types of services APS provides, what help can be provided, and what information can be shared per the Delaware Code.

- Education – DSAAPD continues to work to improve the education of staff on how to identify adults who may become vulnerable to abuse, neglect, and exploitation.

Recommendation 8: Training and Procedures for Self-Neglect Cases

DSAAPD suggested codifying training requirements under the APS statute for the purpose of advancing the section.

"The Department shall conduct ongoing training programs to advance the purpose of this section. The Department shall continuously publicize the existence of the 24-hour report-line to those required to report abuse or neglect pursuant to §3910 of this title of their responsibilities and to the public the existence of the 24-hour statewide toll-free telephone number to receive reports of abuse or neglect."

Recommendation 10: Investigative Time Frames

DSAAPD suggested codifying investigative time frames under the APS statute to establish a time frame for State responses to reports of abuse, neglect, or financial exploitation

"It is the role of the Department, that upon receipt of a report concerning allegations of abuse, neglect, or exploitation, to commence an investigation within the following time frame:

a) Physical/Sexual Abuse – 1 Business Day
b) Emotional Abuse, Neglect – 3 Business Days
c) Exploitation – 5 Business Days"

Recommendation 15: Define Self-Neglect in Statute

"The term "self-neglect" means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including—

a) obtaining essential food, clothing, shelter, and medical care
b) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or
c) managing one's own financial affairs."

SPONSOR:

HOUSE OF REPRESENTATIVES

150th GENERAL ASSEMBLY

HOUSE OR SENATE BILL NO. __

AN ACT TO AMEND TITLE 29 OF THE DELAWARE CODE RELATING TO COUNCIL ON SERVICES FOR AGING AND ADULTS WITH PHYSICAL DISABILITIES

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Chapter 79 of Title 29 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 7915 Council on Services for Aging and Adults with Physical Disabilities.

(a) There is established the Council on Services for Aging and Adults with Physical Disabilities.

(b) The Council on Services for Aging and Adults with Physical Disabilities (the Council) shall serve in an advisory capacity to the Director of the Division of Services for the Aging and Adults with Physical Disabilities and shall consider matters relating to the formation of local community councils for the aging and for adults with physical disabilities, programs and projects in this State to benefit the aging and adults with physical disabilities and such other matters as may be referred to it by the Governor, the Secretary of the Department or the Director of the Division of Services for the Aging and Adults with Physical Disabilities. The Council may study, research, plan and advise the Director, the Secretary and the Governor on matters it deems appropriate to enable the Division to function in the best possible manner.

(c) The Council on Services for Aging and Adults with Physical Disabilities shall be composed of 15 members. Members shall be appointed by the Governor for terms of up to 3 years. The terms of the Council members shall be staggered in such a manner so that the terms of no more than 7 members expire in 1 year. The Council shall consist of the following:

(1) Three members, each being a resident from a different county in this State and an aging or elderly person or a caregiver of an aging or elderly person as defined in § 7920 of this title.

(2) ~~Four~~ Three members, each being from a public or nonprofit agency that provides services to aging persons.

(3) Three members, each being a resident from a different county in this State and an adult with a physical disability or a caregiver of an adult with a physical disability as defined in § 7920 of this title.

(4) ~~Four~~ Three members, each being from a public or nonprofit agency that provides services to persons with physical disabilities.

(5) Two members, each being from a public or nonprofit agency that provide services to alleged victims as defined in §3902 of Title 31.

~~(5)~~(6) One member who represents veterans' issues.

(d) The Council membership shall be composed of representatives in the following areas: aging persons, representatives of public and/or nonprofit agencies that serve aging persons, persons with a physical disability, low income older persons, low income persons with a physical disability, minority older persons, minority persons with a physical disability, veterans' affairs, representatives of public and/or nonprofit agencies that provide services to alleged victims, and representatives of public and/or nonprofit agencies that serve adults with physical disabilities. Each Council member can be representative of more than 1 area, but no Council member shall be representative of more than 3 areas.

(e) Members of the Council shall serve without compensation, except that they may be reimbursed for reasonable and necessary expenses incident to their duties as members of the Council.

(f) A Chairperson of the Council shall be elected annually by the members of the Council from among its members, except that the office shall rotate between representatives of the aging community and representatives of adults with physical disabilities. In its first year of operation, the Council shall be chaired by a representative of the aging community. In its second year of operation, the Council shall be chaired by a representative of adults with physical disabilities. Thereafter, the chairperson shall alternate and shall serve a 2-year term. A chairperson shall be eligible to serve 2 nonconsecutive terms.

(g) Any replacement appointment to the Council to fill a vacancy prior to the expiration of a term shall be filled for the remainder of the term.

(h) Members who are absent from more than 3 consecutive meetings, unless excused by the Council, shall be discharged from the Council by the Council Chairperson.

(i) The Council may establish subcommittees and make appointments to any such subcommittees with the approval of all members of the Council.

(j) A quorum of the Council consists of a majority of the council members.

(k) All decisions made by the Council relative to policy and budget shall be made by a majority of the members present at a meeting with a quorum. Staff assistance shall be given to the Council and any subcommittees

SYNOPSIS

This bill sets forth revisions to the composition of the Council on Services for Aging and Adults with Physical Disabilities.

SPONSOR:

HOUSE OF REPRESENTATIVES or DELAWARE STATE SENATE
150th GENERAL ASSEMBLY

HOUSE OR SENATE BILL NO. __

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE CREATING A VULNERABLE ADULT POPULATIONS COMMISSION

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Title 16 of the Delaware Code, by adding a new Chapter, designated as Chapter 106, which new Chapter shall read as follow:

"CHAPTER 106: VULNERABLE ADULT POPULATIONS COMMISSION. §10601 Creation.

The General Assembly hereby creates a permanent Vulnerable Adult Populations Commission.

§10602. Composition.

The Commission shall consist of nineteen members with the at-large members appointed by the Governor. Members of the Commission serving by virtue of position may appoint a designee to serve in their stead. The Commission shall be comprised of the following:

(1) The Secretary of the Department of Health and Social Services;

(2) The Director of the Division of Services for Aging and Adults with Physical Disabilities;

(3) The Director of the Division of Health Care Quality;

(4) The Long Term Care Ombudsman

(5) The Chancellor of the Court of Chancery;

(6) One member of the House of Representatives appointed by the Speaker of the House of Representatives;

(7) One member of the Senate appointed by the President Pro Tempore of the Senate;

(8) The Attorney General;

(9) The Public Guardian;

(10) The Chair of the Domestic Violence Coordinating Council;

(11) The Superintendent of the Delaware State Police;

(12) The Chief Medical Examiner;

(13) A board-certified physician licensed to practice in this State,

(14) Six at-large members appointed by the Governor with 1 person from the Senior Protection Initiative, 1 person from a law enforcement agency other than the State Police, and 4 persons from the vulnerable adult protection community. The law-enforcement representative may designate a proxy as needed.

§10603. Purpose; powers; duties. The Commission shall:

(1) Continuously study Court services and procedures, Law Enforcement procedures and protocol, and criminal justice data collection and analysis as it relates to abuse, neglect, and exploitation of vulnerable adult populations, as defined in 31 Del C.§3902. Vulnerable adult is defined in 11 Del C. §1105(c);

(2) Effectuate coordination between agencies, departments, and the courts to benefit vulnerable adult victims of abuse, neglect, and exploitation;

(3) Promote effective prevention, intervention, and service provision based upon research and data collection;

(4) Recommend standards for treatment programs for perpetrators of vulnerable adult abuse, neglect, and exploitation to the Department of Health and Social Services and the Department of Correction;

(5) Review and comment upon legislation relating to vulnerable adult abuse, neglect, and exploitation introduced in the General Assembly at the request of any member of the General Assembly or on its own initiative;

(6) Improve Delaware's response to vulnerable adult abuse, neglect, and exploitation so as to reduce the incidents thereof; and

(7) Investigate and review, through a review panel, the facts and circumstances of at least 4 deaths and near deaths, representing a cross-section of agency involvement, that occur in Delaware as a result of vulnerable adult abuse, neglect, and exploitation. "Near death" means a victim who has suffered life-threatening injuries. Deaths include both homicides and suicides resulting from vulnerable adult abuse, neglect, and exploitation. The cases chosen should represent trends and gaps in service delivery identified through the other powers and duties of this Commission as defined.

7(a) The Division of Forensic Science shall submit to the Commission a monthly report within 30 days of the last day of the previous month, of all the homicides and suicides that occurred in Delaware. The Attorney General, the Department of Health and Social Services, and any other state or local agency with knowledge of a vulnerable adult abuse, neglect, or exploitation-related death or near-death incident shall report such incident to the Commission within 14 days. The Commission shall delay the review of deaths involving criminal investigations until the completion of the prosecution. For purposes of this subsection, "completion of the prosecution" means the decision to file no information or seek no indictment, conviction or adjudication, acquittal, dismissal of an information or indictment by a court, the conditional dismissal under a program established by Delaware law or court program, or the nolle prosequi of an information or indictment by the Attorney General.

(b) All members of the Commission, plus other individuals invited to participate, shall be considered part of the review panel for a particular case or incident. The Commission shall invite other law-enforcement personnel to serve and participate as full members of a review panel in any case in which a law-enforcement agency has investigated the death or near death under review or any prior vulnerable adult abuse, neglect, or exploitation incident involving the decedent or near-death victim. The Commission may also invite other relevant persons to serve on an ad-hoc basis and participate as full members of the review

panel for a particular review. Such persons may include individuals with particular expertise that would be helpful to the review panel, representatives from those organizations or agencies that had contact with or provided services to the individual prior to that individual's own death or near death, that individual's family member, and the alleged perpetrator of the death or near death.

c) A review panel shall be convened by the co-chairs of the Commission on an as-needed basis and may also be convened by any 2 other members of the Commission.

(d) As part of any review, a review panel shall have the power and authority to administer oaths and to compel the attendance of witnesses whose testimony is related to the death or near death under review and the production of records related to the death or near death under review by filing a praecipe for a subpoena, through the Delaware Department of Justice, with the Prothonotary of any County of this State. Such a subpoena will be effective throughout the State and service of such subpoena will be made by any sheriff. Failure to obey such a subpoena will be punishable according to the Rules of the Superior Court.

(e) Each review panel shall prepare a report, to be maintained by the Commission, including a description of the incident reviewed, and the findings and recommendations of the review panel.

(f) Findings and recommendations by the panel shall be adopted only upon a 60 percent vote of participating members of the review panel.

(g) The Commission shall establish rules and procedures to govern each review prior to the first review to be conducted. The Commission shall include in its annual report a summary in an aggregate fashion all findings and recommendations made over the year by each review panel and any systemic changes that were effectuated as a result of the Commission's work. The report shall not identify the specific case or case review that led to such findings and recommendations.

(h) The review process, and any records created therein, shall be exempt from the provisions of the Freedom of Information Act in Chapter 100 of Title 29. The records of any such review, including all original documents and documents produced in the review process with regard to the facts and circumstances of each death or near death, shall be confidential, shall be used by the Commission only in the exercise of its proper function and shall not be disclosed. The records and proceedings shall not be available through court subpoena and shall not be subject to discovery. No person who participated in the review nor any member of the Commission shall be required to make any statement as to what transpired during the review or information collected during the review. Statistical data and recommendations based on the reviews, however, may be released by the Commission at its discretion.

(i) Members of the Commission and members of each review panel, as well as their agents or employees, shall be immune from claims and shall not be subject to any suits, liability, damages or any other recourse, civil or criminal, arising from any act, proceeding, decision or determination undertaken or performed or recommendation made, provided such persons acted in good faith and without malice in carrying out their responsibilities; good faith is presumed until proven otherwise, with

the complainant bearing the burden of proving malice or a lack of good faith. No organization, institution or person furnishing information, data, testimony, reports or records to the review panels or the Commission as part of such an investigation shall, by reason of furnishing such information, be liable in damages or subject to any other recourse, civil or criminal.

§10604. Meetings; quorum; officers; committees; procedure.

(a) The Commission shall meet at least 4 times per year. Ten members shall constitute a quorum.

(b) The Chairperson shall have the duty to convene and preside over meetings of the Commission and prepare an agenda for meetings.

(c) The Secretary of the Department of Health and Social Services shall convene the initial meeting of the Commission.

(d) At the initial meeting of the Commission a Chairperson and Vice-Chairperson shall be elected by the Commission members. Thereafter, in December of each year, the Commission shall elect a Chairperson and Vice-Chairperson. The Vice-Chairperson's duty shall be to act as chairperson in the absence of the Chairperson.

(e) The Commission shall establish committees composed of Commission members and other knowledgeable individuals, as it deems advisable, to assist in planning, policy, goal and priority recommendations, and developing implementation plans to achieve the purposes of the Commission.

(f) The Commission shall promulgate rules of procedure governing its operations, provided that they are in accordance with Chapters 100 and 101 of Title 29, and provided that no rule shall permit proxy voting.

(a) The Commission shall submit a written report of its activities and recommendations to the Governor, General Assembly, and the Chief Justice of the Supreme Court at least once every year on or before March 15."

Section 2. Effective date. This Act shall take effect upon its enactment.

SYNOPSIS

This bill sets forth creation of the Vulnerable Adult Populations Commission.

APS CONTENTS

OVERVIEW

Adult Protective Services ("APS") is located under the Department of Health and Social Services ("DHSS"), within the Division of Services of Aging and Adults with Physical Disabilities ("DSAAPD"). Under DSAAPD, APS provides social services intervention for those who are living in the community, 18 years or older, physically or mentally impaired, and subject to abuse, neglect, or exploitation.

APS was established as a comprehensive and coordinated services delivery system to protect vulnerable adults who, due to their disabilities, are unable to provide for their daily living needs and are consequently subject to psychological or physical injury or exploitation. APS's mission is achieved when an adult with an infirmity or incapacity is living in an environment that has been made safer after a potential or actual danger has been removed.

APS was selected for review by the Joint Legislative Oversight and Sunset Committee ("JLOSC" or "Committee") in August 2018. After a comprehensive review, the Committee made several recommendations for APS at its May 13, 2019 meeting which included staff development and training, updating interagency Memorandum of Understandings ("MOUs"), website modifications, reviewing staffing structures, recruitment initiatives, modifying operational hours, and making statutory modifications in order to define self-neglect, modify the APS Advisory Council, and to implement an Elder Justice Multidisciplinary Team. The Committee recommended to hold over the review of APS. APS submitted progress updates for October and December 2019. APS will report back to the Committee in February 2020 and the Committee will review the Agency's progress in implementing recommendations and will consider its release from review.

OCT UPDATE

DSAAPD Staff Development and Training Department[1] – APS Topics (Recommendation 3)

- DSAAPD posted an APS training position on August 21, 2019 for a Trainer/Educator III (Registered Nurse BSN).[2]
    - Since the trainer is required to be a registered nurse, recruitment has taken time and effort.
    - The position closed on September 24, 2019.
    - The DSAAPD Staff Development and Training department held interviews for the APS Trainer on October 21, 2019 and the position was offered to one of the candidates.
- DSAAPD has also completed the registration of APS through the National Adult Protective Services Association (NAPSA) Certificate Program and is tracking completion of that program for all staff.

DSAAPD Staff Development and Training Department – Develop a Survey to Identify Training Priorities (Recommendation 4)

- The DSAAPD Staff Development and Training department, in coordination with the Planning, Policy and Program Development unit, developed a survey.[3]
    - The survey was made available on October 17, 2019 to all staff that may be involved with APS cases, including APS, the Aging and Disability Resource Center (ADRC),

[1] APS is the entity under JLOSC review, but APS is a unit under the purview of DSAAPD which has oversight responsibilities, including fiscal. Recommendations will frequently reference DSAAPD as they are the agency charged with implementing and maintaining APS operations.
[2] See Appendix A for position summary.
[3] See Appendix A for survey.

Community Services Program (CSP), Community Nursing, and the Diversion and Discharge Unit.
    - In total, almost 80 staff members received the survey. As of the October Progress Report, 58 staff members have taken the survey.

Increase APS-Specific Training (Recommendation 5)

- An APS training plan has been developed for all APS staff, including APS nurses.[4]
    - This plan is included in all staff performance plans to ensure all trainings are completed in a timely fashion.
    - The APS Self-Neglect Home Visit Training and the MASTER program training are part of this APS Training Plan.
    - Staff will have the opportunity to complete some of the trainings at monthly staff APS meetings.

Provide Formal Training for Dangerous Situations (Recommendation 6)

- The DSAAPD Staff Development and Training department has reached out to the Dover Police Department and State Police Training Academy to form a self-defense training partnership.
- All APS staff required to participate in the Mandt System® training.
    - The training was held on November 5, 12, 19 and on December 3, 11, 17.
    - This training uses a continuous learning and development approach to prevent, de-escalate, and if necessary, intervene in behavioral interactions that could become aggressive.

Increase Financial Exploitation Training (Recommendation 7)

- The APS Administrator, in coordination with the APS Supervisors and the DSAAPD Staff Development and Training department, has developed a training plan, for all APS staff, including APS nurses.

[4] See Appendix A for training plan.

- This plan is included in all staff performance plans to ensure all trainings are completed in a timely fashion. Elder Financial Abuse Online Training and Financial Abuse Training from MASTER are included in this APS Training Plan.

Training and Procedures for Self-Neglect Cases (Recommendation 8)

- DSAAPD is revising internal written procedures for handling of self-neglect cases within APS.
- For the training in self-neglect, the APS Administrator, in coordination with the APS Supervisors and the DSAAPD Staff Development and Training department, has developed an APS Training Plan, for all APS staff, including APS nurses.
    - This plan is included in all staff performance plans to ensure all trainings are completed in a timely fashion.
- The NAPSA self-neglect module training will be held on October 31, 2019 for all APS staff facilitated by the APS Supervisors.

Updates to MOUs (Recommendation 9)

- DSAAPD has sent updated MOUs to the following entities. As of the October Progress Report, these MOUs are awaiting signatures.
    - Division of Developmental Disabilities Services.
    - Division of Health Care Quality.
- DSAAPD is working to develop MOUs with:
    - The Department of Justice.
    - The Long-Term Care Ombudsman Program.
    - The Office of the Public Guardian.
    - Delaware State Police.

Investigative Time Frames (Recommendation 10)

- DSAAPD has updated its policies and procedures to reflect national best practices regarding investigative time frames.[5]

[5] See Appendix A for relevant policy and procedure.

Website Modifications (Recommendation 11)

- DSAAPD has updated its website to reflect this recommendation. The updates are attached as Appendix D.[6]

Review Staffing Structure (Recommendation 12)

- DSAAPD is currently working with ADvancing States (formerly National Association of States United Aging and Disabilities (NASUAD)) to streamline and strengthen its community services and support system.
    - ADvancing States is the national expert in aging and disability issues and is the only agency of its kind.
    - The organization represents the nation's 56 state and territorial agencies on aging and disabilities and long-term services and supports directors.
    - DSAAPD needs their expertise to implement the dramatic community reset which will result in the necessary improvements in the Aging and Disability Resource Center, the person-centered assessment process, community nursing, and Adult Protective Services, and ensure that people are served appropriately.
- In preparation for the changes that will result from ADvancing States, DSAAPD is actively filling APS vacancies. DSAAPD has filled four out of five vacancies. The one vacancy is for a grant funded contract position that the APS Administrator is seeking to fill immediately.
- DSAAPD is also hiring an additional three APS nurses to address complex cases, including self-neglect.[7]

[6] See Appendix A for website updates.
[7] See Appendix A for position summary.

Recruitment (Recommendation 13)

- DSAAPD has reached out to two local colleges to participate in their upcoming job fairs:
  - Wilmington University – November 2019
  - Delaware Technical Community College – Spring 2020
- DSAAPD will continue to engage with the local colleges to discuss future employment opportunities.
- DSAAPD has reached out to schedule speaking engagements at the following high schools:
  - Newark High School.
  - Caesar Rodney High School.
  - Milford High School.
  - Woodbridge High School.
- DSAAPD has offered to educate students on the work of DSAAPD and positions available within the division and APS.

Operational Hours (Recommendation 14)

- DSAAPD is actively reviewing the APS staffing structure and the need to extend operational hours. This includes reviewing the number of referrals made after hours and those who could be interviewed for investigations during normal operating hours.
- As stated in Recommendation 12, DSAAPD is currently working with ADvancing States to streamline and strengthen its community services and support system.
- DSAAPD anticipates that ADvancing States will recommend necessary modifications to the agency's operating hours.

DEC UPDATE

DSAAPD Staff Development and Training Department – APS Topics (Recommendation 3)

- The DSAAPD Staff Development and Training department hired a Trainer/Educator III, who began working with APS on November 4, 2019.
- The Trainer has met with DSAAPD Leadership and APS Leadership to begin to develop training plans for the division related to abuse, neglect and exploitation.

DSAAPD Staff Development and Training Department – Develop a Survey to Identify Training Priorities (Recommendation 4)

- The survey closed on November 1, 2019 with 59 of 80 employees (74%) completing it.
- APS staff, ADRC and community support services staff were included in the survey.
- A small workgroup convened to discuss the results of the surveys and develop training plans, utilizing the survey results.[8]
    - The workgroup includes:
        - DSAAPD Deputy Director.
        - Staff Development and Training department.
        - Adult Protective Services unit.
        - Planning, Policy and Program Development unit.

[8] See Appendix F for comprehensive APS Training Plan.

Increase APS-Specific Training (Recommendation 5)

- As of this progress report, 15 APS employees (62.5% of all APS staff) completed the ENGAGE-IL training on October 31, 2019.
- Any staff that have not finished the training have until March 31, 2020 to complete it.
- Staff will also can complete some of the trainings at monthly staff APS meetings.

Provide Formal Training for Dangerous Situations (Recommendation 6)

- As of this progress report, all APS employees have completed the Mandt System® training, an evidence-based training that prevents, de-escalates, and addresses interactions that could become aggressive.
- The need for self-defense becomes much less likely for people who have been trained in the Mandt System®.
- The partnerships developed with Dover Police and the State Police Training Academy will round out the round out the need for self-defense classes.

Increase Financial Exploitation Training (Recommendation 7)

- As of this progress report, 18 APS employees (75%) completed financial exploitation training on November 26, 2019.
    - Any staff that have not finished the training have until March 31, 2020 to complete it.
- In addition, APS' Financial Exploitation Advocate shared with all APS staff a PowerPoint presentation, with staff about well-known scams that staff have seen in Delaware.[9]

[9] See Appendix F for presentation.

Training and Procedures for Self-Neglect Cases (Recommendation 8)

- The DSAAPD Staff Development and Training department developed a Self-Neglect and Hoarding Disorders PowerPoint Presentation, to share with APS staff and nurses.[10]
- The presentation is based on national best practices and utilizes information gleaned from the Administration for Community Living and the National Center on Law & Elder Rights.
- This PowerPoint Presentation will be used as part of the DSAAPD APS Training Plan.

Updates to MOUs (Recommendation 9)

- DSAAPD continues to develop MOUs with partner agencies including:
  - The Long-Term Care Ombudsman Program.
  - The Office of the Public Guardian.
  - Delaware State Police.
- Many of the MOUs will include a component related to annual training about abuse, neglect and exploitation and define a collaborative partnership between the agencies.
- DSAAPD reviews all MOUs annually.

Investigative Time Frames (Recommendation 10)

- DSAAPD continues to ensure all staff are abiding by its policies and procedures, including investigative time frames.

Website Modifications (Recommendation 11)

- DSAAPD continues to ensure its website is up to date, including information related to abuse, neglect, and exploitation.

[10] See Appendix F for presentation.

Review Staffing Structure (Recommendation 12)

- As of this progress report, there are no vacancies within APS.
- DSAAPD continues to work with ADvancing States to streamline and strengthen its community services and support system.

Recruitment (Recommendation 13)

- DHSS has a department-wide recruiter who is targeting individuals interested in the subjects of social work, elder care, and APS.

Operational Hours (Recommendation 14)

- DSAAPD reviewed the need to extend its operational hours.
- Currently, the data does not support this, as most APS referrals are received between 8:00 and 4:30 pm.
- Additionally, APS has a 24-hour live referral line already in place.
- DSAAPD plans to consult with ADvancing States regarding the optimal way to serve alleged victims.
- Following the conclusion of its work with ADvancing States, DSAAPD will review its operational hours annually and make adjustments, as needed, to address any service gaps within APS.

LEGISLATION

The following recommendations were adopted and require legislation. JLOSC and DSAPPD staff will collaborate during the drafting process.

Statutory Update & Technical Corrections (Recommendation 2)

JLOSC will sponsor a bill to make technical corrections to APS's entire governing statute, Chapter 39, Title 31.

Define Self-Neglect in Statute (Recommendation 15) Based on DSAAPD's request, JLOSC will sponsor a bill define "self-neglect" in Chapter 39, Title 31, using the federal Elder Justice Act's definition as a guide:

> The term "self-neglect" means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including— a. obtaining essential food, clothing, shelter, and medical care b. obtaining goods and services necessary to maintain physical health, mental health, or general safety; or c. managing one's own financial affairs.

Note: If this recommendation is approved, the Committee's legislative attorney will include in the draft bill any additional language that may be required to ensure the definition does not conflict with current Delaware law regarding the determination of an individual's capacity.

Option: This recommendation shall be drafted as a bill separate from other legislation resulting from these recommendations.

Define Self-Neglect in Statute "Duty to Report" (Recommendation 16) JLOSC will sponsor a bill to modify § 3910(a), Title 31, APS's "duty to report" statute, to require medical practitioners to file a report.

Option: This recommendation shall be drafted as a bill separate from other legislation resulting from these recommendations.

Modify the APS Advisory Council (Recommendation 17) According to DSAAPD, the APS Advisory Council is not providing meaningful input or oversight to APS activities. DSAAPD suggested that APS oversight should be incorporated into the already established Council on Services for Aging and Adults with Physical Disabilities. DSAAPD also suggested developing an Elder Justice Multidisciplinary Team. The following are options to implement these suggestions.

Option 1: JLOSC will sponsor a bill to remove the APS Advisory Council from § 3903, Title 31 and incorporate APS advisory duties and add Council members representing elder justice partners into the Council on Services for Aging and Adults with Physical Disabilities under § 7915, Title 29.

Option 2: JLOSC will sponsor a bill to modify the APS Advisory Council under § 3903(a), Title 31 to create an Elder Justice Multidisciplinary Team. Members will be appointed by the Governor rather than the DHSS Secretary, serve no more than 2, 3-year terms, and include:

- APS.
- Aging services network personnel.
- Geriatricians/physicians.
- Law enforcement.
- Prosecutors.
- Psychologists/neuropsychologists.
- Victim-witness advocates/victim service providers.

Option 3: If Option 2 is adopted, some of the professional members listed in Option 2 may serve as consultants-as-needed rather than as council members.

Note: A state multi-disciplinary team comprised of a different and distinct membership would review all eligible elder justice cases in Delaware, not just those with APS involvement, and would make recommendations to any appropriate agencies.

The APS Advisory Council currently consists of representatives from:

- Office of the Public Guardian.
- Division of Social Services.
- Division of Services for Aging and Adults with Physical Disabilities.
- Division of Developmental Disabilities Services.
- Division of Substance Abuse and Mental Health.
- Division of Public Health, and Elder Law Program.
- Delaware Emergency Medical Services Oversight Council.
- 3 members from either the medical profession or the general public.

UPDATE 01/23/2020: DSAAPD and APS are currently working with the Department of Justice on a grant to help in forming the state multi-disciplinary team. So, at this point they may not be ready to move forward with the legislation in Recommendation 17 options 2 and 3 but are working on draft language and general ideas for the first option in Recommendation 17. The legislation in this recommendation will take longer to draft.

RECOMMENDATIONS

The following is an easy reference list of all recommendations adopted by the Committee for APS.

RECOMMENDATION 1: APS shall continue, subject to any further recommendations that JLOSC adopts.

RECOMMENDATION 2: The Committee will sponsor a bill to make technical corrections to APS's entire governing statute, including Chapter 39, Title 31.

RECOMMENDATION 3: The DSAAPD staff development and training department shall require at least 1 training position to specialize in APS training topics, offer all DSAAPD staff training in APS topics, and facilitate group registration for the National Adult Protective Services Association (NAPSA) Certificate Program and track progress of completion.

RECOMMENDATION 4: The DSAAPD Staff Development and Training Department shall develop an electronic survey to assess staff knowledge of APS topics, practices, and procedures in order to identify key training priorities.

RECOMMENDATION 5: All staff members, including nurses, who handle APS cases, must complete APS specific training offered by organizations such as Multi-Disciplinary Adult Services Training and Evaluation for Results (MASTER), the University of Illinois at Chicago (UIC), and National Adult Protective Services Association (NAPSA). Additionally, staff shall enroll in the NAPSA Certificate Program.

RECOMMENDATION 6: The DSAAPD Staff Development and Training Department shall network with local and state law enforcement to provide field staff and supervisors with self-defense training and techniques for defusing dangerous situations.

RECOMMENDATION 7: All staff members who specifically handle financial exploitation cases shall complete financial abuse training from providers such as MASTER and the Association of Certified Financial Crime Specialists.

RECOMMENDATION 8: DSAAPD shall create internal training and written procedures for handling cases of self-neglect and assessing capacity in the setting of self-neglect using resources and scholarly articles available from sources such as NAPSA, the National Institute of Health, Adult Protective Services Technical Assistance Resource Center (APR TARC), and other subject matter experts on the topics.

Option: DSAAPD suggested codifying training requirements under the APS statute for the purpose of advancing the section.

RECOMMENDATION 9: The MOUs on file with the Attorney General's Office and the Division of Developmental Disabilities Services were signed more than 5 years ago and should be reviewed and updated.

Option 1: DSAAPD shall review current practices and create additional MOUs with agencies needed to facilitate proper handling of APS cases. Example: Form a MOU with the State Police to provide consult for APS cases.

Option 2: DSAAPD shall review and define interagency roles, response times, and processes for reported cases of abuse, neglect, or financial exploitation cases and include agreed upon roles, response times, and processes in MOU documents.

RECOMMENDATION 10: DSAAPD shall review and implement any needed revisions to policy and procedures regarding investigative time frames.

Option: DSAAPD suggested codifying investigative time frames under the APS statute to establish a time frame for State responses to reports of abuse, neglect, or financial exploitation.

RECOMMENDATION 11: DSAAPD shall make the following modifications to their website:

a) Provide easy to locate APS topics to educate the public and provide clear information on what the agency can and cannot do in APS cases.
b) Provide APS program criteria.
c) Provide information on APS topics in the "information" section of the website.
d) Make the link to APS more prominent on DSAAPD's website; the link is currently hidden in the "all services" section.
e) Provide information for family members and caregivers on how to prevent, identify, and provide help in cases of abuse and neglect, including self-neglect.
f) Make 24-hour report line prominent on website.

RECOMMENDATION 12: DSAAPD shall review its current staffing structures department-wide to determine whether appropriate numbers of personnel and resources are dedicated to handle APS cases, or if personnel or resources in other areas would be better dedicated to APS casework. DSAAPD will follow State procedures to request any necessary reclassifications.

RECOMMENDATION 13: DSAAPD shall partner with high schools and colleges and participate in recruitment events in order to highlight careers available within DSAAPD and the need for professionals in the field of APS. The aging population will continue to grow, and outreach is essential to acquire talented individuals interested in the subjects of social work, elder care, and APS.

RECOMMENDATION 14: DSAAPD shall review its current operating hours and made modifications as necessary. DSAAPD has suggested extending APS operations hours to 8:00 a.m. through 8:00 p.m.

RECOMMENDATION 15: Based on DSAAPD's request, JLOSC will sponsor a bill define "self-neglect" in Chapter 39, Title 31, using the federal Elder Justice Act's definition as a guide: The term "self-neglect" means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including—

a) obtaining essential food, clothing, shelter, and medical care.
b) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or
c) managing one's own financial affairs.

Note: If this recommendation is approved, the Committee's legislative attorney will include in the draft bill any additional language that may be required to ensure the definition does not conflict with current Delaware law regarding the determination of an individual's capacity.

Option: This recommendation shall be drafted as a bill separate from other legislation resulting from these recommendations.

RECOMMENDATION 16: JLOSC will sponsor a bill to modify § 3910(a), Title 31, APS's "duty to report" statute, to require medical practitioners to file a report.

Option: This recommendation shall be drafted as a bill separate from other legislation resulting from these recommendations.

RECOMMENDATION 17: According to DSAAPD, the APS Advisory Council is not providing meaningful input or oversight to APS activities. DSAAPD suggested that APS oversight should be incorporated into the already established Council on Services for Aging and Adults with Physical Disabilities. DSAAPD also suggested developing an Elder Justice Multidisciplinary Team. The following are options to implement these suggestions.

Option 1: JLOSC will sponsor a bill to remove the APS Advisory Council from § 3903, Title 31 and incorporate APS advisory duties and add Council members representing elder justice partners into the Council on Services for Aging and Adults with Physical Disabilities under § 7915, Title 29.

Option 2: JLOSC will sponsor a bill to modify the APS Advisory Council under § 3903(a), Title 31 to create an Elder Justice Multidisciplinary Team. Members will be appointed by the Governor rather than the DHSS Secretary, serve no more than 2, 3-year terms, and include:

- APS.
- Aging services network personnel.
- Geriatricians/physicians.
- Law enforcement.
- Prosecutors.
- Psychologists/neuropsychologists.
- Victim-witness advocates/victim service providers.

Option 3: If Option 2 is adopted, some of the professional members listed in Option 2 may serve as consultants-as-needed rather than as council members.

RECOMMENDATION 18: APS is held over and shall report to the Committee in January 2020.

ANALYST RECOMMENDATIONS

DSAAPD and APS have made admirable and positive progress on all the Committee's recommendations regarding staff development and training, updating MOUs, website modifications, reviewing staffing structures, and recruitment initiatives. After thoughtful review and research, DSAAPD ultimately determined that revising their operational hours to 8:00 a.m. through 8:00 p.m. will not be appropriate. The Committee's Analyst agrees with this assessment.

The remaining recommendations requiring legislation will be drafted jointly between JLOSC and DSAAPD staff. Legislative items such as defining self-neglect, modifying the APS Advisory Council, and implementing an Elder Justice Multidisciplinary Team will take more drafting time. The Committee's Analyst believes that this should not prevent a release from review.

ANALYST RECOMMENDATION: APS is released from review upon enactment of a bill to apply technical corrections to APS's entire governing statute.

DHIN Talking Points for JLOSC Holdover Review

Bold and highlighted items are those most urgently desired by DHIN.

JLOSC Recommendations Requiring Further Action

- Recommendation 3: Continued Federal Funding Initiatives
  - Since the December report provided to JLOSC, the MOU between DMMA and DHIN to execute the terms of the IAPD was signed and work has begun.
  - The current IAPD applies through FY21 (Sep 30, 2021). The bulk of enhanced Federal Financial Participation (FFP) in the first year is 90/10, transitioning to primarily 75/25 by the third year.
  - **DHIN requests that the unspent portion of the $2M State appropriation in support of the HCCD be carried over to FY21 to ensure the availability of the required State match.**
  - **The State will need to commit 25% of HCCD operating costs on an ongoing basis in order to continue to secure 75% FFP in future years.** This is approximately $500K per year in FY20 dollars.

- Recommendation 6: Task Force to Address Statutory Updates to Strengthen HCCD & Ensure DHIN's Continued Success

  The specific elements of this recommendation can be grouped as follows:

  - Maximize the number and type of claims submitted to the HCCD: Draft legislation submitted to:
    - Include dental plans and Dept of Corrections as mandatory reporting entities.
    - Permit DHIN to collect claims for genetic testing and HIV testing – these are sensitive areas requiring further discussion.

- Expand the allowable uses of clinical data:
  - 16 *Del. C.* § 10307(a) currently specifies, "The DHIN shall by rule or regulation ensure that patient specific health information be disclosed only in accordance with the patient's consent or best interest to those having a need to know" (underlining added for emphasis).
  - **DHIN requests the addition of statutory language permitting the use of de-identified or limited data sets which do not include patient-specific health information to be used for all lawful purposes, to include analytics for purposes of evaluating utilization patterns, quality and outcomes, coverage and access, population and public health, and health system performance.**
  - **DHIN requests the addition of statutory language permitting the use of de-identified or limited data sets which do not include patient-specific health information to be used for research purposes.**
  - **DHIN requests the addition of statutory language permitting Gift of Life (the organization overseeing the matching of organ donors and recipients) and any other entity to whom holders of clinical data would be required to provide data if requested, to have direct access to the DHIN clinical data consistent with their statutory authority and obligations and subject to DHIN's privacy and security policies.**
  - DHIN requests the addition of statutory language stating that DHIN may provide access to data or reports to a public health authority legally authorized to receive such data or reports for a public health purpose on behalf of the entities who submitted such data.

- Maximize the amount and types of clinical data submitted to the DHIN:
  - **Draft legislation previously introduced to require Urgent Care/Walk-in facilities to provide DHIN with an electronic summary of care for each episode.**
    - **Recommend similar legislation requiring telehealth providers and each long-term care facility that uses an electronic health record to provide DHIN with an electronic summary of care for each episode.**
  - A possible generic approach to statutory language could be, "all providers of health services paid for in part or in whole through public funding, whether federal or state, shall submit to DHIN a summary of each visit or episode of care in an electronic format to be determined by DHIN."

Draft legislation submitted to:

- **Request support and potential statutory language designating DHIN as a lawful holder of claims data governed by 42 CFR Part 2 ("Part 2"). DHIN will continue to be a lawful holder of clinical data governed by Part 2, if agreed to and supported by the organization(s) sending data to DHIN that is subject to Part 2. In any circumstance, DHIN will only disclose Part 2 data in accordance with patient consent and the requirements of Part 2 that are in effect at the time of disclosure.**
- Allow the Delaware Prescription Monitoring Program to provide prescription drug data to the DHIN. Further legislation would be required to authorize the PDMP to collect all prescription data from participating pharmacies, not just controlled substances.
- Require Dept of Corrections to send electronic summaries of each episode of Care to the DHIN. This will support transitions of inmates into the community health care

system upon release. There would be costs to DOC for sending clinical data, consistent with the business model applied to all other clinical data submitters. Spurred by JLOSC, DHIN and DOC are currently in discussions and DOC is reviewing a pricing proposal from DHIN.

- Recommendation 7: Reduce Overlap and Duplicated Efforts:

  DHIN believes that having all health data used by the State and its various agencies, departments, and divisions flow through DHIN would lead to a reduction in the number of interfaces and end points that the State must manage, as well as a reduction in redundant reporting and storage of the same or similar data in multiple databases and data warehouses. DHIN intends to bid on RFPs involving health data. An amendment to Title 29, Chapter 69 (State Procurement) could include an exception to the requirement for competitive procurements for services obtained from a public instrumentality, such as DHIN. The ability of a state agency to directly contract with DHIN could save time and money in the procurement process.

Additional Legislative Action DHIN Feels Would Be Helpful

- Current language in 16 *Del. C.* § 10301 identifies DHIN as the "State-sanctioned provider of health information exchange services." The following additions could enhance the impact of that description:
  - "As such, submission of health data to any state agency, department, or division should be done through DHIN to the extent it is feasible to do so."
  - DHIN is the State Designated Entity (SDE) authorized to apply for and receive Federal grants pertaining to health information technology and health information exchange.
  - Amend Title 29 Chapter 69 (State Procurement) § 6904(b) as follows: "This chapter shall not apply to any purchase of materials or services from the federal government or from the government of the State including any agency of the State, as defined in § 6902 of this title, <u>or any public instrumentality of the State created by State statute and operated for public purposes</u>."

DHIN CONTENTS

OVERVIEW

The Delaware Health Information Network ("DHIN") was established in 1997 by statute, under the direction of the Delaware Healthcare Commission. In July of 2010, the General Assembly removed DHIN from the Delaware Healthcare Commission's organizational structure. DHIN is currently operating as a statutory not-for-profit instrumentality of the State of Delaware with certain rights, obligations, and privileges and the purpose to promote the design, implementation, operation, and maintenance of facilities for public and private use of health care information in the State.

DHIN's statutory mission is to develop and operate a statewide health information network integrating patient satisfaction, clinical, and financial data sources to inform decisions. The law intends for DHIN to be a public-private partnership for the benefit of all citizens of Delaware.

In July 2016, the General Assembly created the Delaware Health Care Claims Database ("HCCD") to be administered and operated under the existing DHIN framework. The Delaware HCCD was created to assist with Delaware's ongoing work to transform the State's health care system from a fee-for-service system to a value-based system that rewards health care providers for quality and efficiency of care. This bill created the basic structure and parameters of the HCCD, which was subject to further guidance set forth in rules and regulations to be promulgated by the DHIN, in continued consultation with the Department of Health and Social Services, the Health Care Commission, and stakeholders in the health care community. On May 1, 2019, DHIN publically unveiled the HCCD at the University of Delaware's STAR campus. is fully functional. As of January 1, 2020, the HCCD contains 495,000 unique records which represent more than half of Delaware residents and include claims from 2013 through 2018 of all required payers.

The Committee made several recommendations for DHIN. The Committee's recommendations included creating and submitting an annual status report regarding the HCCD, updating DHIN's governing statute to strengthen the HCCD and overall DHIN operations, reducing overlap and duplicated efforts, updating current regulations and HCCD internal procedures, and updating the website. Due to the many recommended statutory changes, the Committee recommended the creation of a task force in order to adequately review, discuss, and finalize draft legislation for the Committee to review in January 2020.

The Committee recommended DHIN be held over and report back to the Committee in January 2020. At that time, the Committee will review the agency's progress in implementing recommendations, the proposed draft legislation from the task force, and consider releasing from review.

DEC UPDATE

MOUs for HCCD (Recommendation 2)

- DHIN has memorandum of understandings ("MOUs") and data use agreements ("DUAs") with the following state agencies and is currently engaged in the studies listed:
  - Delaware Health Care Commission
    - Report – Delaware Primary Care Total Spend
    - Report (pending contract) – Cost Transparency
    - Request in pipeline – Prevalence of certain diseases of interest
  - Division of Public Health
    - Data extract – Lung Cancer Cost Study
    - Request in Pipeline – Data extract: HPV immunization prevalence
  - Division of Medicaid and Medical Assistance (IAPD)
    - Data extract – supports various DMMA analytics
  - Special Council for Persons with Disabilities
    - Brain Trauma prevalence and geography
  - Delaware Health and Social Services
  - Gift of Life – DHIN is proceeding with making the required changes to statute to execute data requests.
  - Dept. of Correction – DHIN met with DOC team to discuss next steps in formalizing partnership and providing assistance with preliminary technical requirements.

Continued Federal Funding Initiatives (Recommendation 3)

- DHIN and DMMA received approval for proposed IAPD from CMS in May 2019. DMMA required separate contracting documentation for IAPD. DHIN signed the revised contract December 10, 2019.
    - As of December 20, 2019, DMMA has not yet countersigned.

Annual HCCD Status Report (Recommendation 4)

- DHIN completed and released an annual HCCD status report.
    - The report can be found in Appendix K.

Reduce Overlap and Duplicated Efforts (Recommendation 7)

- DHIN has continued to investigate ways in which it can assist the State as its only sanctioned provider of health information services and an available "single point of contact" for delivery of health data on Delaware residents to assist state and federal public health efforts.
    - DHIN has already begun preparations to engage, if necessary, in the RFP that will be issued by the State Employee Benefits Committee relating to data warehousing and analytics services associated with the State's employee health benefit plan.
- Certain tasks currently being performed by third parties and paid for by the State could be performed by DHIN, likely at a cost savings to the State. DHIN intends to bid on those services in any RFP process, and to engage in a dialogue with the agency to determine whether there are any other areas in which DHIN could provide the State with replacement or enhanced services on a more cost-effective basis than possible with entities that do not share DHIN's status as a not-for-profit State instrumentality.
- DHIN also has begun conversations with DMMA with respect to data warehousing and analytics services contracts to maintain and improve the State's Medicaid Program. Those conversations resulted in the IAPD project, discussed separately, that will both enhance the Health Care Claims Database and provide additional services to Medicaid at a reasonable (and federally matched) cost.

- DHIN intends to continue to work with DMMA to determine if there are other areas where it currently contracts with third parties – especially in the areas of data warehousing and analytics – where DHIN could leverage the data in the HCCD and its status as a not-for-profit State instrumentality to provide more cost-effective services to other areas of the Medicaid program.
- Finally, DHIN believes that it can provide additional services to healthcare-related state agencies at a competitive cost, with the added benefit of diversifying DHIN's revenue stream and helping to ensure that the State-sanctioned provider of health information exchange services continues to thrive.
- DHIN will be discussing, with potential sponsors, an extension of the current statutory language that permits certain divisions of state government to contract with DHIN for healthcare data warehousing and analytics services without going through the typical procurement process.
    - The model for this legislation is Section 6904(m) of Title 29, which permits the Department of Education to contract directly with the University of Delaware, Delaware State University, and Delaware Technical and Community College for any goods and services.
    - Under DHIN's proposed statutory edits, the Department of Health and Social Services and Department of Insurance will be able to contract directly with DHIN for goods and services without going through the more onerous procurement process.

Update Current Regulations (Recommendation 8)

- DHIN has begun the process of re-drafting its regulations. Given that legislation is being proposed as a result of the task force, DHIN has not finalized those regulations at this time.
    - Once any legislation recommended by the task force becomes law, DHIN will finish the process of drafting updated regulations and will submit them for public review and comment as is the standard process.

- Currently, DHIN expects to be able to initiate the regulatory change process in the 3rd calendar quarter of 2020.

Update Current HCCD Internal Procedures (Recommendation 9)

- DHIN embraces the ITIL frameworks of Best Practices in the provision of IT services. One ITIL process that exists throughout DHIN's operational culture is the Continual Service Improvement process. Consistent with that process, DHIN is always engaged in a process of self-reflection and examination, with a goal towards improving the quality of services it offers to end users. Specifically concerning the HCCD, DHIN consistently reviews (along with its vendors) the internal procedures with respect to the processes of obtaining, storing and providing access to data in the HCCD.

- DHIN's report to the Governor and General Assembly (Recommendation 4 above) discusses some of the immediate improvements DHIN is working on implementing, including improvements designed to streamline the way in which its most consistent users of the HCCD – state agencies – apply for and access data.
  - DHIN management also has an internal goal of developing a three-year sustainability and business plan for the HCCD, and to present it to its Board for approval during this fiscal year.
  - Finally, with respect to data access pricing, DHIN's board approved a pricing paradigm earlier this fiscal year.[11]

- As applications continue to come in – and as DHIN continues to speak to potential users and researchers who would like to access data in the HCCD – it intends to take any feedback on our pricing model and approach the Board with any recommended changes.

[11] See Appendix N for DHIN Pricing Schedule and Budget.

Website Updates (Recommendation 10)

- Website updates are nearly complete.
    a. Banner has been added.
    b. Addition of banner makes the addition of an icon duplicative.
    c. HCCD added to dropdown menus for Providers and Data Senders, in addition to appearing as a banner on each individual page.
    d. “In the News” has been updated.
    e. Two HCCD videos have been created, posted to dhin.org, and shared via social media.
    f. Redesign is underway and ongoing.
    g. Data access application requires updates; fillable web form functionality will be added to the updated application.
    h. Link has been added.

- Additional website enhancements are planned per Recommendation 4 – Future Plans.

TASK FORCE UPDATE

FACT SHEET

January 16, 2020 JLOSC Task Force on DHIN

Joint Legislative Oversight & Sunset Committee

Task Force Composition and Objectives

- 11-member task force.
- 4 meetings to discuss JLOSC Recommendations 2, 4, and 6.
  - Recommendations relate to statutory changes to DHIN's governing statute and require additional research and discussion.
- DHIN provided PowerPoint presentations during meetings 2 and 3 which aided discussion.
- DHIN's General Counsel drafted 7 bills for Task Force discussion.

Legislative Proposals with Task Force Support

- Use of clinical data for research.
- Sharing with DHIN important data, such as pharmacy, dental, and post-acute.
- Gift of Life is excited to work with DHIN.
  - Secure direct access supports mission of coordinating organ and tissue donation and transplant efforts for Delaware.
  - DHIN information helped secure a life-saving liver transplant last year.

Legislative Proposals with Areas of Concern

- Division of Public Health noted there are conflicts regarding HIV and genetic testing results.
- Mike Records with the Department of Corrections voiced concerns with the cost and use of data.
- DHIN recognizes these concerns and agrees that proper measures need to be in place to ensure redisclosure rules are followed so that sensitive data is accessible only by those authorized.
- DHIN anticipates additional conversations to take place with DOC, further conversations are needed before moving forward with legislation involving DOC.
- The task force agreed that these areas of concern require further discussion prior to statutory changes.

LEGISLATION

The following recommendations were adopted and require legislation. JLOSC and DHIN staff will collaborate during the drafting process.

Statutory Update & Technical Corrections (Recommendation 5)

JLOSC will sponsor a bill to make technical corrections to DHIN's entire governing statute, Chapter 103, Title 16.

Statutory Updates to Strengthen HCCD & Ensure DHIN's Continued Success (Recommendation 6)

At DHIN's request, DHIN wishes to work with the Committee's legislative attorney to draft bills that will:

a. Maximize the number and types of claims that are submitted to the Delaware HCCD.
b. Permit more detailed reporting of claims related to sensitive diagnoses (by, for example, identifying DHIN as an appropriate holder of data associated with an HIV-related test (16 Del. C. § 717) or genetic testing (16 Del. C. § 1205)).
c. Maximize the number and types of entities that submit clinical information to the DHIN.
d. Permit use of clinical data for public health reporting and research.
e. Permit the use of de-identified clinical data for appropriate research purposes.
f. Ensure that pharmacy prescription fill data is provided to the DHIN.
g. Permit DHIN to provide data to the Gift of Life program on potential donors (this would be needed to establish a partnership between the two entities as referenced in recommendation number 2).

TASK FORCE UPDATE: 7 drafts exist from the task force process.[12]

4 drafts have no known conflicts and can move forward (pending technical corrections and JLOSC review):

- DENTAL CLAIMS DATA
- LONG-TERM CARE FACILITIES
- DELAWARE PRESCRIPTION MONITORING PROGRAM DATA AND DHIN[13]
- TELEMEDICINE AND DHIN

Conflicts exist with 3 drafts; DHIN is continuing discussions, but cannot move forward at this time:

- DOC PARTICIPATION IN DHIN
- GENETIC TESTING DATA AND CLAIMS INFORMATION
- HIV TEST RESULTS AND CLAIMS INFORMATION

[12] See Appendix O for draft legislation from the task force.

[13] Attempts were made to receive comment from DPR on the draft. As of 1/31/2020, DPR has not submitted comments and could potentially have issues. This legislation would also require amendments to DPR's statute for the prescription monitoring program, which is currently not authorized to collect prescription data on prescriptions dispensed for non-controlled medications.

RECOMMENDATIONS

The following is an easy reference list of all recommendations adopted by the Committee for DHIN.

RECOMMENDATION 1: DHIN shall continue, subject to any further recommendations that JLOSC adopts.

RECOMMENDATION 2: DHIN shall continue to work with the Department of Health and Social Services, Delaware Office of Management and Budget, Division of Public Health, Division of Medicaid and Medical Assistance ("DMMA"), and Delaware Health Care Commission to finalize MOUs permitting those collaborating state agencies to access data in the HCCD.

Option: DHIN shall explore possible partnerships and develop MOUs with other agencies that will strengthen research and data for the HCCD. For example, DHIN could explore partnership with the Department of Correction ("DOC") and organ procurement organizations (such as the Gift of Life program) to identify ways in which DHIN data can be used to safely and quickly assist with organ donation suitability determinations.

RECOMMENDATION 3: DHIN shall continue their work with DMMA to leverage their previously appropriated state funding for the HCCD by seeking a federal match through the Implementation Advance Planning Document ("IAPD") process.

Option: Should the IAPD process be unsuccessful for any reason, DHIN shall work with JLOSC to ensure that the $2 million already appropriated funds remain available to DHIN for its work setting up and maintaining the HCCD.

RECOMMENDATION 4: DHIN shall submit an annual status report, no later than January 1, to the Governor and General Assembly, regarding the HCCD. Reports shall include:

a. Analysis of strengths and weakness of HCCD.
b. Current status and future plans of HCCD.
c. Detailed Budget for HCCD operations.
d. Grant applications and status for HCCD operational funding.
e. Status of contracts with vendors supporting HCCD operations.
f. Number of data access requests submitted and granted.

Option 1: The first report shall be submitted no later than January 1, 2020.
Option 2: The annual reports shall be included on the DHIN website.

RECOMMENDATION 5: JLOSC will sponsor a bill to make technical corrections to DHIN's entire governing statute, Chapter 103, Title 16.

RECOMMENDATION 6: At DHIN's request, DHIN wishes to work with the Committee's legislative attorney to draft bills that will:

h. Maximize the number and types of claims that are submitted to the Delaware HCCD.
i. Permit more detailed reporting of claims related to sensitive diagnoses (by, for example, identifying DHIN as an appropriate holder of data associated with an HIV-related test (16 Del. C. § 717) or genetic testing (16 Del. C. § 1205)).
j. Maximize the number and types of entities that submit clinical information to the DHIN.
k. Permit use of clinical data for public health reporting and research.
l. Permit the use of de-identified clinical data for appropriate research purposes.
m. Ensure that pharmacy prescription fill data is provided to the DHIN.
n. Permit DHIN to provide data to the Gift of Life program on potential donors (this would be needed to establish a partnership between the two entities as referenced in recommendation number 2).

Option 1: Create a small JLOSC subcommittee to will discuss the proposed statutory amendments and report back to the JLOSC in January 2020. Subcommittee membership will include DHIN's private counsel, the Committee's legislative attorney, and other members the Committee deems appropriate.

Option 2: Same as Option 1 but create a task force instead of a JLOSC subcommittee.

RECOMMENDATION 7: At DHIN's request, DHIN shall identify areas of overlap between its capabilities and those separately contracted for or provided by State agencies, and work with those agencies to eliminate overlap or redundancies. As a part of these efforts, DHIN shall explore whether it can reasonably be the "single point of contact" for delivery of health data on Delaware residents to assist state and federal public health efforts. By statute, DHIN is the "State's sanctioned provider of health information exchange (HIE) services" (16 Del. C. § 10301).

Option: DHIN will report back to the JLOSC on progress of this research in January 2020.

RECOMMENDATION 8: DHIN shall update its regulations to reflect current operational procedures.

Option: DHIN will report back to the JLOSC on progress of these efforts in January 2020.

RECOMMENDATION 9: DHIN shall review and apply updates as needed to internal procedures involving HCCD operations. Areas of focus must include:

a. Data staging, storage, and management.
b. Reviewing and granting data access applications.
c. Reviewing data access pricing.
d. Reviewing and implementing marketing strategies and goals.

Option: DHIN will report back to the JLOSC on progress of these efforts in January 2020.

RECOMMENDATION 10: DHIN shall make the following updates to their website to advertise and promote the use of the HCCD to increase private funding opportunities associated with granting data access applications:

a. Create a banner for the HCCD on the DHIN homepage.
b. Include an icon on the DHIN homepage for the HCCD (current icons only include Patients, Healthcare Providers, and Data Senders).
c. Add a specific webpage menu for the HCCD that would be included at the top of all DHIN webpages.
d. Update the "in the news" section of the DHIN website and include recent news regarding the HCCD. The most recent news item was from August 2018.
e. Create and include a HCCD brochure for the website.
f. Redesign the HCCD webpage in order to adequately market the HCCD and attract data access applications.
g. Make the HCCD data access application a fillable PDF document or fillable web form for easier submissions.
h. Include a prominent link to the HCCD Committee's information including meeting agendas and minutes.

RECOMMENDATION 11: DHIN is held over and shall report to the Committee in January 2020.

ANALYST RECOMMENDATIONS

DHIN has made admirable and positive progress on the Committee's recommendations regarding reducing overlap and duplicated efforts, updating current regulations and HCCD internal procedures, and updating the website. DHIN created and submitted an annual status report regarding the HCCD.[14]

As outlined in the HCCD annual status report, DHIN has made positive progress in seeking federal matching funds through the IAPD process for maintaining HCCD operations. As noted in the report, it is important to mention that other state sustainability models for All Payer Claims Databases, such as the HCCD, indicate that the sale of data products alone is not a viable sole funding source. Other states with functioning All Payer Claims Databases receive a combination of state, federal, and grant funding.

DHIN shall continue their work with DMMA to leverage their previously appropriated state funding for the HCCD by seeking a federal match through the Implementation Advance Planning Document ("IAPD") process.

Due to the many recommended statutory changes, the Committee recommended the creation of a task force in order to adequately review, discuss, and finalize draft legislation for the Committee. The task force held a total of four meetings and produced 7 pieces of draft legislation. There is still more work to accomplish, but the task force provided meaningful discussion and a good starting point.

[14] See Appendix K for 2019 HCCD annual report.

The recommendations requiring legislation will be drafted jointly between JLOSC and DHIN staff using all information collected during the review and task force process. Legislative items such as updating DHIN's governing statute to strengthen the HCCD and overall DHIN operations will take additional time. The Committee's Analyst believes that this should not prevent a release from review.

ANALYST RECOMMENDATION: DHIN is released from review upon enactment of a bill to apply technical corrections to DHIN's entire governing statute.

APPENDICES

Recommendation & Status	Progress Reporting
Recommendation 1: Continue or Terminate Under §10213(a), Title 29, the Committee must determine whether there is a genuine public need for an agency under review. To meet this requirement, the Committee may select one of the following options. Option 1: APS shall continue, subject to any further recommendations that JLOSC adopts. - OR - Option 2: APS is terminated and the Committee will sponsor legislation to implement this recommendation. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 1 with option 1.	**Progress Reporting not needed for this recommendation**

Recommendation & Status	Progress Reporting
Recommendation 2: Statutory Update & Technical Corrections JLOSC will sponsor a bill to make technical corrections to APS's entire governing statute, Chapter 39, Title 31.* **Status:** 5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 2.	**Progress Reporting not needed for this recommendation**

* The Committee's legislative attorney will draft any legislation resulting from approved recommendations, unless otherwise noted.

Recommendation & Status	Progress Reporting
Recommendation 3: DSAAPD Staff Development and Training Department† – APS Topics DSAAPD has a dedicated staff development and training department that has 8 training positions and 2 administrative assistants. The DSAAPD staff development and training department shall: a. Require at least 1 training position to specialize in APS training topics. b. Offer all DSAAPD staff who work with APS-related topics continual training offerings in order to remain on top of the latest field trends. c. Facilitate group registration for the National Adult Protective Services Association (NAPSA) Certificate Program and track progress of completion. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 3.	**October Update:** DSAAPD posted the APS training position on 8/21/2019 for a Trainer/Educator III (Registered Nurse BSN). Because the trainer is required to be a registered nurse, recruitment has taken time and effort. The position closed on 9/24/2019. The summary statement reads: *The incumbent in this position will be responsible for the training of programs for professional, paraprofessional and ancillary staff. A primary responsibility of this position will include planning, developing and presenting on-going training/education programs for Adult Protective Services (APS) staff. Responsibilities includes training APS staff in statewide locations, continued education in APS best practices, networking with other trainers in this area, and evaluating the effectiveness of training materials. Additional training in other subject matter areas may also be required.* The DSAAPD Staff Development and Training department held interviews for the APS Trainer on 10/21/2019 and the position was offered to one of the candidates. DSAAPD has also completed the registration of APS through the National Adult Protective Services

† APS is the entity under JLOSC review, but APS is a unit under the purview of DSAAPD which has oversight responsibilities, including fiscal. Draft recommendations will frequently reference DSAAPD as they are the agency charged with implementing and maintaining APS operations. DSAAPD comments are included with yellow highlights.

	Association (NAPSA) Certificate Program and is tracking completion of that program for all staff. **December Update:**
Recommendation & Status	**Progress Reporting**
Recommendation 4: DSAAPD Staff Development and Training Department – Develop a Survey to Identify Training Priorities The DSAAPD Staff Development and Training Department shall develop an electronic survey to assess staff knowledge of APS topics, practices, and procedures in order to identify key training priorities. The survey shall allow all DSAAPD employees involved in APS cases to anonymously complete it, including APS-assigned nurses and employees of the Aging Disability Resource Center (ADRC) hotline. DSAAPD shall develop training plans to address the priorities identified through the survey. The State of Georgia completed a similar study of their APS unit. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 4.	**October Update:** The DSAAPD Staff Development and Training department, in coordination with the Planning, Policy and Program Development unit, developed a survey. The survey is attached as Appendix A. The survey was made available on 10/17/2019 to all staff that may be involved with APS cases, including APS, the Aging and Disability Resource Center (ADRC), Community Services Program (CSP), Community Nursing, and the Diversion and Discharge Unit. In total, almost 80 staff members received the survey. As of the October Progress Report, 58 staff members have taken the survey. **December Update:**
Recommendation & Status	**Progress Reporting**
Recommendation 5: Increase APS-Specific Training All staff members, including nurses, who handle APS cases, must complete the following training or similar offerings: a. APS Self-Neglect Home Visit Training Videos available online and free of charge by Multi-Disciplinary Adult Services Training and Evaluation for Results (MASTER), which is a program of Academy for Professional Excellence, a project of the San Diego State University School of Social Work.	**October Update:** The APS Administrator, in coordination with the APS Supervisors and the DSAAPD Staff Development and Training department, has developed an APS Training Plan, attached as Appendix B, for all APS staff, including APS nurses. This plan is included in all staff performance plans to ensure all trainings are completed in a timely fashion. The APS Self-Neglect Home Visit Training and

b. Individual Module titled Elder Abuse and Self-Neglect available online and free of charge online by ENGAGE-IL, an interprofessional, collaborative education and practice initiative to enhance care of older adults by The University of Illinois at Chicago (UIC). c. Training modules in the National Adult Protective Services Association (NAPSA) Certificate Program curriculum. Staff shall enroll in the NAPSA Certificate Program. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 5.	the MASTER program training are part of this APS Training Plan. In addition, staff will have the opportunity to complete some of the trainings at monthly staff APS meetings. **December Update:**
Recommendation & Status	**Progress Reporting**
Recommendation 6: Provide Formal Training for Dangerous Situations The DSAAPD Staff Development and Training Department shall network with local and state law enforcement to provide field staff and supervisors with self-defense training and techniques for defusing dangerous situations. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 6.	**October Update:** The DSAAPD Staff Development and Training department has reached out to the Dover Police Department and State Police Training Academy to form a self-defense training partnership. In addition, all APS staff will be required to participate in The Mandt System® training. The training will be held on November 5th, 12th and 19th and on December 3rd, 11th and 17th. This training uses a continuous learning and development approach to prevent, de-escalate, and if necessary, intervene in behavioral interactions that could become aggressive. **December Update:**
Recommendation & Status	**Progress Reporting**
Recommendation 7: Increase Financial Exploitation Training All staff members who specifically handle financial exploitation cases shall complete the following training or similar offerings:	**October Update:** The APS Administrator, in coordination with the APS Supervisors and the DSAAPD Staff Development and

a. Elder Financial Abuse Online Training offered by the Association of Certified Financial Crime Specialists. b. Financial Abuse Training e-learning modules available online by MASTER. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 7.	Training department, has developed a training plan, attached as Appendix B, for all APS staff, including APS nurses. This plan is included in all staff performance plans to ensure all trainings are completed in a timely fashion. Elder Financial Abuse Online Training and Financial Abuse Training from MASTER are included in this APS Training Plan. **December Update:**
Recommendation & Status	**Progress Reporting**
Recommendation 8: Training and Procedures for Self-Neglect Cases DSAAPD shall create internal training and written procedures for handling cases of self-neglect and assessing capacity in the setting of self-neglect using resources and scholarly articles available from sources such as NAPSA, the National Institute of Health, Adult Protective Services Technical Assistance Resource Center (APR TARC), and other subject matter experts on the topics. Option: DSAAPD suggested codifying training requirements under the APS statute for the purpose of advancing the section. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 8 with option.	**October Update:** DSAAPD is revising internal written procedures for handling of self-neglect cases within APS. For the training in self-neglect, the APS Administrator, in coordination with the APS Supervisors and the DSAAPD Staff Development and Training department, has developed an APS Training Plan, attached as Appendix B, for all APS staff, including APS nurses. This plan is included in all staff performance plans to ensure all trainings are completed in a timely fashion. In addition, the NAPSA self-neglect module training will be held on 10/31/2019 for all APS staff. The APS Supervisors will facilitate this training. **December Update:**
Recommendation & Status	**Progress Reporting**
Recommendation 9: Updates to MOUs	**October Update:**

The following MOUs on file were signed more than 5 years ago and should be reviewed and updated: a. With the Attorney General's Office, dated April 7, 1997. b. With the Division of Developmental Disabilities Services, dated June 21, 2012. Option 1: DSAAPD shall review current practices and create additional MOUs with agencies needed to facilitate proper handling of APS cases. Example: form a MOU with the State Police to provide consult for APS cases. Option 2: DSAAPD shall review and define interagency roles, response times, and processes for reported cases of abuse, neglect, or financial exploitation cases and include agreed upon roles, response times, and processes in MOU documents. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 9 with options 1 and 2.	DSAAPD has sent updated MOU's to the following entities: • Division of Developmental Disabilities Services • Division of Health Care Quality As of the October Progress Report, these MOU's are awaiting signatures from these divisions. In addition, DSAAPD is working to develop MOU's with: • The Department of Justice • The Long Term Care Ombudsman Program • The Office of the Public Guardian • Delaware State Police **December Update:**
Recommendation & Status	**Progress Reporting**
Recommendation 10: Investigative Time Frames DSAAPD shall review and implement any needed revisions to policy and procedures regarding investigative time frames. Option: DSAAPD suggested codifying investigative time frames under the APS statute to establish a time frame for State responses to reports of abuse, neglect, or financial exploitation. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 10 with option	**October Update:** DSAAPD has updated its policies and procedures to reflect national best practices regarding investigative time frames. The relevant policy and procedure is attached as Appendix C. **December Update:**
Recommendation & Status	**Progress Reporting**
Recommendation 11: Website Modifications DSAAPD shall make the following modifications to their website:	**October Update:**

a. Provide easy to locate APS topics to educate the public and provide clear information on what the agency can and cannot do in APS cases. b. Provide APS program criteria. c. Provide information on APS topics in the "information" section of the website. d. Make the link to APS more prominent on DSAAPD's website; the link is currently hidden in the "all services" section. e. Provide information for family members and caregivers on how to prevent, identify, and provide help in cases of abuse and neglect, including self-neglect. f. Make 24-hour report line prominent on website. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 11.	DSAAPD has updated its website to reflect this recommendation. The updates are attached as Appendix D. **December Update:**
Recommendation & Status	**Progress Reporting**
Recommendation 12: Review Staffing Structure DSAAPD shall review its current staffing structures department-wide to determine whether appropriate numbers of personnel and resources are dedicated to handle APS cases, or if personnel or resources in other areas would be better dedicated to APS casework. DSAAPD will follow State procedures to request any necessary reclassifications. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 12.	**October Update:** DSAAPD is currently working with ADvancing States (formerly National Association of States United Aging and Disabilities (NASUAD)) to streamline and strengthen its community services and support system. ADvancing States is the national expert in aging and disability issues, and is the only agency of its kind. The organization represents the nation's 56 state and territorial agencies on aging and disabilities and long-term services and supports directors. DSAAPD needs their expertise to implement the dramatic community reset which will result in the necessary improvements in

	the Aging and Disability Resource Center, the person-centered assessment process, community nursing, and Adult Protective Services, and ensure that people are served appropriately. In preparation for the changes that will result from ADvancing States, DSAAPD is actively filling APS vacancies. DSAAPD has filled four out of five vacancies. The one vacancy is for a grant funded contract position that the APS Administrator is seeking to fill immediately. DSAAPD is also hiring an additional three APS nurses to address complex cases, including self-neglect. The summary reads: *The incumbent provides a comprehensive overall health assessment for individuals referred to Adult Protective Services. Referrals include clients that are hoarders, mentally ill, demented, frail, self-neglect and disabled. The RN follows the Nursing Process (assessment, diagnosis, planning, implementation and evaluation). The incumbent will lend medical assistance to individuals in need, such as first aid, cardiopulmonary resuscitation (CPR), or naloxone administration. Work includes evaluating the competency of clients and their ability to function in their home and the community. The RN will develop and implement plans designed to meet the personal, social, and health care needs of the client. RNs will coordinate with available programs and resources to assist clients to remain safely in their homes or assist with placement in a safer environment.*

	APS has also balanced out the workload between staff to ensure the future changes can be implemented in an equitable fashion. **December Update:**
Recommendation & Status	**Progress Reporting**
Recommendation 13: Recruitment DSAAPD shall partner with high schools and colleges and participate in recruitment events in order to highlight careers available within DSAAPD and the need for professionals in the field of APS. The aging population will continue to grow and outreach is essential to acquire talented individuals interested in the subjects of social work, elder care, and APS. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 13.	**October Update:** DSAAPD has reached out to two local colleges in order to participate in their upcoming job fairs: • Wilmington University – November 2019 • Delaware Technical Community College – Spring 2020 DSAAPD will continue to engage with the local colleges to discuss future employment opportunities. DSAAPD has reached out to schedule speaking engagements at the following high schools: • Newark High School • Caesar Rodney High School • Milford High School • Woodbridge High School DSAAPD has offered to educate students on the work of DSAAPD and positions available within the division, including those with APS. **December Update:**

Recommendation & Status	**Progress Reporting**
Recommendation 14: Operational Hours DSAAPD shall review its current operating hours and make modifications as necessary. DSAAPD has suggested extending APS operations hours to 8:00 a.m. through 8:00 p.m. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 14.	**October Update:** DSAAPD is actively reviewing the APS staffing structure and the need to extend operational hours. This includes reviewing data, like number of referrals made to APS after hours and the number people who could be interviewed for investigations during normal operating hours. As stated in Recommendation 12, DSAAPD is currently working with ADvancing States to streamline and strengthen its community services and support system. DSAAPD anticipates that ADvancing States will recommend necessary modifications to the agency's operating hours. **December Update:**
Recommendation & Status	**Progress Reporting**
Recommendation 15: Define Self-Neglect in Statute Based on DSAAPD's request, JLOSC will sponsor a bill define "self-neglect" in Chapter 39, Title 31, using the federal Elder Justice Act's definition as a guide: The term "self-neglect" means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including— a. obtaining essential food, clothing, shelter, and medical care b. obtaining goods and services necessary to maintain physical health, mental health, or general safety; or c. managing one's own financial affairs.	**Progress Reporting not needed for this recommendation**

Note: If this recommendation is approved, the Committee's legislative attorney will include in the draft bill any additional language that may be required to ensure the definition does not conflict with current Delaware law regarding the determination of an individual's capacity. Option: This recommendation shall be drafted as a bill separate from other legislation resulting from these recommendations. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 15 with option.	
Recommendation & Status	**Progress Reporting**
Recommendation 16: Define Self-Neglect in Statute JLOSC will sponsor a bill to modify § 3910(a), Title 31, APS's "duty to report" statute, to require medical practitioners to file a report. Option: This recommendation shall be drafted as a bill separate from other legislation resulting from these recommendations. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 16 with option.	**Progress Reporting not needed for this recommendation**
Recommendation & Status	**Progress Reporting**
Recommendation 17: Modify the APS Advisory Council According to DSAAPD, the APS Advisory Council is not providing meaningful input or oversight to APS activities. DSAAPD suggested that APS oversight should be incorporated into the already established Council on Services for Aging and Adults with Physical Disabilities. DSAAPD also suggested developing an Elder Justice Multidisciplinary Team. The following are options to implement these suggestions. Option 1: JLOSC will sponsor a bill to remove the APS Advisory Council from § 3903, Title 31 and incorporate APS advisory duties and add Council members representing elder justice	**Progress Reporting not needed for this recommendation** Note: A state multi-disciplinary team comprised of a different and distinct membership would review all eligible elder justice cases in Delaware, not just those with APS involvement, and would make recommendations to any appropriate agencies. The APS Advisory Council currently consists of representatives from:

partners into the Council on Services for Aging and Adults with Physical Disabilities under § 7915, Title 29. Option 2: JLOSC will sponsor a bill to modify the APS Advisory Council under § 3903(a), Title 31 to create an Elder Justice Multidisciplinary Team. Members will be appointed by the Governor rather than the DHSS Secretary, serve no more than 2, 3-year terms, and include: • APS. • Aging services network personnel. • Geriatricians/physicians. • Law enforcement. • Prosecutors. • Psychologists/neuropsychologists. • Victim-witness advocates/victim service providers. Option 3: If Option 2 is adopted, some of the professional members listed in Option 2 may serve as consultants-as-needed rather than as council members. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 15 with options 1, 2, and 3.	• Office of the Public Guardian. • Division of Social Services. • Division of Services for Aging and Adults with Physical Disabilities. • Division of Developmental Disabilities Services. • Division of Substance Abuse and Mental Health. • Division of Public Health, and Elder Law Program. • Delaware Emergency Medical Services Oversight Council. • 3 members from either the medical profession or the general public.
Recommendation & Status	**Progress Reporting**
Recommendation 18: Release from Review or Hold Over Option 1: APS is released from review upon enactment of recommended legislation. - OR - Option 2: APS is held over and shall report to the Committee in January 2020. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 18 with option 2.	**Progress Reporting not needed for this recommendation**

Adult Protective Services Training Needs Survey

1. What unit/department do you work in?

- ○ Adult Protective Services
- ○ Aging and Disability Resource Center (ADRC)
- ○ Community Services Program (CSP)
- ○ Community Nursing
- ○ Other (please specify)

2. About how many years have you been with the division?

- ○ Less than 1 year
- ○ At least 1 year but less than 3 years
- ○ At least 3 years but less than 5 years
- ○ At least 5 years but less than 10 years
- ○ 10 years or more

3. APS STAFF ONLY: How important is this activity to the successful performance of your job?

	1 = Not At All Important	2	3	4	5	6	7 = Very Important
Detecting non-accidental injury in vulnerable adults	○	○	○	○	○	○	○

	1 = Not At All Important	2	3	4	5	6	7 = Very Important
Communicating with at-risk families	○	○	○	○	○	○	○
Probing unexplained injuries, bruising or bedwetting	○	○	○	○	○	○	○
Having a clear understanding of your appropriate role in prevention of adult abuse and neglect	○	○	○	○	○	○	○
Deciding whether to intervene or not in cases of suspected abuse	○	○	○	○	○	○	○
Observing interactions of both caregivers and families with at-risk adults	○	○	○	○	○	○	○
Recognizing inconsistencies in caregivers' descriptions of their care recipient's accidents	○	○	○	○	○	○	○
Liaising/communicating with the police and other authorities	○	○	○	○	○	○	○
Understanding your responsibilities when dealing with at-risk adults	○	○	○	○	○	○	○
Using approved guidelines on referral procedures	○	○	○	○	○	○	○
Discussing potential further action with other care workers	○	○	○	○	○	○	○
Coping with stress when questioning a family about adult abuse	○	○	○	○	○	○	○

	1 = Not At All Important	2	3	4	5	6	7 = Very Important
Trying to make an early identification of adult abuse	○	○	○	○	○	○	○
Detecting persistent injuries	○	○	○	○	○	○	○
Understanding adult protection legislation	○	○	○	○	○	○	○
Providing on-going support for families connected with adult abuse	○	○	○	○	○	○	○
Dealing with behavior or emotions of others in the home	○	○	○	○	○	○	○
Knowing when to alert the authorities	○	○	○	○	○	○	○
Discussing individual adults with medical practitioner	○	○	○	○	○	○	○
Having a clear understanding of your legal responsibilities for protecting at-risk adult	○	○	○	○	○	○	○

4. APS STAFF ONLY: How well do you consider that you currently perform this activity?

	1 = Not Well	2	3	4	5	6	7 = Very Well
Detecting non-accidental injury in vulnerable adults	○	○	○	○	○	○	○
Communicating with at-risk families	○	○	○	○	○	○	○
Probing unexplained injuries, bruising or bedwetting	○	○	○	○	○	○	○

	1 = Not Well	2	3	4	5	6	7 = Very Well
Having a clear understanding of your appropriate role in prevention of adult abuse and neglect	○	○	○	○	○	○	○
Deciding whether to intervene or not in cases of suspected abuse	○	○	○	○	○	○	○
Observing interactions of both caregivers and families with at-risk adults	○	○	○	○	○	○	○
Recognizing inconsistencies in caregivers' descriptions of their care recipient's accidents	○	○	○	○	○	○	○
Liaising/communicating with the police and other authorities	○	○	○	○	○	○	○
Understanding your responsibilities when dealing with at-risk adults	○	○	○	○	○	○	○
Using approved guidelines on referral procedures	○	○	○	○	○	○	○
Discussing potential further action with other care workers	○	○	○	○	○	○	○
Coping with stress when questioning a family about adult abuse	○	○	○	○	○	○	○
Trying to make an early identification of adult abuse	○	○	○	○	○	○	○
Detecting persistent injuries	○	○	○	○	○	○	○

	1 = Not Well	2	3	4	5	6	7 = Very Well
Understanding adult protection legislation	○	○	○	○	○	○	○
Providing on-going support for families connected with adult abuse	○	○	○	○	○	○	○
Dealing with behavior or emotions of others in the home	○	○	○	○	○	○	○
Knowing when to alert the authorities	○	○	○	○	○	○	○
Discussing individual adults with medical practitioner	○	○	○	○	○	○	○
Having a clear understanding of your legal responsibilities for protecting at-risk adult	○	○	○	○	○	○	○

5. Please specify the areas in which you feel APS needs to receive further training or instruction.

6. What type of cross training opportunities would be beneficial for you to perform your job in order to support APS?

7. Which of the following training formats would you be likely to participate in? Check all that apply.

- [ ] Classroom Training
- [ ] Day-Long Workshop Style Event
- [ ] Webinar Presentation
- [ ] Other (please specify)
- [ ] Distance Education that can be Completed At Your Own Pace
- [ ] Job Shadow

8. How often should training be held?

- ( ) Monthly
- ( ) Twice annually
- ( ) Quarterly
- ( ) Annually
- ( ) Other (please specify)

Delaware Department of Services for Aging and Adults with Physical Disabilities (DSAAPD)

Adult Protective Services (APS) Strategic Training Plan 2019 – 2020

Executive Summary

The Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) advocates for, provides access to, and coordinates long-term services and supports in the most appropriate setting. DSAAPD provides a broad range of services to support older persons, persons with disabilities and caregivers. Some of these services are operated directly by DSAAPD staff. Others are funded through DSAAPD and operated under contract by outside organizations.

Strategic Plan Overview

The core focus of the Adult Protective Services (APS) training plan is to provide ongoing professional, paraprofessional and industry specific training to all APS staff. One of the primary goals of the DSAAPD Training Section is to provide continuous education in APS best practices while networking with other states and organizations to maximize resources. Utilization of technology and various other training methods (i.e. classroom, online, self-study, etc.) will be used to enhance staff efficacy in the delivery of services to individuals requiring care. The DSAAPD Training Section will work with APS Supervisors and Administration to design, plan and implement a comprehensive APS training program over the next six to twelve months starting with immediate and available training modalities.

APS Project Team

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Social Services Chief Administrator - Community	Teresa Ritter	302-255-9038
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Training Administrator II	Rudy Bailey	302-223-1403
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Training Administrator I	Mike Cattermole	302-255-9363
APS Administrator	Michelle Welch	302-424-7222

APS Staff Development and Training Matrix

Goal	Action Step	Timeline	Completion Date	Measure of Completion	Responsibility	Resources	Cost
DSAAPD Staff Development and Training Department[1] – APS Topics	Require at least 1 training position to specialize in APS training topics. (See Appendix A)	4Q 2019		The DSAAPD Staff Development and Training department held interviews for the APS Trainer on 10/21/2019 and the position was offered to one of the candidates.	Rudy Bailey		
	Offer all DSAAPD staff who work with APS-related topics continual training offerings in order to remain on top of the latest field trends.	Nov 2019		APS Training Plan (See Appendix B)			
	Facilitate group registration for the National Adult Protective Services Association (NAPSA) Certificate Program and track progress of completion.			DSAAPD has also completed the registration of APS through the National Adult Protective Services			
DSAAPD Staff Development and Training Department – Develop a Survey to Identify Training Priorities	The DSAAPD Staff Development and Training Department shall develop an electronic survey to assess staff knowledge of APS topics, practices, and procedures in order to identify key training priorities	10/2019	10/25/19	The survey was made available on 10/17/2019	Rudy Bailey		

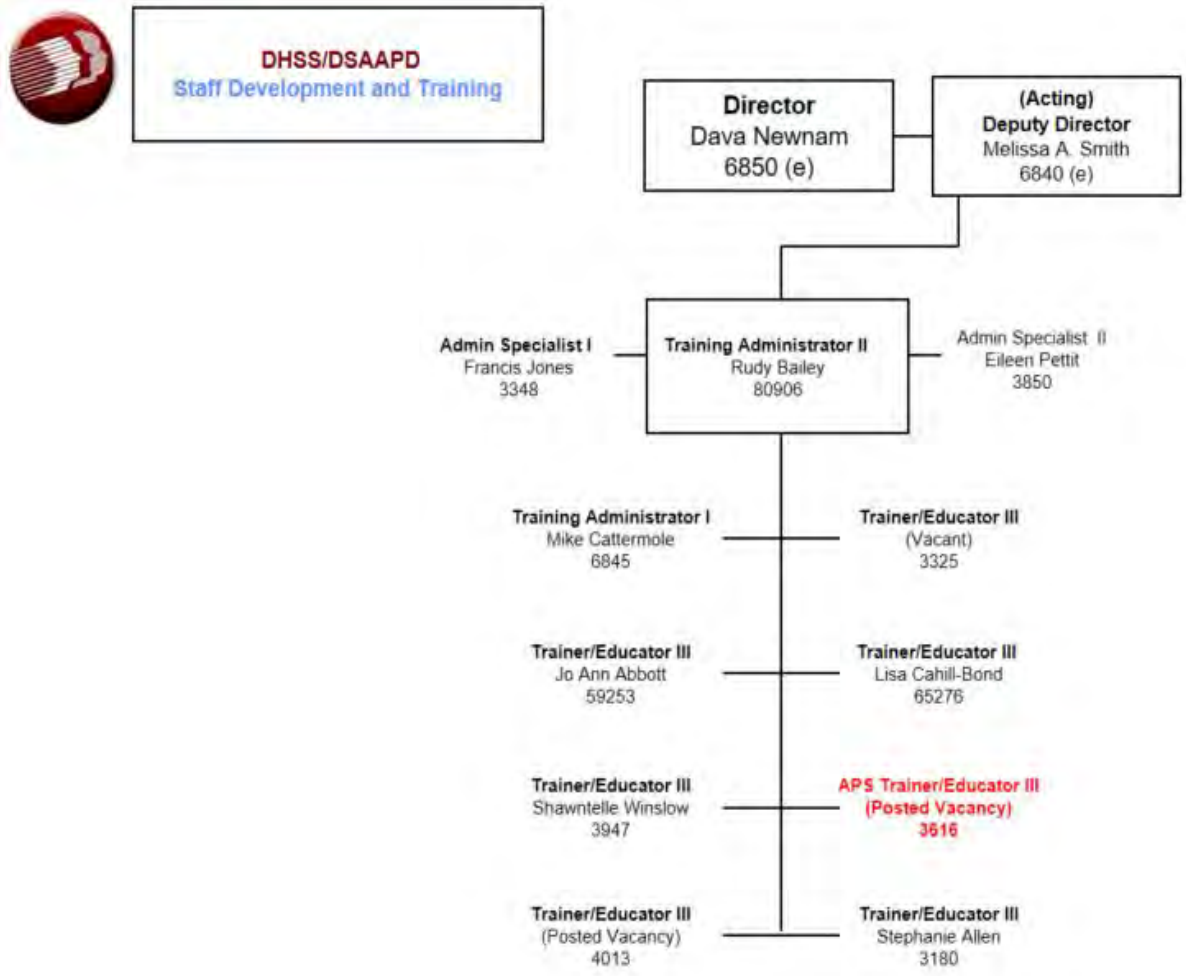
[1] APS is the entity under Joint Legislative Oversight and Sunset Review, of which these goals came from, but APS is a unit under the purview of DSAAPD which has oversight responsibilities, including fiscal. Draft recommendations will frequently reference DSAAPD, as they are the agency charged with implementing and maintaining APS operations.

Goal	Action Step	Timeline	Completion Date	Measure of Completion	Responsibility	Resources	Cost
	DSAAPD shall develop training plans to address the priorities identified through the survey.	4Q 2019		Updates will be made to current APS Training Plan			
Increase APS-Specific Training All staff members, including nurses, who handle APS cases, must complete the following training or similar offerings:	APS Self-Neglect Home Visit Training Videos available online and free of charge by Multi-Disciplinary Adult Services Training and Evaluation for Results (MASTER), which is a program of Academy for Professional Excellence, a project of the San Diego State University School of Social Work.	4Q 2019		APS Mandatory Training Plan			
	Individual Module titled Elder Abuse and Self-Neglect available online and free of charge online by ENGAGE-IL, an interprofessional, collaborative education and practice initiative to enhance care of older adults by The University of Illinois at Chicago	4Q 2019		APS Mandatory Training Plan			
	Training modules in the National Adult Protective Services Association (NAPSA) Certificate Program curriculum. Staff shall enroll in the NAPSA Certificate Program.	4Q 2019		APS Mandatory Training Plan			

Goal	Action Step	Timeline	Completion Date	Measure of Completion	Responsibility	Resources	Cost
Provide Formal Training for Dangerous Situations	The DSAAPD Staff Development and Training Department shall network with local and state law enforcement to provide field staff and supervisors with self-defense training and techniques for defusing dangerous situations.	4Q 2019		Training Section to offer MANDT Classes to APS staff Nov. 5, 12, 19, 2019	Rudy Bailey		
Increase Financial Exploitation Training All staff members who specifically handle financial exploitation cases shall complete the following training or similar offerings:	Elder Financial Abuse Online Training offered by the Association of Certified Financial Crime Specialists.	4Q 2019		APS Staff to complete online training			
	Financial Abuse Training e-learning modules available online by MASTER.	4Q 2019		APS Staff to complete online training			

Goal	Action Step	Timeline	Completion Date	Measure of Completion	Responsibility	Resources	Cost
Training and Procedures for Self-Neglect Cases	DSAAPD shall create internal training and written procedures for handling cases of self-neglect and assessing capacity in the setting of self-neglect using resources and scholarly articles available from sources such as NAPSA, the National Institute of Health, Adult Protective Services Technical Assistance Resource Center (APR TARC), and other subject matter experts on the topics.	4Q 2019		APS Staff to complete online training			

Appendix A: DSAAPD Training Section Organizational Chart



Appendix B: APS Training Plan

Adult Protective Services (APS) Training Plan Matrix

Mandatory Courses:

Course Name:	***Timeline:***	***Refresher Frequency:***
APS Self-Neglect Home Visit Training (MASTER)	Immediate	Annually
DSAAPD Specific APS Self Neglect and Capacity Assessment (Internal Training to be created)	1Q 2020 Target date – Feb 2020	Annually
Elder Abuse and Self-Neglect Training (ENGAGE-IL)	Immediate	Annually
National APS Certificate Program	TBD	Bi-Annually
Diffusing Dangerous Situations Training (MANDT)	November 5, 12, 19, 2019 3-day Certificate Course	Bi-Annually
Financial Exploitation Awareness Training (MASTER)	Immediate	Bi-Annually
Elder Financial Abuse Training (MASTER)	Immediate	Bi-Annually
APS New Employee Orientation	TBD	Initial only
DHSS/DSAAPD Policies Procedures	TBD	Initial only
DTI – Cyber security	TBD	Annually
Fostering Customer Service	TBD	Annually
Promoting a Culture of Diversity and Teamwork	TBD	Bi-Annually
Active Shooter/HIPPA	TBD	Annually
Disaster Preparedness	TBD	Annually
Fire plan, fire extinguisher	TBD	Annually
Technology Training	TBD	Initial only

Other Recommended Staff Courses:

Course Name:	*Format*
Person Centered Care	Online/Classroom
Trauma Informed Services	Classroom
Effective Communication	Classroom
Customer Service	Classroom
Dementia Awareness	Online/Classroom
Professionalism in the Workplace	Classroom
Professional Ethics/Boundaries	Classroom

SECTION: Investigation	**SUBJECT:** Home Visits and Assessments
NUMBER: 700	**DATE REVISED:** 10/18/2018

I. POLICY/POSITION STATEMENT

It is the policy of Adult Protective Services that the program will investigate all reports of abuse, neglect and/or exploitation of infirm adults that have been determined to meet APS criteria. Investigations consist of in person visits with an alleged victim and the completion of several assessments, all done in the Harmony for APS system.

II. PROCEDURES

ACTION	RESPONSIBLE PARTY
Once a report of abuse, neglect and/or exploitation has been determined to meet APS criteria and referred to an APS investigator, the investigator must make an in-person contact with the alleged victim within a set amount of days, based on the priority level: • Emergency – Within 1 business day • Priority 1 – 1 to 3 business days • Priority 2 – Within 5 business days Physical abuse, sexual abuse and severe neglect will be an Emergency priority level. All other abuse and neglect will be a Priority 1 priority level. Financial exploitation will be a Priority 2 Priority level. If any questions exists regarding the determination or existence of an emergency situation, the APS Supervisor or Program Administrator should be contacted.	APS Investigator
An adult will not be considered to be abused, mistreated, neglected, infirm or incapacitated or in need of protective services for the sole reason they rely upon, or is being furnished with, treatment by spiritual means through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination; nor shall anything in these procedures be construed to authorize or require any medical care or treatment over the implied or express objections of said person.	APS Investigator
The investigator should not enter the home of an un-consenting adult or the home of an adult whose caregiver does not consent to entrance unless there is police involvement.	APS Investigator
If the investigator cannot gain entry and has reason to believe an emergency exists, they should follow the procedures outlined in Subsection 703 for immediate assistance.	APS Investigator

ACTION	RESPONSIBLE PARTY
If the investigator cannot gain entry, they must retry an in-person contact with the alleged victim within a set amount of days, based on the priority level: • Emergency and Priority 1– The next business day after the first attempt before noon. If the investigator still cannot make contact with the alleged victim, they must try to make contact again before 4:30 pm the same day. If the third contact attempt fails, the investigator shall contact law enforcement for a well-being check of the alleged victim. • Priority 2 – Within 5 business days after the first attempt. If the investigator still cannot make contact with the alleged victim, they must try to make contact again within 5 more business days. If the third contact attempt fails, the investigator may close the case. Investigators will leave their contact information and reason for trying to make contact with the alleged victim at the last known address of the victim. The investigator will also contact known collateral contacts (referral source, neighbors, etc.) within the original set amount of days, based on priority level: • Emergency – Within 24 hours • Priority 1 – 1 to 3 business days • Priority 2 – Within 5 business days	APS Investigator
The investigator will evaluate information gathered from the report and any information available from collateral contacts. If the situation is urgent, the investigator will consult with the APS Supervisor and take appropriate emergency action as outlined in Subsection 703.	APS Investigator
The investigator will interview collateral contacts to gain greater understanding of the alleged victim's situation. Contacts may include, but not limited to: legal professionals, social service professionals, medical professionals, police, neighbors, friends, and relatives.	APS Investigator
An Authorization for Release of Information form, located within Harmony for APS, will be received from the alleged victim when requesting confidential information from collateral contacts. If the alleged victim is unable to consent, a release of information form can be signed by their legal representative.	APS Investigator

ACTION	RESPONSIBLE PARTY
As deemed appropriate, the investigator will inform the alleged victim or legal representative of the investigator's intention to contact the collateral contacts. Collateral contacts are not to be made without the alleged victim's knowledge unless: • The investigator has reason to believe that a serious emergency exists which endangers the health and safety of the alleged victim. • The investigator had made an attempt to inform the alleged victim of the intent to make collateral contacts. • The investigator had doubts concerning the reliability of the complainant or the information given. • The investigator lacks sufficient information to evaluate the seriousness of the report or the appropriateness of the referral.	APS Investigator
The investigator is to complete all required screens and assessments with any available information through the Harmony for APS system, using an APS assigned tablet. The following forms are required to be completed by the end of the first visit: • Documentation of the 1st Visit • Risk Assessment • Functional Assessment All required screens and assessments must be completed before an investigator meets with a different alleged victim.	APS Investigator
If the investigator does not have access to the internet, they are to complete all forms and assessments using the electronic word versions found on the tablet. Once the investigator has access to the internet, they must put the information from the electronic word versions into the Harmony for APS system.	APS Investigator
Investigators are required to maintain monthly follow-up contacts with alleged victims throughout the investigation process.	APS Investigator
Investigations should be conclude within 90 days, however, investigators can request additional time through the Harmony for APS system.	APS Investigator

III. SCOPE

All employees of the Adult Protective Services program who investigate reports of abuse, neglect and/or exploitation in the field.

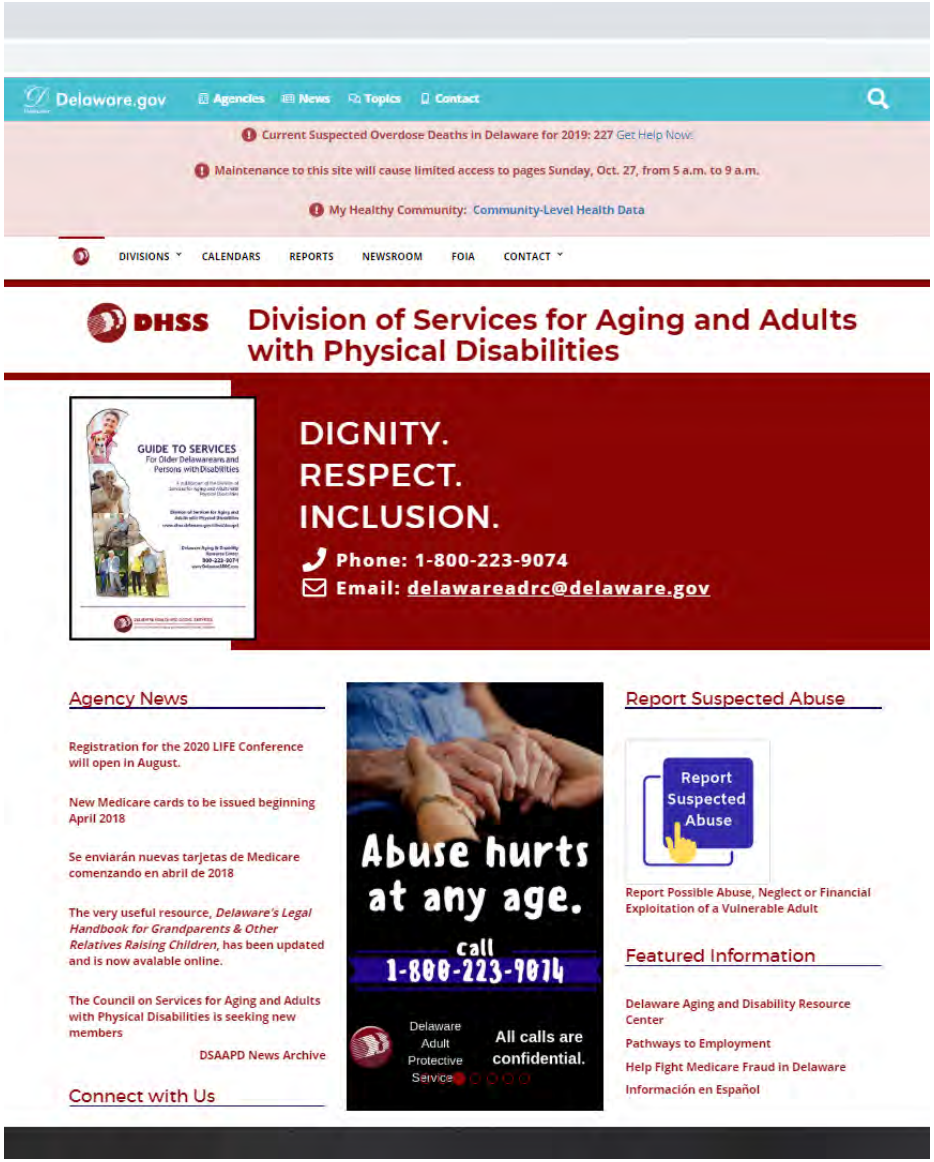
IV. RELATED DOCUMENTS

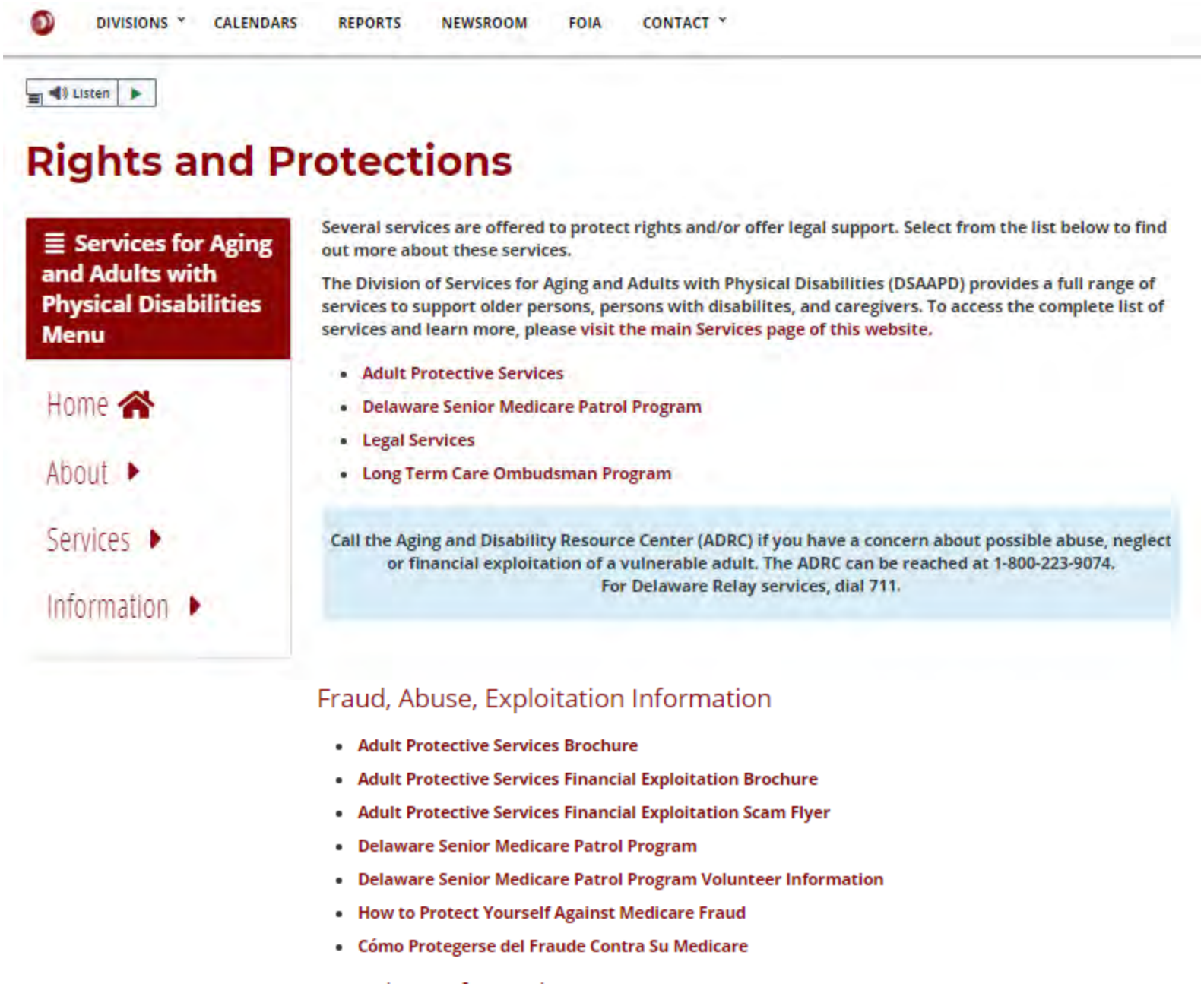
DE APS Training Manual for Investigators

V. OTHER REFERENCES

None.

Division of Services for Aging and Adults with Physical Disabilities
Appendix C – APS Website Updates, Recommendation 10




DIVISIONS
CALENDARS
REPORTS
NEWSROOM
FOIA
CONTACT
Listen
Rights and Protections
Services for Aging and Adults with Physical Disabilities Menu
Home
About
Services
Information
Several services are offered to protect rights and/or offer legal support. Select from the list below to find out more about these services.
The Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) provides a full range of services to support older persons, persons with disabilites, and caregivers. To access the complete list of services and learn more, please visit the main Services page of this website.
Adult Protective Services
Delaware Senior Medicare Patrol Program
Legal Services
Long Term Care Ombudsman Program
Call the Aging and Disability Resource Center (ADRC) if you have a concern about possible abuse, neglect or financial exploitation of a vulnerable adult. The ADRC can be reached at 1-800-223-9074.
For Delaware Relay services, dial 711.
Fraud, Abuse, Exploitation Information
Adult Protective Services Brochure
Adult Protective Services Financial Exploitation Brochure
Adult Protective Services Financial Exploitation Scam Flyer
Delaware Senior Medicare Patrol Program
Delaware Senior Medicare Patrol Program Volunteer Information
How to Protect Yourself Against Medicare Fraud
Cómo Protegerse del Fraude Contra Su Medicare

Listen

Adult Protective Services

Services for Aging and Adults with Physical Disabilities Menu

- Home
- About
- Services
- Information

Adult Protective Services

We are here to help you. Our services are voluntary. You can choose if you need services or not.

We will not force you to move or do anything that you don't want to. We are here to help you live in a safe and healthy environment and receive the services you need. Please contact our office at 1-800-223-9074 if you need help or have any questions. For Delaware Relay services, dial 711.

File a REPORT of HARM or ask for help

- Adult Protective Services helps to prevent or stop harm from occurring to vulnerable adults. Delaware law requires that protective services not affect adults who are capable of caring for themselves.
- Delaware law defines vulnerable adult as a person 18 years of age or older who, because of isolation, sickness, debilitation, mental illness or physical, mental or cognitive disability, is easily susceptible to abuse, neglect, mistreatment, intimidation, manipulation, coercion or exploitation.

Below are examples of things to report:

People may suffer harm because they have been abandoned, abused, exploited, neglected or they have neglected their own care needs. Adult Protective Services will support people who have been harmed by:

- Physical Abuse - inflicting physical pain or injury on a senior, e.g. slapping, bruising, or restraining by physical or chemical means.
- Sexual Abuse - non-consensual sexual contact of any kind.
- Neglect - the failure by those responsible to provide food, shelter, health care, or protection for a vulnerable adult.
- Exploitation - the illegal taking, misuse, or concealment of funds, property, or assets of a vulnerable adult for someone else's benefit.
- Emotional Abuse - inflicting mental pain, anguish, or distress on an elder person through verbal or nonverbal acts, e.g. humiliating, intimidating, or threatening.
- Abandonment - desertion of a vulnerable adult by anyone who has assumed the responsibility for care or custody of that person.
- Self-Neglect - characterized as the failure of a person to perform essential, self-care tasks and that such failure threatens his/her own health or safety.

Who are mandated reporters required to make a Report of Harm?

- Everyone has a duty to report if they suspect abuse, neglect or exploitation. However, there are certain groups of people who are required to do additional things. They include:
    - Financial institutions who have direct contact with a vulnerable adult and have reasonable

cause to believe that person may be subject to past, current or attempted financial exploitation, have a duty to report the alleged harm.

- Medical practitioners who have direct contact with a vulnerable adult and have reasonable cause to believe that the person may be subject to past, current or attempted abuse, neglect or exploitation have a duty to report the alleged harm.

What must be reported to Adult Protective Services?

Any incident in which a vulnerable adult is believed to be abandoned, abused, exploited, neglected or have neglected his or her own care needs.

To Whom Should Reports be Made?

Reports should be made to Adult Protective Services within 24 hours by calling the Aging and Disability Resource Center at 1-800-223-9074.

Financial institutions only: To make a referral to APS related to suspected financial exploitation, complete the Report of Suspected Financial Exploitation form.

How is Confidentiality Protected?

- Investigative reports and reports of the abandonment, abuse, exploitation, neglect and self-neglect of a vulnerable adult are confidential cannot be accessed by the general public.
- Investigative reports may be used by appropriate agencies or individuals inside and outside of the state in connection with investigations or judicial proceeding involving the abandonment, abuse, exploitation, neglect or self-neglect of a vulnerable adult.
- Individuals who file a Report of Harm with Adult Protective Services will remain confidential. Reports may also be made anonymously.

More Resources

Guide to Services for Older Delawareans and Persons with Disabilities
Delaware Aging and Disability Resource Center Service Provider Search

Related Links

National Center on Elder Abuse
National Adult Protective Services Association
US Department of Justice - Elder Justice Initiative
National Resource Center on Domestic Violence: Preventing and Responding to Domestic and Sexual Violence in Later Life

Call the Aging and Disability Resource Center (ADRC) if you have a concern about possible abuse, neglect or financial exploitation of a vulnerable adult. The ADRC can be reached at 1-800-223-9074.
For Delaware Relay services, dial 711.

Abuse, Neglect and Exploitation

Services for Aging and Adults with Physical Disabilities Menu

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Services

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Abuse, Neglect and Exploitation
Advance Directives
Alzheimer's Toolkit
Brain Injury and Coma
Caregiver Information
Demographic Information
Emergency Preparedness
Health and Wellness
Información en Español
Information for Professionals
Laws and Regulations
Medicare Fraud
Publications and Forms
State-Run Long Term Care Facilities
Volunteer Opportunities

Call the Aging and Disability Resource Center (ADRC) if you have a concern about possible abuse, neglect or financial exploitation of a vulnerable adult. The ADRC can be reached at 1-800-223-9074. For Delaware Relay services, dial 711.

Be on the lookout for abuse of vulnerable adults!

Have you seen physical signs of abuse, such as:

- Cuts, wounds, black and blue marks, bruises, or welts
- Burns
- Unusual injuries
- Appearing dirty, unshaven, smelly
- Undernourished, dehydrated
- Untreated medical condition

Have you seen behavioral signs of abuse, such as:

- Confusion, forgetfulness
- Anger
- Depression
- Fear, helplessness, shame

Have you seen social signs of abuse, such as:

- Isolated, little outside contact
- Violence or drug abuse
- Unable to speak freely

Have you seen financial signs of abuse, such as:

- Unusual bank account activity
- Change in spending habits
- Signature on checks do not match
- Unpaid bills

If you notice these signs, call 1-800-223-9074. For Delaware Relay services, dial 711.

How do I report the abuse of an older person or a person with a disability?

Services for Aging and Adults with Physical Disabilities Menu

- Home
- About
- Services
- Information

If someone is in immediate danger, call 911.
Call the Aging and Disability Resource Center (ADRC) if you have a concern about possible abuse, neglect or financial exploitation of a vulnerable adult. The ADRC can be reached at 1-800-223-9074.
For Delaware Relay services, dial 711.

Two programs are available in Delaware to handle reports of suspected abuse, neglect or exploitation of older persons or persons with disabilities. Which program you contact depends on whether or not the individual lives in a licensed long-term care facility.

- **To report a case of suspected abuse, neglect, or exploitation of an older person or a person with a disability *who does not live in a licensed long term care facility* (for example, the person lives in his or her own house or apartment, in a group home, or in an unlicensed adult foster care home), contact the Adult Protective Services Program at 1-800-223-9074.**
- **To report a case of suspected abuse, neglect or exploitation of a resident of a *long-term care facility* (for example, a nursing home or assisted living facility), contact the Division of Health Care Quality at 1-877-453-0012.**

Recommendation & Status	Progress Reporting
Recommendation 1: Continue or Terminate Under §10213(a), Title 29, the Committee must determine whether there is a genuine public need for an agency under review. To meet this requirement, the Committee may select one of the following options. Option 1: APS shall continue, subject to any further recommendations that JLOSC adopts. - OR - Option 2: APS is terminated and the Committee will sponsor legislation to implement this recommendation. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 1 with option 1.	**Progress Reporting not needed for this recommendation**

Recommendation & Status	Progress Reporting
Recommendation 2: Statutory Update & Technical Corrections JLOSC will sponsor a bill to make technical corrections to APS's entire governing statute, Chapter 39, Title 31.* **Status:** 5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 2.	**Progress Reporting not needed for this recommendation**

* The Committee's legislative attorney will draft any legislation resulting from approved recommendations, unless otherwise noted.

Recommendation & Status	Progress Reporting
Recommendation 3: DSAAPD Staff Development and Training Department† – APS Topics DSAAPD has a dedicated staff development and training department that has 8 training positions and 2 administrative assistants. The DSAAPD staff development and training department shall: a. Require at least 1 training position to specialize in APS training topics. b. Offer all DSAAPD staff who work with APS-related topics continual training offerings in order to remain on top of the latest field trends. c. Facilitate group registration for the National Adult Protective Services Association (NAPSA) Certificate Program and track progress of completion. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 3.	**October Update:** DSAAPD posted the APS training position on 8/21/2019 for a Trainer/Educator III (Registered Nurse BSN). Because the trainer is required to be a registered nurse, recruitment has taken time and effort. The position closed on 9/24/2019. The summary statement reads: *The incumbent in this position will be responsible for the training of programs for professional, paraprofessional and ancillary staff. A primary responsibility of this position will include planning, developing and presenting on-going training/education programs for Adult Protective Services (APS) staff. Responsibilities includes training APS staff in statewide locations, continued education in APS best practices, networking with other trainers in this area, and evaluating the effectiveness of training materials. Additional training in other subject matter areas may also be required.* The DSAAPD Staff Development and Training department held interviews for the APS Trainer on 10/21/2019 and the position was offered to one of the candidates. DSAAPD has also completed the registration of APS through the National Adult Protective Services

† APS is the entity under JLOSC review, but APS is a unit under the purview of DSAAPD which has oversight responsibilities, including fiscal. Draft recommendations will frequently reference DSAAPD as they are the agency charged with implementing and maintaining APS operations. DSAAPD comments are included with yellow highlights.

	Association (NAPSA) Certificate Program and is tracking completion of that program for all staff. **December Update:** The DSAAPD Staff Development and Training department hired a Trainer/Educator III, who began working with APS on November 4, 2019. The Trainer has met with DSAAPD Leadership and APS Leadership to begin to develop training plans for the division related to abuse, neglect and exploitation.
Recommendation & Status	**Progress Reporting**
Recommendation 4: DSAAPD Staff Development and Training Department – Develop a Survey to Identify Training Priorities The DSAAPD Staff Development and Training Department shall develop an electronic survey to assess staff knowledge of APS topics, practices, and procedures in order to identify key training priorities. The survey shall allow all DSAAPD employees involved in APS cases to anonymously complete it, including APS-assigned nurses and employees of the Aging Disability Resource Center (ADRC) hotline. DSAAPD shall develop training plans to address the priorities identified through the survey. The State of Georgia completed a similar study of their APS unit. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 4.	**October Update:** The DSAAPD Staff Development and Training department, in coordination with the Planning, Policy and Program Development unit, developed a survey. The survey was made available on 10/17/2019 to all staff that may be involved with APS cases, including APS, the Aging and Disability Resource Center (ADRC), Community Services Program (CSP), Community Nursing, and the Diversion and Discharge Unit. In total, almost 80 staff members received the survey. As of the October Progress Report, 58 staff members have taken the survey. **December Update:** The survey closed on 11/1/2019 with 59 of 80 employees (74%) completing it. APS staff, ADRC and community support services staff were included in the survey. A small workgroup convened to discuss the results of the

	surveys and develop training plans, utilizing the survey results. The workgroup includes: • DSAAPD Deputy Director • Staff Development and Training department • Adult Protective Services unit • Planning, Policy and Program Development unit The Comprehensive APS Training Plan is attached as Appendix A.
Recommendation & Status	**Progress Reporting**
Recommendation 5: Increase APS-Specific Training All staff members, including nurses, who handle APS cases, must complete the following training or similar offerings: a. APS Self-Neglect Home Visit Training Videos available online and free of charge by Multi-Disciplinary Adult Services Training and Evaluation for Results (MASTER), which is a program of Academy for Professional Excellence, a project of the San Diego State University School of Social Work. b. Individual Module titled Elder Abuse and Self-Neglect available online and free of charge online by ENGAGE-IL, an interprofessional, collaborative education and practice initiative to enhance care of older adults by The University of Illinois at Chicago (UIC). c. Training modules in the National Adult Protective Services Association (NAPSA) Certificate Program curriculum. Staff shall enroll in the NAPSA Certificate Program. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 5.	**October Update:** The APS Administrator, in coordination with the APS Supervisors and the DSAAPD Staff Development and Training department, has developed an APS Training Plan for all APS staff, including APS nurses. This plan is included in all staff performance plans to ensure all trainings are completed in a timely fashion. The APS Self-Neglect Home Visit Training and the MASTER program training are part of this APS Training Plan. In addition, staff will have the opportunity to complete some of the trainings at monthly staff APS meetings. **December Update:** As of this progress report, fifteen APS employees (62.5% of all APS staff) completed the ENGAGE-IL training on October 31, 2019. Any staff that have not finished the training have until March 31, 2020 to complete it.

	In addition, staff will have the opportunity to complete some of the trainings at monthly staff APS meetings.
Recommendation & Status	**Progress Reporting**
Recommendation 6: Provide Formal Training for Dangerous Situations The DSAAPD Staff Development and Training Department shall network with local and state law enforcement to provide field staff and supervisors with self-defense training and techniques for defusing dangerous situations. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 6.	**October Update:** The DSAAPD Staff Development and Training department has reached out to the Dover Police Department and State Police Training Academy to form a self-defense training partnership. In addition, all APS staff will be required to participate in The Mandt System® training. The training will be held on November 5th, 12th and 19th and on December 3rd, 11th and 17th. This training uses a continuous learning and development approach to prevent, de-escalate, and if necessary, intervene in behavioral interactions that could become aggressive. **December Update:** As of this progress report, all APS employees have completed the Mandt System® training, an evidence-based training that prevents, de-escalates, and addresses interactions that could become aggressive. The need for self-defense becomes much less likely for people who have been trained in the Mandt System®. The partnerships developed with Dover Police and the State Police Training Academy will round out the round out the need for self-defense classes.
Recommendation & Status	**Progress Reporting**
Recommendation 7: Increase Financial Exploitation Training	**October Update:**

All staff members who specifically handle financial exploitation cases shall complete the following training or similar offerings: a. Elder Financial Abuse Online Training offered by the Association of Certified Financial Crime Specialists. b. Financial Abuse Training e-learning modules available online by MASTER. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 7.	The APS Administrator, in coordination with the APS Supervisors and the DSAAPD Staff Development and Training department, has developed a training plan for all APS staff, including APS nurses. This plan is included in all staff performance plans to ensure all trainings are completed in a timely fashion. Elder Financial Abuse Online Training and Financial Abuse Training from MASTER are included in this APS Training Plan. **December Update:** As of this progress report, eighteen APS employees (75%) completed financial exploitation training on November 26, 2019. Any staff that have not finished the training have until March 31, 2020 to complete it. In addition, APS' Financial Exploitation Advocate shared with all APS staff a PowerPoint presentation, Appendix B, with staff about well-known scams that staff have seen in Delaware.
Recommendation & Status	**Progress Reporting**
Recommendation 8: Training and Procedures for Self-Neglect Cases DSAAPD shall create internal training and written procedures for handling cases of self-neglect and assessing capacity in the setting of self-neglect using resources and scholarly articles available from sources such as NAPSA, the National Institute of Health, Adult Protective Services Technical Assistance Resource Center (APR TARC), and other subject matter experts on the topics. Option: DSAAPD suggested codifying training requirements under the APS statute for the purpose of advancing the section. **Status:**	**October Update:** DSAAPD is revising internal written procedures for handling of self-neglect cases within APS. For the training in self-neglect, the APS Administrator, in coordination with the APS Supervisors and the DSAAPD Staff Development and Training department, has developed an APS Training Plan, attached as Appendix B, for all APS staff, including APS nurses. This plan is

5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 8 with option.	included in all staff performance plans to ensure all trainings are completed in a timely fashion. In addition, the NAPSA self-neglect module training will be held on 10/31/2019 for all APS staff. The APS Supervisors will facilitate this training. **December Update:** The DSAAPD Staff Development and Training department developed a Self-Neglect and Hoarding Disorders PowerPoint Presentation, Appendix C, to share with APS staff and nurses. The presentation is based on national best practices and utilizes information gleaned from the Administration for Community Living and the National Center on Law & Elder Rights. This PowerPoint Presentation will be used as part of the DSAAPD APS Training Plan.
Recommendation & Status	**Progress Reporting**
Recommendation 9: Updates to MOUs The following MOUs on file were signed more than 5 years ago and should be reviewed and updated: a. With the Attorney General's Office, dated April 7, 1997. b. With the Division of Developmental Disabilities Services, dated June 21, 2012. Option 1: DSAAPD shall review current practices and create additional MOUs with agencies needed to facilitate proper handling of APS cases. Example: form a MOU with the State Police to provide consult for APS cases.	**October Update:** DSAAPD has sent updated MOU's to the following entities: • Division of Developmental Disabilities Services • Division of Health Care Quality As of the October Progress Report, these MOU's are awaiting signatures from these divisions. In addition, DSAAPD is working to develop MOU's with:

Option 2: DSAAPD shall review and define interagency roles, response times, and processes for reported cases of abuse, neglect, or financial exploitation cases and include agreed upon roles, response times, and processes in MOU documents. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 9 with options 1 and 2.	• The Department of Justice • The Long Term Care Ombudsman Program • The Office of the Public Guardian • Delaware State Police **December Update:** DSAAPD continues to develop MOU's with partner agencies including: • The Long Term Care Ombudsman Program • The Office of the Public Guardian • Delaware State Police Many of the MOU's will include a component related to annual training about abuse, neglect and exploitation and define a collaborative partnership between the agencies. DSAAPD reviews all MOUs annually.
Recommendation & Status	**Progress Reporting**
Recommendation 10: Investigative Time Frames DSAAPD shall review and implement any needed revisions to policy and procedures regarding investigative time frames. Option: DSAAPD suggested codifying investigative time frames under the APS statute to establish a time frame for State responses to reports of abuse, neglect, or financial exploitation. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 10 with option	**October Update:** DSAAPD has updated its policies and procedures to reflect national best practices regarding investigative time frames. **December Update:** DSAAPD continues to ensure all staff are abiding by its policies and procedures., including investigative time frames.

Recommendation & Status	**Progress Reporting**
Recommendation 11: Website Modifications DSAAPD shall make the following modifications to their website: a. Provide easy to locate APS topics to educate the public and provide clear information on what the agency can and cannot do in APS cases. b. Provide APS program criteria. c. Provide information on APS topics in the "information" section of the website. d. Make the link to APS more prominent on DSAAPD's website; the link is currently hidden in the "all services" section. e. Provide information for family members and caregivers on how to prevent, identify, and provide help in cases of abuse and neglect, including self-neglect. f. Make 24-hour report line prominent on website. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 11.	**October Update:** DSAAPD has updated its website to reflect this recommendation. **December Update:** DSAAPD continues to ensure its website is up-to-date, including information related to abuse, neglect and exploitation.
Recommendation & Status	**Progress Reporting**
Recommendation 12: Review Staffing Structure DSAAPD shall review its current staffing structures department-wide to determine whether appropriate numbers of personnel and resources are dedicated to handle APS cases, or if personnel or resources in other areas would be better dedicated to APS casework. DSAAPD will follow State procedures to request any necessary reclassifications. **Status:**	**October Update:** DSAAPD is currently working with ADvancing States (formerly National Association of States United Aging and Disabilities (NASUAD)) to streamline and strengthen its community services and support system. ADvancing States is the national expert in aging and

5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 12.	disability issues, and is the only agency of its kind. The organization represents the nation's 56 state and territorial agencies on aging and disabilities and long-term services and supports directors. DSAAPD needs their expertise to implement the dramatic community reset which will result in the necessary improvements in the Aging and Disability Resource Center, the person-centered assessment process, community nursing, and Adult Protective Services, and ensure that people are served appropriately. In preparation for the changes that will result from ADvancing States, DSAAPD is actively filling APS vacancies. DSAAPD has filled four out of five vacancies. The one vacancy is for a grant funded contract position that the APS Administrator is seeking to fill immediately. DSAAPD is also hiring an additional three APS nurses to address complex cases, including self-neglect. The summary reads: *The incumbent provides a comprehensive overall health assessment for individuals referred to Adult Protective Services. Referrals include clients that are hoarders, mentally ill, demented, frail, self-neglect and disabled. The RN follows the Nursing Process (assessment, diagnosis, planning, implementation and evaluation). The incumbent will lend medical assistance to individuals in need, such as first aid, cardiopulmonary resuscitation (CPR), or naloxone administration. Work includes evaluating the competency of clients and their ability to function in their home and the community. The RN will develop and implement plans designed to meet the*

	personal, social, and health care needs of the client. RNs will coordinate with available programs and resources to assist clients to remain safely in their homes or assist with placement in a safer environment. APS has also balanced out the workload between staff to ensure the future changes can be implemented in an equitable fashion. **December Update:** As of this progress report, there are no vacancies within APS. In addition, DSAAPD continues to work with ADvancing States to streamline and strengthen its community services and support system
Recommendation & Status	**Progress Reporting**
Recommendation 13: Recruitment DSAAPD shall partner with high schools and colleges and participate in recruitment events in order to highlight careers available within DSAAPD and the need for professionals in the field of APS. The aging population will continue to grow and outreach is essential to acquire talented individuals interested in the subjects of social work, elder care, and APS. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 13.	**October Update:** DSAAPD has reached out to two local colleges in order to participate in their upcoming job fairs: • Wilmington University – November 2019 • Delaware Technical Community College – Spring 2020 DSAAPD will continue to engage with the local colleges to discuss future employment opportunities. DSAAPD has reached out to schedule speaking engagements at the following high schools: • Newark High School

	• Caesar Rodney High School • Milford High School • Woodbridge High School DSAAPD has offered to educate students on the work of DSAAPD and positions available within the division, including those with APS. **December Update:** DHSS has a department-wide recruiter who is targeting individuals interested in the subjects of social work, elder care, and APS
Recommendation & Status	**Progress Reporting**
Recommendation 14: Operational Hours DSAAPD shall review its current operating hours and make modifications as necessary. DSAAPD has suggested extending APS operations hours to 8:00 a.m. through 8:00 p.m. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 14.	**October Update:** DSAAPD is actively reviewing the APS staffing structure and the need to extend operational hours. This includes reviewing data, like number of referrals made to APS after hours and the number people who could be interviewed for investigations during normal operating hours. As stated in Recommendation 12, DSAAPD is currently working with ADvancing States to streamline and strengthen its community services and support system. DSAAPD anticipates that ADvancing States will recommend necessary modifications to the agency's operating hours. **December Update:**

	DSAAPD reviewed the need to extend its operational hours. Currently, the data does not support this, as most APS referrals are received between 8:00 and 4:30 pm. In addition, APS has a 24-hour live referral line already in place. DSAAPD plans to consult with ADvancing States regarding the optimal way to serve alleged victims. Following the conclusion of its work with ADvancing States, DSAAPD will review its operational hours annually and make adjustments, as needed, to address any service gaps within APS.
Recommendation & Status	**Progress Reporting**
Recommendation 15: Define Self-Neglect in Statute Based on DSAAPD's request, JLOSC will sponsor a bill define "self-neglect" in Chapter 39, Title 31, using the federal Elder Justice Act's definition as a guide: The term "self-neglect" means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including— a. obtaining essential food, clothing, shelter, and medical care b. obtaining goods and services necessary to maintain physical health, mental health, or general safety; or c. managing one's own financial affairs. Note: If this recommendation is approved, the Committee's legislative attorney will include in the draft bill any additional language that may be required to ensure the definition does not conflict with current Delaware law regarding the determination of an individual's capacity. Option: This recommendation shall be drafted as a bill separate from other legislation resulting from these recommendations. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 15 with option.	**Progress Reporting not needed for this recommendation**

Recommendation & Status	Progress Reporting
Recommendation 16: Define Self-Neglect in Statute JLOSC will sponsor a bill to modify § 3910(a), Title 31, APS's "duty to report" statute, to require medical practitioners to file a report. Option: This recommendation shall be drafted as a bill separate from other legislation resulting from these recommendations. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 16 with option.	**Progress Reporting not needed for this recommendation**

Recommendation & Status	Progress Reporting
Recommendation 17: Modify the APS Advisory Council According to DSAAPD, the APS Advisory Council is not providing meaningful input or oversight to APS activities. DSAAPD suggested that APS oversight should be incorporated into the already established Council on Services for Aging and Adults with Physical Disabilities. DSAAPD also suggested developing an Elder Justice Multidisciplinary Team. The following are options to implement these suggestions. Option 1: JLOSC will sponsor a bill to remove the APS Advisory Council from § 3903, Title 31 and incorporate APS advisory duties and add Council members representing elder justice partners into the Council on Services for Aging and Adults with Physical Disabilities under § 7915, Title 29. Option 2: JLOSC will sponsor a bill to modify the APS Advisory Council under § 3903(a), Title 31 to create an Elder Justice Multidisciplinary Team. Members will be appointed by the Governor rather than the DHSS Secretary, serve no more than 2, 3-year terms, and include: • APS. • Aging services network personnel. • Geriatricians/physicians. • Law enforcement.	**Progress Reporting not needed for this recommendation** Note: A state multi-disciplinary team comprised of a different and distinct membership would review all eligible elder justice cases in Delaware, not just those with APS involvement, and would make recommendations to any appropriate agencies. The APS Advisory Council currently consists of representatives from: • Office of the Public Guardian. • Division of Social Services. • Division of Services for Aging and Adults with Physical Disabilities. • Division of Developmental Disabilities Services. • Division of Substance Abuse and Mental Health. • Division of Public Health, and Elder Law Program. • Delaware Emergency Medical Services Oversight Council. • 3 members from either the medical profession or the general public.

• Prosecutors. • Psychologists/neuropsychologists. • Victim-witness advocates/victim service providers. Option 3: If Option 2 is adopted, some of the professional members listed in Option 2 may serve as consultants-as-needed rather than as council members. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 15 with options 1, 2, and 3.	
Recommendation & Status	**Progress Reporting**
Recommendation 18: Release from Review or Hold Over Option 1: APS is released from review upon enactment of recommended legislation. - OR - Option 2: APS is held over and shall report to the Committee in January 2020. **Status:** 5/13: First consideration of this recommendation. 5/13: JLOSC adopted recommendation 18 with option 2.	**Progress Reporting not needed for this recommendation**

Division of Services for Aging and Adults with Physical Disabilities

Adult Protective Services Training Plan Matrix

APS Worker Mandatory Training Courses

Course Name:	*Audience*	*Frequency*
APS Self-Neglect Home Visit Training (MASTER)	All Staff	Annually
DSAAPD Specific APS Self Neglect and Capacity Assessment (Internal Training)	All Staff	Annually
Elder Abuse and Self-Neglect Training (ENGAGE-IL)	All Staff	Annually
National APS Certificate Program	All Staff	Bi-Annually
Diffusing Dangerous Situations Training (MANDT)	All Staff	Bi-Annually
Financial Exploitation Awareness Training	All Staff	Bi-Annually
Elder Financial Abuse Training (MASTER)	All Staff	Bi-Annually
APS New Employee Orientation	All Staff	Initial only
DHSS/DSAAPD Policies Procedures	All Staff	Initial only
DTI – Cyber security	All Staff	Annually
Fostering Customer Service	All Staff	Initial only
Promoting a Culture of Diversity and Teamwork	All Staff	Initial only
Active Shooter/HIPPA	All Staff	Initial only
Disaster Preparedness	All Staff	Initial only
Fire plan, fire extinguisher	All Staff	Initial only
Technology Training (E-Star, Fleet, Email, etc.)	All Staff	Initial only
Person Centered Care	All Staff	Initial only
Trauma Informed Awareness Practices	All Staff	Initial only
Effective Communication	All Staff	Initial only
Customer Service	All Staff	Initial only
Dementia Awareness and Competency	All Staff	Initial only
Professionalism in the Workplace	All Staff	Initial only
Professional Ethics/Boundaries	All Staff	Initial only

APS New Hire Orientation (Proposed Training Plan)

Training Level	*Domain*	*Primary Focus Areas*	*Duration*
Level 1	Introductory	Welcome/ Introduction to APS, complete any pending/initial onboarding processes and review job performance plan with supervisor to clarify job expectations and requirements.	1 day
Level 2	Awareness	Completion of DSAAPD Orientation and department overview to include values, ethics, laws and regulations, tour, review of DHSS policies and participation in safety/prevention trainings.	4 days
Level 3	Knowledge	The aging process, physical and developmental disabilities, mental health issues, dementia awareness, diffusing dangerous situations, field safety, substance abuse, self-neglect and hoarding, abusive relationships, caregiver perpetrator neglect, financial exploitation, elder financial abuse, physical sexual abuse, capacity assessment	1-2 weeks
Level 4	Skills/Competencies	APS Case management documentation best practices, use of job related technology platforms and APS Harmony System, Overview ADRC, intake process, OMAHA system and prioritization, Time management, professional communication, and conducting interviews, Investigating alleged victim capacity, risk and functional assessment, capacity needs assessment, Voluntary / Involuntary Service Planning, proper handling of legal, law enforcement, and guardianship issues.	1 month
Level 5	Experiential	Shadowing, field/home visits, participation in field observations, case reviews, and a variety of scenario-based situations to increase proper handling of complex APS cases.	1 month
Level 6	Training Evaluation	Pre/Post Training Assessment to measure orientee's comprehension, skill, and competency level. Offer remediation as applicable.	TBD

APS Training Needs Survey (Proposed Training Plan)

Primary Focus Areas	*Possible Delivery Method(s)*	*Timeline*
• APS role clarity and identification – better understanding one's appropriate role in the prevention of adult abuse and neglect. • Situational Awareness – recognizing threats, inconsistencies, and other anomalies in the home and whether or not to intervene.	• Webinar /Technology-based learning • Classroom LIVE training • Self-Study Packets	1Q 2020
• Positive Behavior Support – how to appropriately deal with behaviors or emotions of APS clients and others in the home. • Communication – how best to collaborate and work with other authorities and law enforcement	• Webinar /Technology-based learning • Classroom LIVE training • Self-Study Packets	2Q 2020
• Cross Training – review opportunities to better understanding partnering agency's role in supporting APS clients. • Field Safety – review ongoing concerns to enhance APS worker safety and provide training. • Refreshers – review core APS competencies • Competency based training- family therapy, effective documentation, alignment with national APS standards and best practices	• Webinar /Technology-based learning • Classroom LIVE training • Self-Study Packets	3Q 2020

FINANCIAL EXPLOITATION

Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)

Mission Statement

- The mission of the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) is promote dignity, respect, and inclusion for older adults and people with disabilities.
- The Division is committed to inclusive healthy communities that promote the engagement of older adults and individuals with disabilities.

Adult Protective Services

- Established though legislation in 1982, Delaware Code, Title 31, Chapter 39, to a develop a system of services for impaired adults designed to protect their health, safety and welfare
- Housed within Department of Health and Social Services, Division of Services for Aging and Adults with Physical Disabilities
- Mission: *Ensure the safety and well being of elderly and adults with physical disabilities who are in danger of being mistreated and unable to protect themselves*
- Adult Protective Services (APS) provides support and assistance at NO COST.
- Services include: Resources, Education, Prevention, Risk Reduction, Safety Planning, Counseling, Referrals for Legal and Medical Services, Support with Law Enforcement Agencies, Criminal Justice Process, Court Process

Victim Service Advocate for Financial Exploitation

- The Victim Service Advocate program is funded through the Delaware Criminal Justice Council by the Department Of Justice, Office Of Justice Programs, Office Of Victims of Crime
- The Victim Service Advocate does not cost anything but your time.
  - If you believe you are being exploited – Call!
  - If someone you know is being exploited – Call!
  - You can remain anonymous.
- Delaware's Aging & Disability Resource Center (ADRC) - 1-800-223-9074

Key Points

- Financial Elder Abuse is called "The Crime of the Century" with losses of $21.6 BILLION in 2016 alone.
- Financial exploitation can happen to ANYONE at ANY TIME. Do not be ashamed or afraid to report it.
- Only 1 in 5 cases are reported.
- Know that you can fight back.
- When help is needed, we are your support.

What is Elder Financial Exploitation?

- Elder Financial Exploitation is the theft of money, property or belongings of an older person or actions that result in depriving an older person of the benefits, resources, belongings or assets to which he/she is entitled.
- Most victims are between the ages of 80 and 89. Most live alone. Women are twice as likely as men to be victimized by a scam artist. *However, ANYONE can be the victim of financial exploitation.* It crosses all social, educational and economic boundaries.

Why Are Older Adults At Greater Risk?

- Older Americans hold the largest percentage of the nation's wealth
- They may have regular income, accumulated assets and established credit
- They tend to be more trusting, polite and loyal to those close to them
- They may be lonely and socially isolated
- They may require in-home assistance, creating the potential for exploitation by strangers in their home
- They may be reluctant, afraid or embarrassed to report a crime
- They may be unaware they are a victim of fraud

The senior population is growing, providing a continuous source of wealth for financial exploiters.

Who Are The Abusers?

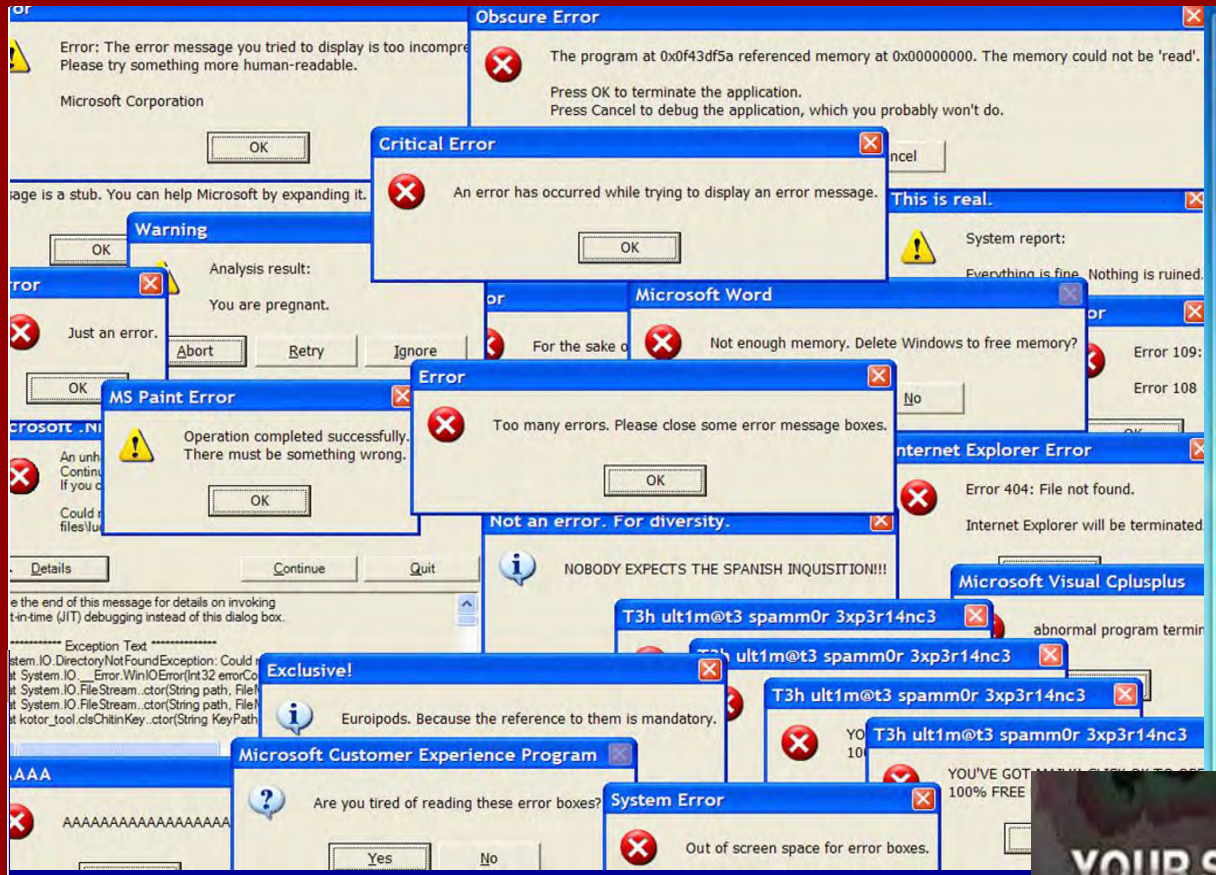
- Family Members and Caregivers
- Friends, Neighbors or Acquaintances
- Financial Advisors or Persons with authority to access a victim's money
- Telephone, Mail and Internet Scammers
- Home Repair Contractors
- Other Persons known or unknown to the victim

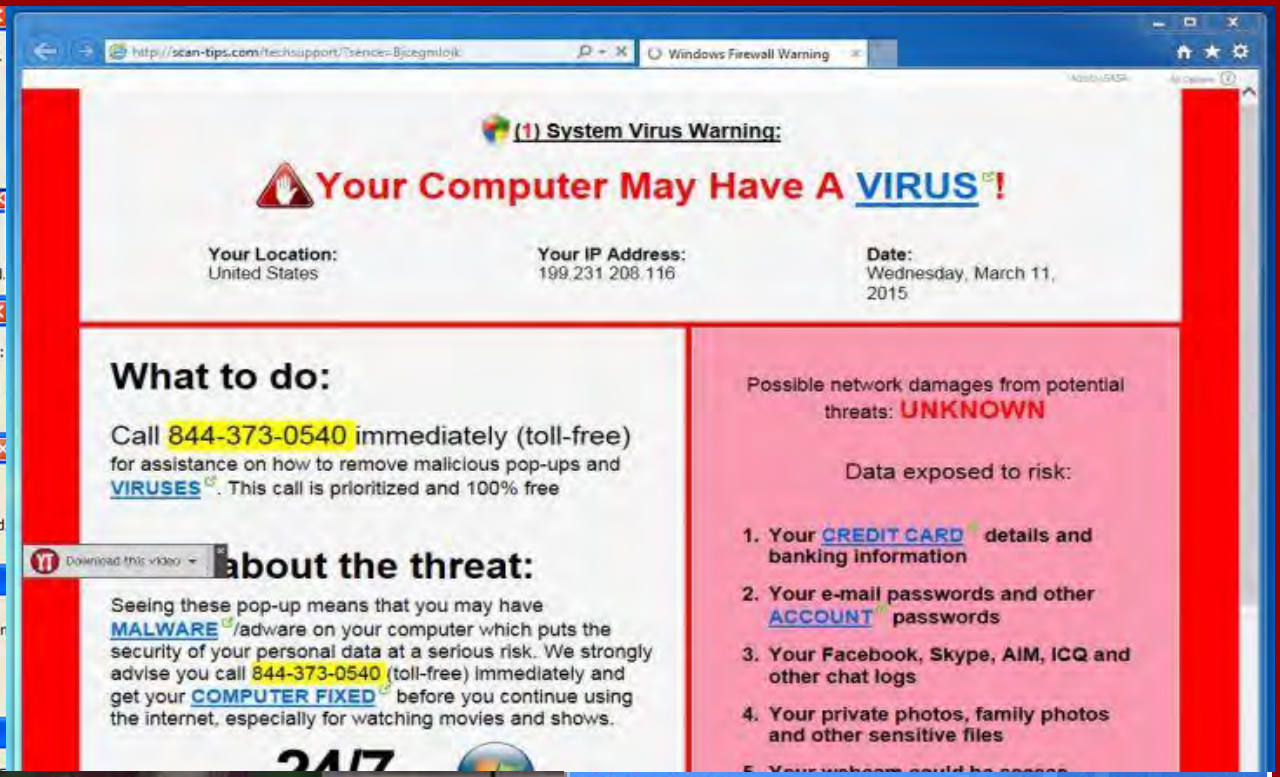
Examples of Financial Exploitation

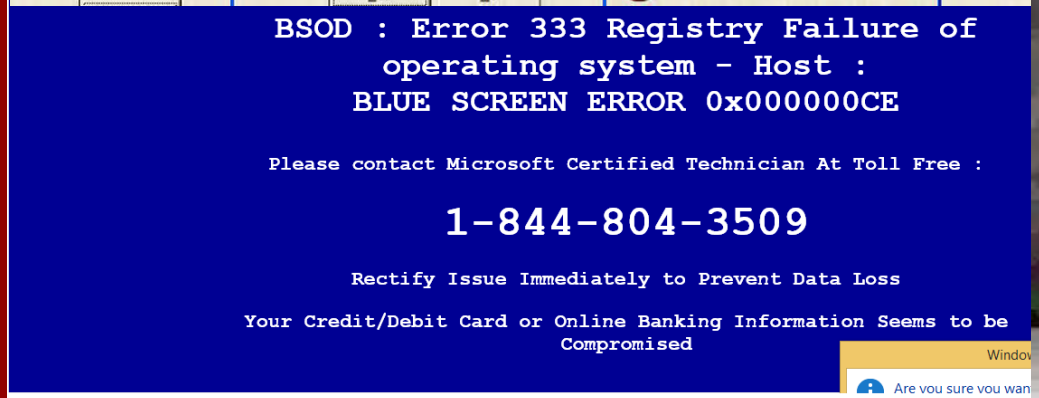
- Identity Theft
- Exploitation Under Power Of Attorney or Fiduciary Relationship
- Theft of Money or Property by a Caregiver or In-Home Helper
- Lottery or Sweepstakes Scams
- Computer and Internet Scams
- Scams by Telemarketers, Door-to-Door Salespersons, Phone Calls or Mail Offers
- Reverse Mortgage Fraud
- "Free Seminar" Scams
- Contractor Fraud and Home Improvement Scams

Telephone Scams

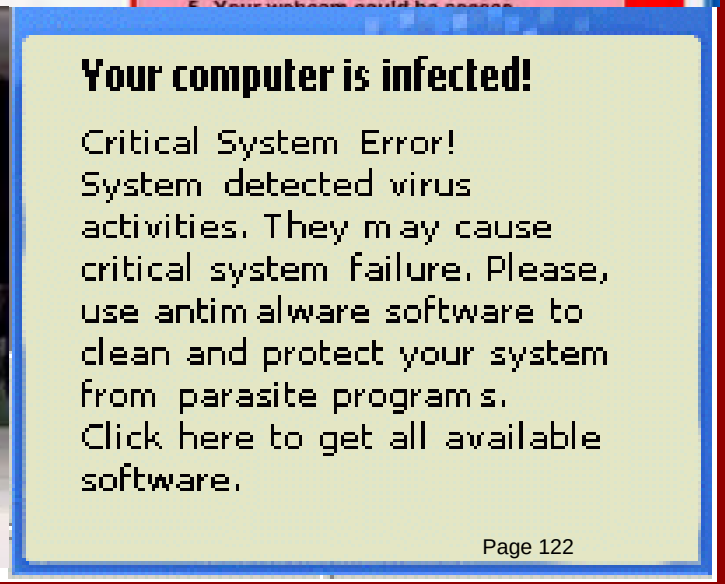
- Don't trust Caller ID. Scammers can alter the name and location displayed to make the call seem to be local. This is known as Neighborhood Spoofing. Caller ID can be changed to disguise a call originating from outside the United States or to have it appear to be from a well-known company like Microsoft, a bank or credit card company or an agency such as local law enforcement, the Social Security Administration or the IRS.
- Learn to say "No Thank You" and hang up. That's not being rude – that's taking care of you! Let the call go directly to voicemail.
- Register your home and mobile numbers with the National Do Not Call Registry at www.donotcall.gov or by calling 1-888-382-1222. This stops most unsolicited telemarketing sales calls.


Obscure Error
The program at 0x0f43df5a referenced memory at 0x00000000. The memory could not be 'read'.
Press OK to terminate the application.
Press Cancel to debug the application, which you probably won't do.
Critical Error
An error has occurred while trying to display an error message.
OK
Warning
Analysis result:
You are pregnant.
Abort
Retry
Ignore
Microsoft Word
Not enough memory. Delete Windows to free memory?
MS Paint Error
Operation completed successfully.
There must be something wrong.
Error
Too many errors. Please close some error message boxes.
This is real.
System report:
Internet Explorer Error
Error 404: File not found.
Internet Explorer will be terminated
Not an error. For diversity.
NOBODY EXPECTS THE SPANISH INQUISITION!!!
Microsoft Visual Cplusplus
abnormal program termin
T3h ult1m@t3 spamm0r 3xp3r14nc3
Exclusive!
Euroipods. Because the reference to them is mandatory.
Microsoft Customer Experience Program
Are you tired of reading these error boxes?
Yes
No
System Error
Out of screen space for error boxes.
Details
Continue
Quit


Windows Firewall Warning
(1) System Virus Warning:
Your Computer May Have A VIRUS!
Your Location:
United States
Your IP Address:
199.231.208.116
Date:
Wednesday, March 11, 2015
What to do:
Call 844-373-0540 immediately (toll-free)
for assistance on how to remove malicious pop-ups and VIRUSES. This call is prioritized and 100% free
about the threat:
Seeing these pop-up means that you may have MALWARE /adware on your computer which puts the security of your personal data at a serious risk. We strongly advise you call 844-373-0540 (toll-free) immediately and get your COMPUTER FIXED before you continue using the internet, especially for watching movies and shows.
Possible network damages from potential threats: UNKNOWN
Data exposed to risk:
1. Your CREDIT CARD details and banking information
2. Your e-mail passwords and other ACCOUNT passwords
3. Your Facebook, Skype, AIM, ICQ and other chat logs
4. Your private photos, family photos and other sensitive files


BSOD : Error 333 Registry Failure of operating system - Host :
BLUE SCREEN ERROR 0x000000CE
Please contact Microsoft Certified Technician At Toll Free :
1-844-804-3509
Rectify Issue Immediately to Prevent Data Loss
Your Credit/Debit Card or Online Banking Information Seems to be Compromised


YOUR SYSTEM MAY BE
INFECTED!
Scanning:
Internet threats and viruses found:
FREE SCAN NOW!


Your computer is infected!
Critical System Error!
System detected virus activities. They may cause critical system failure. Please, use antimalware software to clean and protect your system from parasite programs.
Click here to get all available software.

Tech Support Scams

- Pop Ups offering a "Free Security Scan" are bogus. Messages alerting you that "Your computer has a virus" are also not real. Do not respond to them.
- Never give remote access to your computer to anyone by telephone! The perpetrator may infect your computer with malware or a virus that will severely damage the computer's operating system and then charge you excessively for unnecessary repair work. Any information stored on your computer will be accessible to the scammer (bank accounts, tax returns, personal information).
- The best defense against this scam is to call your computer software company directly at a TRUSTED phone number, use a local repair service or ask a friend or relative for assistance.

Prevent A Tech Support Scam

- DO NOT click on links.
- NEVER give control to someone at a remote location.
- DO NOT provide credit card details.
- DO NOT purchase gift cards to pay for services or to provide a refund for an excessive credit you've received.
- **GIFT CARDS ARE NOT A LEGITIMATE FORM OF PAYMENT!**

Grandkid Scam

- STOP! Attempt to contact your grandchild directly. Speak to another family member if you cannot speak to the relative in need of money.
- Write down as many details as you are given and check it out first. Call law enforcement or the hospital and verify the information.
- DO NOT give bank account or credit card numbers under stressed or confused circumstances. Taking the time to think with your head, and not with your heart, may be the difference between losing thousands of dollars and preventing a scam.

Wire Transfer and Lottery Scams

- Do not reply to an email, phone call or letter stating you have won a prize or the lottery and are required to make an upfront payment for a promised prize.
- If you are told you have to pay fees or taxes to receive proceeds, it's a scam. Legitimate sweepstakes don't operate like that. It is in violation of Federal law.
- There is no legitimate reason why someone would give you a check and ask you to send money in return. The story is as phony as the check.
- Do not assist anyone needing access to a bank in the United States. This is illegal as well.

IRS Scam

IRS
Department of the Treasury
Internal Revenue Service

- Using Caller ID manipulation, the call appears to come from the IRS or a Washington, DC area code.
- HANG UP THE PHONE! When the IRS first contacts you about unpaid taxes, they do it by mail, not by phone AND they NEVER ask you to wire money or pay by credit card over the phone. They DO NOT accept gift cards as a form of payment.
- You can contact the IRS directly at 1-800-829-1040.

Telephone Scam Prevention Tips

- Do not provide credit card or bank account information to anyone who calls to verify your "log-in credentials". A bank or credit card company will NEVER ask for this. Report the incident to the phone number from a statement, website or card.
- If you receive a suspicious call, please hang up and call the National Fraud Hotline at 1-855-303-9470.
- A good rule of thumb: **Never give out personal information unless YOU have made the call to a VERIFIED phone number**.
- NEVER RESPOND TO AN OFFER YOU DO NOT THOROUGHLY UNDERSTAND.

Sending money to people you do not personally know, giving remote access of your computer to unknown callers and disclosing personal/financial information over the phone significantly increase your chances of becoming a fraud victim.

Gift Card Scams

- Store gift cards (Walmart, Target, Best Buy, Home Depot, etc.) Pre-paid debit cards, Google Play cards, iTunes gift cards, Vanilla, Money Pak, Reloadit or ANY other card purchased ARE NOT A LEGITIMATE FORM OF PAYMENT for legitimate companies.
- Utility Companies, Cell Phone Providers, Software Companies and Government Agencies will NEVER ask for this type of payment.
- RED FLAG ALERT: **Do not do business with a company requiring payment by gift cards. No matter how convincing the pitch - you are being scammed!**

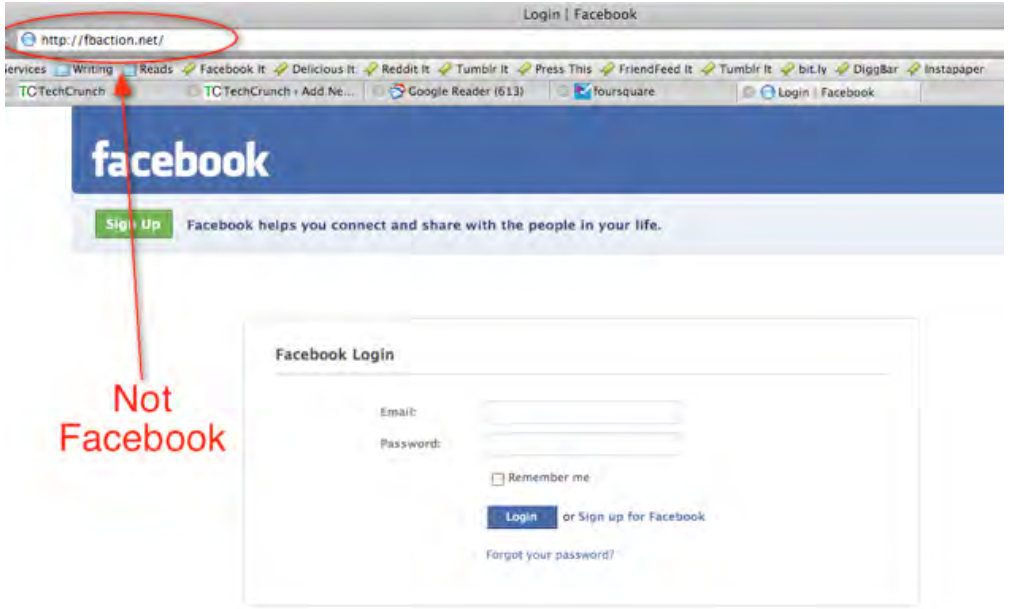
Victim Relief Fund Scam

- The Federal government has NOT set up a relief fund for victims who have been financially exploited.
- DO NOT pay any money due for tax purposes by gift card, wire transfer or credit card.

Computer-Based Fraud

- A phishing scammer creates authentic looking emails, text messages and Internet pages to entice victims into disclosing sensitive information.
- Spoofing is a fraudulent practice in which communication is sent from an unknown source disguised as a source known to the receiver.
- E-mail notifications from spoofers include messages such as:
  - "Our records indicate that your account was overcharged. You must call within 7 days to receive your refund."
  - "During our regular verification of accounts, we couldn't verify your information. Please click here to update and verify your information."
  - "We suspect an unauthorized transaction on your account. To ensure your account is not compromised, please click the link below and confirm your identity."

Examples of Spoofing



TrustedBank™

Dear valued customer of TrustedBank,

We have recieved notice that you have recently attempted to withdraw the following amount from your checking account while in another country: $135.25.

If this information is not correct, someone unknown may have access to your account. As a safety measure, please visit our website via the link below to verify your personal information:

http://www.trustedbank.com/general/custverifyinfo.asp

Once you have done this, our fraud department will work to resolve this discrepency. We are happy you have chosen us to do business with.

Thank you,
TrustedBank

Member FDIC © 2005 TrustedBank, Inc.

E-ZPass

Service Center

Dear customer,

You have not paid for driving on a toll road. This invoice is sent repeatedly, please service your debt in the shortest possible time.

The invoice can be downloaded here. Points to Server in Poland...

Terms & Conditions | Site Map | Privacy Policy | Phishing Policy 2014 E-ZPass

Example of Phishing

Computer Safety Tips

- Reduce The Chances Of Being A Victim Of Identity Theft:
  - Protect your computer with a password
  - Avoid using unsecured Wi-Fi connections when possible
  - Don't answer an email that asks for personal information
  - Only use trusted websites when purchasing online. Use websites beginning with https://
    - This assures the site is using a secure, encrypted connection.
  - Use anti-virus and anti-spyware software to keep your computer protected. NEVER purchase this software from a phone call you receive or a pop-up message on your computer screen

Identity Theft and Credit Card Fraud

- Identity theft crimes may happen without your knowledge. Perpetrators obtain your Social Security number, date of birth, home address or other personal information and use it to open new credit cards, loans or bank accounts in your name. Funds can be redirected from your bank account to a fraudulent account set up in your name elsewhere and emptied very quickly.
- When left unprotected, credit card information can be used to make unauthorized purchases.
- Personal information can also be used to file fraudulent tax returns with the IRS and redirect your refund.

Preventing ID Theft and Account Fraud

- Review your account balances and credit card statements regularly for any unauthorized transactions.
- Check your mail for declined credit card letters or any suspicious bank or credit card statements.
- Set up alerts for activity over a certain dollar amount.
- Never give account number information over the phone unless you make the call to a legitimate phone number.
- Never throw away receipts or statements in useable form - Shred all personal information before placing it in the garbage.
- Monitor your credit on a regular basis - Request a free, annual credit report at www.annualcreditreport.com or by calling 1-877-322-8228.

My Identity Has Been Stolen – Now What?

- Call the companies or banks where you know the fraud has occurred and speak to someone in the Fraud Department. Ask that your account be closed or frozen. They may require you to file a police report to open a fraud investigation.
- Place a fraud alert on your personal information by contacting at least one of the three major credit bureaus:
  - Experian.com/fraudalert or 1-888-397-3742
  - TransUnion.com/fraud or 1-800-680-7289
  - Equifax.com/creditreportassistance or 1-888-766-0008
- A fraud alert is free. It will make it difficult for someone to open new accounts using your name or personal information.
- Identity theft should also be reported to the Federal Trade Commission (FTC) at identitytheft.gov or by calling 1-877-438-4338.

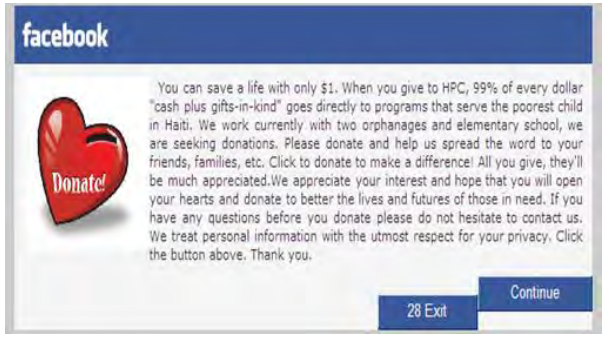
Medicare/Health Insurance Scams

- Every US citizen over the age of 65 qualifies for Medicare, so seniors are an easy target for a scam artist. Perpetrators may pose as a Medicare representative in order to get an individual to divulge personal information or they may provide bogus services at makeshift mobile clinics and use the personal information they have obtained to bill Medicare and pocket the money.
- Never sign blank insurance claims. Always ask what you will pay out of pocket. Keep accurate records of all health care appointments. Carefully review your benefits statement for services and charges. Know if your physician has ordered equipment for you.
- Do not do business with door-to-door or telephone salespeople who promise free medical equipment services.
- Give your insurance/Medicare identification only to those who have provided you with medical services. Do not "verify" any information by telephone.
- DNA testing is not covered under Medicare. Do not respond to any offers for genetic testing "at no cost to you". Contact the DE Senior Medicare Patrol at 800-223-9074 if you have questions.

Romance Scams

- Scammers create fake dating profiles and use photos of others – including military personnel. They build relationships, then suggest moving off the website to email or phone calls. They ask for money to come meet you in person or for an urgent need. Some even make fake wedding plans before they disappear with your money. Every scammer is very good at being persuasive and getting you to do something you might not otherwise do.
- Guard your wallet as well as your heart!

Charity Scams



- Do not feel pressured to donate immediately. Never give credit card or bank account information over the phone. Ask the charity to send you information by mail. Research an organization at FTC.gov/charity, charitynavigator.org or give.org before donating.
- Be careful of charities that "pop up" right after a national disaster. Check with local agencies before making a donation to ensure you are supporting a legitimate police, fire, emergency service, hospital or veteran group.
- Create a "Giving Plan" or budget at the beginning of each year to control your charity spending. Ask to be put on a charity's DO NOT CALL list.
- Report scams to the FTC at 1-877-FTC-HELP or the DE Department of Justice, Fraud and Consumer Protection Division at 302-577-8600.

Direct Mail Scams

- Companies hosting free lunch seminars are NOT being charitable. They are banking on your business. They can be very aggressive in the tactics they use to get you to say "Yes. Sign me up!" DO NOT SIGN anything you do not understand - even with a "Cancel At Any Time" promise.
- Understand the terms of a loan before signing any documents. Ask someone you trust for assistance.
- Be aware that many charities sell your information to other charities. Making a donation for address labels or greeting cards may increase the number of solicitations you receive from other charitable organizations.

- Vehicle Warranty Expiration Notices from a third party can be bogus. Check with your manufacturer before sharing your credit card information.
- NEVER cash an unexpected "refund", "sweepstakes" or any unexplained check you receive in the mail. Do not assist a stranger with wiring money into the United States. It's against the law. These are tactics to obtain your personal information.

FINAL WARRANTY NOTICE

Dear Valued Customer,

This notice is to inform you that your **vehicle's factory warranty has expired,** or may expire soon depending on your current mileage.

Take action now to protect yourself from increasingly high labor cost and unexpected repair bills! **Call us IMMEDIATELY to take advantage of this final offer.** You have been preselected for this exclusive offer.

NATIONAL AVERAGE REPAIR COSTS

Air Conditioning $1,500
Alternator $850
Computer $1,400
Engine $3,750
Starter $725
Power Window Motor $685
Transmission $3,450
Steering $1,350
Water Pump $525
Wiper Motor $655

Actual repair cost may vary depending on vehicle model

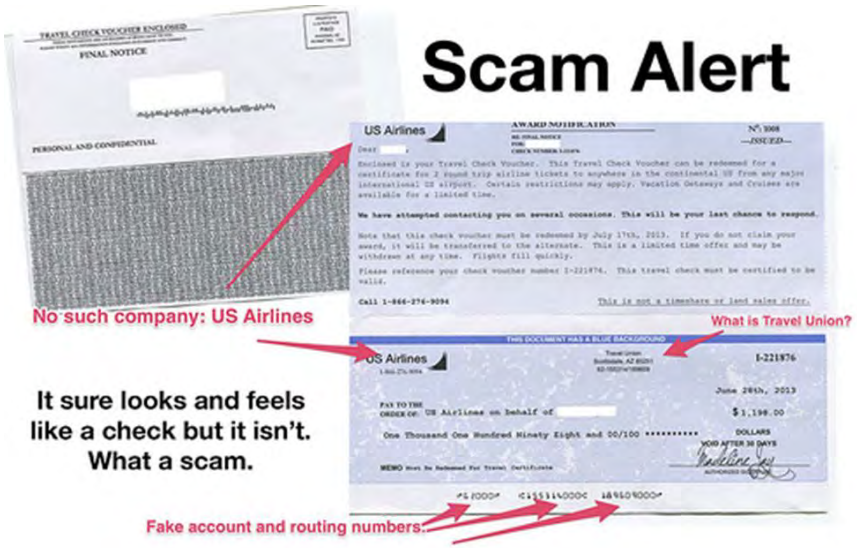
Ask Our Warranty Specialist...

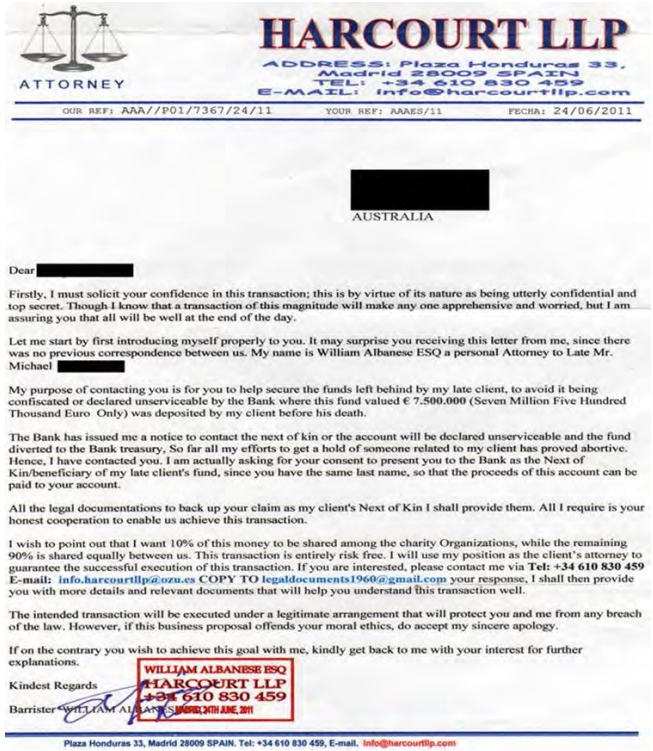
- 0% Interest free financing guaranteed on first call activation.
- All major credit cards and checks accepted.
- This card is good for an additional $250 off. Ask an agent for details.

DISCOVER MasterCard VISA

1-800-581-1575

Business Hours:
Monday-Friday 7AM-9PM
Saturday 9AM-2PM C.S.T





HARCOURT LLP

ATTORNEY

ADDRESS: Plaza Honduras 33, Madrid 28009 SPAIN
TEL: +34 610 830 459
E-MAIL: info@harcourtllp.com

OUR REF: AAA//P01/7367/24/11 YOUR REF: AAAES/11 FECHA: 24/06/2011

[redacted]
AUSTRALIA

Dear [redacted]

Firstly, I must solicit your confidence in this transaction; this is by virtue of its nature as being utterly confidential and top secret. Though I know that a transaction of this magnitude will make any one apprehensive and worried, but I am assuring you that all will be well at the end of the day.

Let me start by first introducing myself properly to you. It may surprise you receiving this letter from me, since there was no previous correspondence between us. My name is William Albanese ESQ a personal Attorney to Late Mr. Michael [redacted]

My purpose of contacting you is for you to help secure the funds left behind by my late client, to avoid it being confiscated or declared unserviceable by the Bank where this fund valued € 7.500.000 (Seven Million Five Hundred Thousand Euro Only) was deposited by my client before his death.

The Bank has issued me a notice to contact the next of kin or the account will be declared unserviceable and the fund diverted to the Bank treasury, So far all my efforts to get a hold of someone related to my client has proved abortive. Hence, I have contacted you. I am actually asking for your consent to present you to the Bank as the Next of Kin/beneficiary of my late client's fund, since you have the same last name, so that the proceeds of this account can be paid to your account.

All the legal documentations to back up your claim as my client's Next of Kin I shall provide them. All I require is your honest cooperation to enable us achieve this transaction.

I wish to point out that I want 10% of this money to be shared among the charity Organizations, while the remaining 90% is shared equally between us. This transaction is entirely risk free. I will use my position as the client's attorney to guarantee the successful execution of this transaction. If you are interested, please contact me via **Tel: +34 610 830 459 E-mail:** info.harcourtllp@ozu.es COPY TO legaldocuments1960@gmail.com your response, I shall then provide you with more details and relevant documents that will help you understand this transaction well.

The intended transaction will be executed under a legitimate arrangement that will protect you and me from any breach of the law. However, if this business proposal offends your moral ethics, do accept my sincere apology.

If on the contrary you wish to achieve this goal with me, kindly get back to me with your interest for further explanations.

Kindest Regards

WILLIAM ALBANESE ESQ
HARCOURT LLP
+34 610 830 459

Barrister WILLIAM ALBANESE

Plaza Honduras 33, Madrid 28009 SPAIN. Tel: +34 610 830 459, E-mail. info@harcourtllp.com

Door-To-Door Scams

- Watch out for unlicensed contractors and handymen who show up at your door and offer a service that seems like a bargain. Services include: roof repair, driveway sealant, power washing, yard clean up, painting, home security system installation and more. The scammers usually ask for payment in advance. They do sub-standard work, or no work at all, and it is nearly impossible to track them down once they've left.
- Never feel pressured to "Act Now Before It Gets Too Busy". Trust your gut. If you have doubts about hiring someone, take your business elsewhere. Ask for references and check them out. Talk with your neighbors about who they have hired for similar work.
- Always ask for a contractor's license and certificate of insurance. Take note of the vehicle information (make, model, color, plate). Get a written estimate and sign a written contract with no blank spaces. Never pay up front and never pay in cash. Pay by credit card so you can dispute the charge or cancel the payment if there are problems later.
- Never pay to have your cable or utilities "reconnected" after a storm.

Skimmers

Use caution when swiping your credit or debit card at an ATM, a gas pump or a store register. Make sure the machine does not appear to be altered. Always block the keypad with your hand when entering your PIN. Small cameras or illegal devices (skimmers) that capture your card number and PIN may be installed on these machines. Fraudulent ATM withdrawals and charges can be made using this information.

Things To Keep You Safe

- Talk to someone you trust before doing anything
- Don't isolate yourself – stay involved with friends, family and community
- Don't share, verify or give ANY personal information by telephone to anyone you do not know personally
- Use caution when opening email or text messages
- Hang up the phone on unknown callers
- Don't sign anything you do not understand
- Be aware that you are at risk from ANYONE!

Four Ways To Prevent Fraud

1. Do Not Be A Courtesy Victim – Don't feel badly about hanging up the phone or saying "No."
2. Never Judge A Person's Integrity By How They Sound – Successful scammers combine professional sales pitches with extremely polite manners knowing that older people may equate good manners with personal integrity.
3. Watch Out For People Who Prey On Your Fears – Do not feel pressured to act immediately. Write down as much information as you can and share it with someone you trust. Take your time making decisions.
4. Do Not Let Embarrassment Or Fear Keep You From Reporting Abuse – Do not fail to report victimization for fear of being judged incapable of handling your affairs. If you become the victim of a scam, do something about it – quickly!

Your information is valuable to you and other people too!

Protect your IDENTITY and your MONEY by PROTECTING you INFORMATION

Reporting Scams

Please share what you have learned with others. Together, we can put a stop to scammers! The Aging and Disability Resource Center takes referrals 24 hours a day, seven days a week. All calls are confidential. Call the ADRC at 1-800-223-9074.

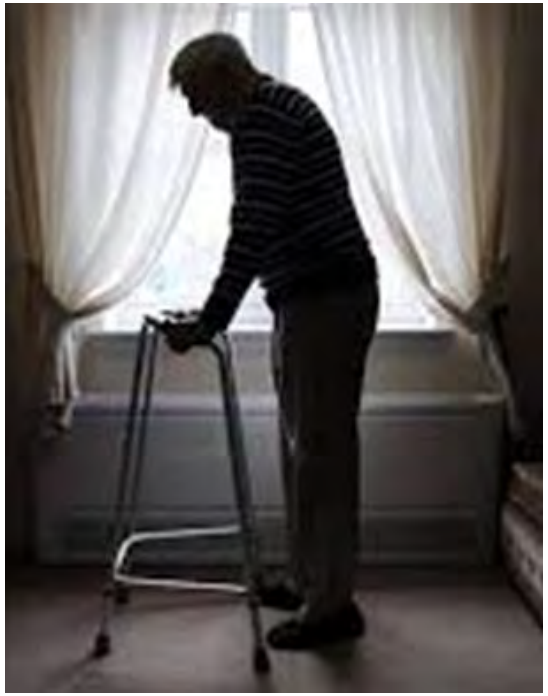
QUESTIONS?

SELF-NEGLECT & HOARDING DISORDERS

Handling Inadequate Self-Care

Key Lessons

- Self-neglect is a failure of a person to meet personal needs such as food, shelter, clothing and medical care.
- Hoarding disorder is a complex condition that requires specialized training to provide meaningful help.
- The first line of help for self-neglect is social service based.
- A team, such as lawyers and doctors, can help address other challenges, while social services coordinates the human and personal services.
- Harm reduction strategies lay a framework for working with people who self-neglect or have a hoarding disorder.

WHAT DO YOU SEE WHEN YOU SEE….?

Maslow's Hierarchy of Needs

What Is Self-Neglect?

- Involves seniors or adults with disabilities who fail to meet their own essential physical, psychological, or social needs, which threatens their health, safety, and well- being. This includes failure to provide adequate food, clothing, shelter, and health care for one's own needs.
- Self-neglect may be a personal choice.
- Self-neglect be the result of a financial inability or physical inability to meet personal needs.
- Social Services should be the first line of help for self-neglect.

Signs of Self-Neglect

- Malnutrition, unexpected weight loss or gain due to lack of appropriate nutrition
- Extreme inappropriate clothing
- Marked decline in personal appearance, without explanation
- Untreated medical conditions
- Unsafe or unsanitary living conditions
- Unpaid bills, utility disconnects
- Noticeable decline in personal hygiene

Hoarding

- Affects approximately 3-6 % of the population
  - Roughly 1 out of every 20 people
  - Suspected 19 million people
  - Underrepresented amount
- Severe hoarding causes risk of serious injury or even death because of the environment that people live in.
  - Falls, avalanches, structural concerns
- People who hoard may also exhibit low functional capacity
  - Ability to perform tasks necessary to live their lives
    - Physical capacity
    - Social capacity
    - Cognitive/Psychological capacity – Low insight/refusal to accept help as most significant

Lack of Care to Home Environment

- Home may be dirty & disorganized
- Clutter may take up all available space
- May have rodent & insect infestations
- May be lack of necessary repairs & routine maintenance
- Lack of essential supplies and services/utilities

Clutter's Interference with Basic Functioning

- Cooking
- Cleaning
- Moving through the house
- Sleeping
- Likelihood of:
  - Fire
  - Fall Risks
  - Poor Sanitation
  - Pest Infestation

- Risk to those who live in the home and neighbors
- Hoarding accounts for 24% of preventable fire fatalities

Understanding Why People Self-Neglect

- Physical Health Issues – Impaired physical functioning; pain, nutritional deficiency
- Mental Health Issues – Depression; mental health problems; frontal lobe dysfunction; impaired cognitive functioning
- Substance Misuse – alcohol; substance misuse
- Psychological and Social Factors – Diminished social networks; limited economic resources; lack of access to social or health services; personality traits; traumatic histories and life-changing events; high perceived self-efficacy; personal values; bereavement

Causes, as Stated By People who Have Self-Neglected

- Demotivation: homelessness, health, loss, isolation – self-image, negative cognitions
- Different Standards: being indifferent to social appearance, having other priorities
- Inability to Self-Care: mental distress, physical ill-health, homelessness
- Influence of the Past: childhood, loss, abuse, bereavement
- Positive Value of Hoarding: emotional comfort, connection to something, "my family", hobby, to be appreciated by others
- Beyond their Control: voices, obsessions, physical ill-health, lack of space

Implication of Self Neglect and Hoarding

- Respect for autonomy and self determination
- Duty to protect from harm and promote dignity (duty of care)
- Communities are also seen as having rights that counter-balance those of individuals, e.g. those living next door to a property with vermin or that is a fire risk.

This can cause a professional dilemma. APS must respect the person who is providing inadequate self-care and the duty to protect the community.

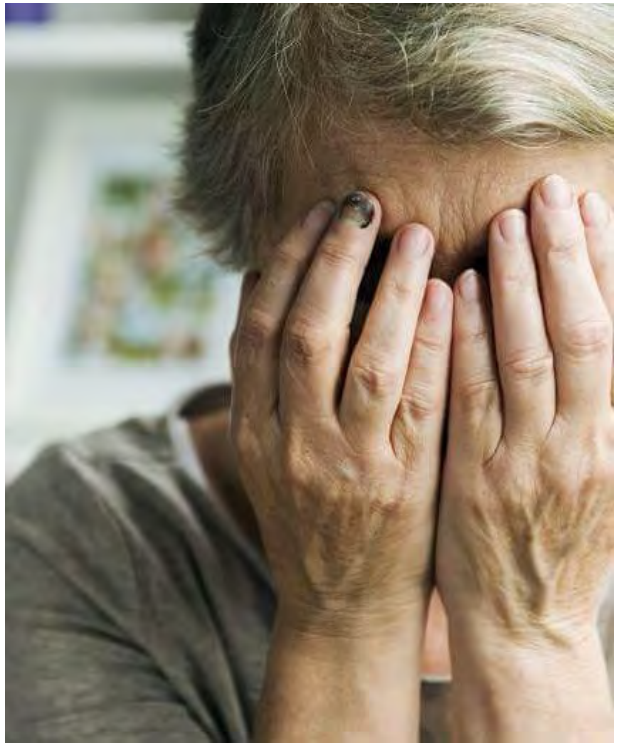
Interventions to Reduce Harm

- Social interventions are important for harm reduction.
  - Assistance from Adult Protective Services – Emergency shelter, food, personal care and transit
  - Assistance from Nurses – can provide navigation services for medical services
- Legal help is sometimes needed as others work on harm reduction.
  - Supportive Decision Maker
  - Power of Attorney
- All alternatives should be exhausted, before considering guardianship.

Why Someone Might Refuse Help

- Level of Insight – Good, fair, poor, absent
- Information Processing
  - Perception, Attention Span, Memory
  - Categorization, Decision Making Deficits
- History of complex trauma
- Beliefs/Attachments
  - Beliefs about Possessions – Sentimental, intrinsic, instrumental
  - Beliefs about Vulnerability – Maladaptive thoughts
  - Beliefs about Responsibility-waste
  - Beliefs about Memory and Control
- Emotional Reactions – Positive and Negative Emotions

Refusal of Help Continued…



- Sometimes seeing the problem differently than others
- "If I had more space this wouldn't be a problem.."
- Fear of help and discovery – Not permitting repairs
- Hopelessness
- Resentment and mistrust
- Personal values

What Works

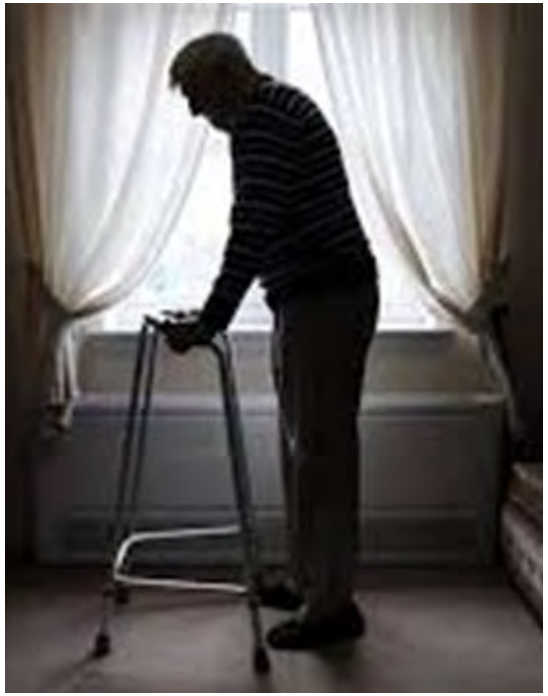
- Harm reduction, not symptom reduction
- Cleaning as a short term solution only
- Assistance with routine daily living
- Early intervention to prevent entrenched patterns
- Combined approaches (sorting tasks and CBT)
- Medication in some cases
- Building rapport and trust
- Working at a pace of the individual
- Keep mental capacity constantly in view
- Open and honest communication about risks and options
- Clear understanding of legal powers and duties
- Creative building on relations and networks
- Working proactively to engage and coordinate agencies

Harm Reduction

- Respect: nonjudgmental understanding of each individual and "where they are at"
- Acceptance: that hoarding is a complex, multi-faceted phenomenon
- Empowerment: of the individual as the primary agent of change
- Compassion: towards the realities of social isolation, past trauma, discrimination, and other social inequalities and vulnerabilities people face
- Collaboration: supporting individuals in developing & implementing strategies that are personally meaningful

A Framework for these Cases

- Interagency strategy
- Shared definitions and understanding
- Clear communication and referral route
- Scope for long-term relationship-based involvement
- Management that enables and challenges

WHAT DO YOU SEE WHEN YOU SEE….?

Questions?

Recommendation	Progress Reporting
Recommendation 1: Continue or Terminate Under §10213(a), Title 29, the Committee must determine whether there is a genuine public need for an agency under review. To meet this requirement, the Committee may select one of the following options. Option 1: DHIN shall continue, subject to any further recommendations that JLOSC adopts. - OR – Option 2: DHIN is terminated and the Committee will sponsor legislation to implement this recommendation. Status: 5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 1 with option 1.	**Progress Reporting not needed for this recommendation.**

Recommendation	**Progress Reporting**
Recommendation 2: MOUs for HCCD DHIN shall continue to work with the Department of Health and Social Services, Delaware Office of Management and Budget, Division of Public Health, Division of Medicaid and Medical Assistance (DMMA), and Delaware Health Care Commission to finalize MOUs permitting those collaborating state agencies to access data in the HCCD. Option: DHIN shall explore possible partnerships and develop MOUs with other agencies that will strengthen research and data for the HCCD. For example, DHIN could explore partnership with the Department of Correction (DOC) and organ procurement organizations (such as the Gift of Life program) to identify ways in which DHIN data can be used to safely and quickly assist with organ donation suitability determinations. DHIN Notes: 1. A potential partnership with the Gift of Life program would likely be for access to clinical data, not the HCCD. DHIN would need legislation explicitly permitting DHIN to provide data to the Gift of Life program regarding potential donors, which they would then use to supplement their work on suitability for donation. Recommendation number 6 includes an additional suggestion for proposed statutory updates. 2. While the DOC may be able to benefit from the use of claims data, DHIN believes a partnership with DOC with respect to the DOC providing DHIN with clinical data may be helpful to the DOC as well.	**December Update:** DHIN has MOUs and DUAs with the following state agencies and is currently engaged in the studies listed: • Delaware Health Care Commission o Report – Delaware Primary Care Total Spend o Report – pending contract– Cost Transparency o Request in pipeline - Prevalence of certain diseases of interest • Division of Public Health o Data extract - Lung Cancer Cost Study o Request in Pipeline - Data extract – HPV immunization prevalence • Division of Medicaid and Medical Assistance (IAPD) o Data extract – supports various DMMA analytics • Special Council for Persons with Disabilities o Brain Trauma prevalence and geography • Delaware Health and Social Services 1. Gift of Life – DHIN is proceeding with making the required changes to statute to execute data requests. 2. Dept. of Correction – DHIN met with DOC team to discuss next steps in formalizing partnership and providing assistance with preliminary technical requirements.

Status: 5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 2 with option.	
Recommendation & Status	**Progress Reporting**
Recommendation 3: Continued Federal Funding Initiatives DHIN shall continue their work with DMMA to leverage their previously-appropriated state funding for the HCCD by seeking a federal match through the Implementation Advance Planning Document (IAPD) process. Option: Should the IAPD process be unsuccessful for any reason, DHIN shall work with JLOSC to ensure that the $2 million already appropriated funds remain available to DHIN for its work setting up and maintaining the HCCD. Status: 5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 3 with option.	**December Update:** DHIN and DMMA received approval for proposed IAPD from CMS in May 2019. DMMA required separate contracting documentation for IAPD. DHIN signed the revised contract 12/10/19. As of 12/20/2019, DMMA has not countersigned.
Recommendation & Status	**Progress Reporting**
Recommendation 4: Annual HCCD Status Report DHIN shall submit an annual status report, no later than January 1, to the Governor and General Assembly, regarding the HCCD. Reports shall include: a. Analysis of strengths and weakness of HCCD. b. Current status and future plans of HCCD. c. Detailed Budget for HCCD operations. d. Grant applications and status for HCCD operational funding.	**December Update:** **A. Strengths and Weaknesses** **1. Strengths:** **a. Quality and Breadth of Data:** Data from Medicaid (FFS and MCO), Medicare FFS, Medicare supplemental, Qualified Health Plans, State Employee Benefits and commercial payers, spanning 1/13 – 10/19 and representing more than half of Delaware residents. **b. Collaboration**

e. Status of contracts with vendors supporting HCCD operations.
f. Number of data access requests submitted and granted.

Option 1: The first report shall be submitted no later than January 1, 2020.

Option 2: The annual reports shall be included on the DHIN website.

Status:
5/13: First consideration of this recommendation
5/13: JLOSC adopted recommendation 4 with options 1 and 2.

i. Collaborative relationships with Payer technical teams with prompt responsiveness to data issues and weekly working group meetings when necessary.
ii. Availability of consultant analytic resources, subject matter expertise and connections with the national body of knowledge for APCDs.
iii. Responsiveness and expertise of technology subcontractor keeping pace with biweekly (2x/week) action item progress.

c. Cloud Technology Platform
i. Enables API, ElastiSearch, Amazon Redshift and conventional analytic access tools.
ii. Clinical and claims data available to analytics with a shared enterprise person ID. Enables quality and cost metrics for value based health care assessments
iii. Enables secure portal access for interactive reporting tools

d. Privacy and Security Controls

2. Weaknesses

a. **Financial Sustainability:** HCCD is currently dependent on State appropriation and the pending IAPD for matching federal funds.
i. DHIN has spent more than 40% of the State's $2 million appropriation for FY20. (Because the IAPD funding is contingent on a State match, this remaining amount will need to be carried over into FY21.)
ii. There is not yet a sustainable business model for the HCCD.

b. **Data Collection from Self-Funded Payers:** It's voluntary and comprises 35% of Delaware residents. While many analytic studies/reports and data extracts will not be significantly affected, some reports will have a population bias with under-representation of Delawareans employed by state's largest employers.

c. **Workforce**: DHIN's current analytic resources are contracted. This cannot be sustainable without steady, dedicated revenue. DHIN plans to hire its own staff to perform the analytics functions currently contracted (see Workforce below).

B. Current Status and Future Plans

1. Current Status

a. Data Access and Request Activity

i. Two Access Committee applications reviewed
   1. CDC PFAS Study data extract approved
   2. Commercial research denied

ii. Eight State agency requests: 3 active, 3 pending, 2 completed
   1. DPH Lung cancer cost study
   2. SCPD Brain Trauma
   3. DHCC Primary Care
   4. DHCC Cost Transparency – pending
   5. DPH HPV Rates pending
   6. DMMA data extract with IAPD work pending
   7. SEBC 2 completed
      a. Elective surgery cost study
      b. RAND hospital transparency study

iii. Inquiries
   1. BioScience Associates
   2. Lown Institute

b. Workforce

i. Two DHIN employees: Director and data quality analyst
ii. Subcontractor: Analytics and project management
iii. Subcontractor: Hosting technology and data management

2. Future Plans

a. Workforce Additions FY20

i. Hire Sr. and Jr. Analyst – Q1 CY20
ii. Maintain analytic subcontractors throughout IAPD work
iii. Knowledge share between subcontractors and DHIN staff

b. Application Process Improvements FY21

i. Develop a State agency-specific application

ii. Provide a more user-friendly public application for de-identified data separate from currently approved comprehensive Access Committee application

c. DHIN HCCD website improvements FY21

i. Data statistics to assist researchers to understand breadth and depth of data available
ii. List of current studies
iii. Readily accessible tools and instructions

d. Data Enhancements FY20-21

i. Risk adjustments
ii. Master Provider Index
iii. Clinical and administrative groupers
    1. Diagnostic related grouper (DRG)
    2. Episode grouper
    3. Analytic flags
    4. Service types (e.g. primary care)
iv. Code and procedure library

e. Data Access FY21-22

i. Expand data access requests from extracts and reports to more self-service analytic tools:
    1. License for portal workspace designed for de-identified research by approved organizations such as INBRE, U of D.
    2. State agency data access portal to de-identified data designed for ad-hoc analyses
    3. Publically available static, periodic and interactive reports via web URL
ii. Data enhancements (B.2.d.) of FY21 are pre-requisites to de-identified data portals

f. **Ongoing Collaboration with Payers** to improve quality and completeness of data submitted

C. Detailed Budget for HCCD operations.

1. Internal Staffing

2. Freedman Subcontractor
    a. Analytic support
    b. Project Management
    c. Subject Matter expertise
3. MedicaSoft Technology Host Subcontractor
    a. Ongoing operations
    b. Developer expenses
    c. Analytic support

D. Grant applications and status for HCCD operational funding.

The pending IAPD referenced above goes through federal FY21 (i.e., until September, 2021). It includes a 90% federal/10% State match for the design, development and implementation ("DDI") costs of new functionality. The first year of the contract is almost all DDI work (with the associated 90/10 federal match), and as the contract continues there will be a mix of DDI work and ongoing maintenance (which has a 75% federal/25% state match rate).

Once the current contract expires, the IAPD can be renewed in perpetuity, but in order to do so the State will need to commit to provide 25% of the costs of such maintenance on an ongoing basis. In 2020 dollars, that match is expected to cost the State approximately $500K annually, assuming no further delays or difficulties in securing the federal match.

E. Status of contracts with vendors supporting HCCD operations.

Per July 2018 agreement, Medicasoft provides hosting, data processing, security and database maintenance services for the HCCD. An additional agreement in July 2019 contracts with Medicasoft to also provide ongoing analytics support services for the HCCD. The contracts are in effect until either DHIN or Medicasoft chooses to end the contract. The combined cost of the two agreements is approximately $600K annually.

DHIN contracted with Freedman Consulting Group in January 2019 for Freedman to provide project management and analytics reporting consulting work at a cost of approximately $360K annually. The contract has an initial

	end date of 1/31/2020 with an option to extend up to an additional four years in increments to be determined by DHIN. F. **Number of data access requests submitted and granted.** a. Two external (non-state agency) access requests submitted. b. One granted
Recommendation & Status	**Progress Reporting**
Recommendation 5: Statutory Update & Technical Corrections JLOSC will sponsor a bill to make technical corrections to DHIN's entire governing statute, Chapter 103, Title 16.* Status: 5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 5.	**Progress Reporting not needed for this recommendation.**

* The Committee's legislative attorney will draft any legislation resulting from approved recommendations, unless otherwise noted.

Recommendation & Status	**Progress Reporting**
Recommendation 6: Statutory Updates to Strengthen HCCD & Ensure DHIN's Continued Success At DHIN's request, DHIN wishes to work with the Committee's legislative attorney to draft bills that will: a. Maximize the number and types of claims that are submitted to the Delaware HCCD. b. Permit more detailed reporting of claims related to sensitive diagnoses (by, for example, identifying DHIN as an appropriate holder of data associated with an HIV-related test (16 *Del. C.* § 717) or genetic testing (16 *Del. C.* § 1205)). c. Maximize the number and types of entities that submit clinical information to the DHIN. d. Permit use of clinical data for public health reporting and research. e. Permit the use of de-identified clinical data for appropriate research purposes. f. Ensure that pharmacy prescription fill data is provided to the DHIN. g. Permit DHIN to provide data to the Gift of Life program on potential donors (this would be needed to establish a partnership between the two entities as referenced in recommendation number 2).	**Progress Reporting not needed for this recommendation.** **First task force meeting will be on August 27, 2019.**

Option 1: Create a small JLOSC subcommittee to will discuss the proposed statutory amendments and report back to the JLOSC in January 2020. Subcommittee membership will include DHIN's private counsel, the Committee's legislative attorney, and other members the Committee deems appropriate. Option 2: Same as Option 1, but create a task force instead of a JLOSC subcommittee. - OR - Option 3: The Committee's legislative attorney will work with DHIN's private counsel to draft proposed bills and report back to the JLOSC in January 2020. Status: 5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 6 with option 2.	
Recommendation & Status	**Progress Reporting**
Recommendation 7: Reduce Overlap and Duplicated Efforts At DHIN's request, DHIN shall identify areas of overlap between its capabilities and those separately contracted for or provided by State agencies, and work with those agencies to eliminate overlap or redundancies. As a part of these efforts, DHIN shall explore whether it can reasonably be the "single point of contact" for delivery of health data on Delaware residents to assist state and federal public health efforts. By statute, DHIN is the "State's sanctioned provider of health information exchange (HIE) services" (16 *Del. C.* § 10301). Option: DHIN will report back to the JLOSC on progress of this research in January 2020.	**December Update:** DHIN has continued to look into ways in which it can assist the State as its only sanctioned provider of health information services and an available "single point of contact" for delivery of health data on Delaware residents to assist state and federal public health efforts. In particular, it has already begun preparations to engage, if necessary, in the RFP that will be issued by the State Employee Benefits Committee related to data warehousing and analytics services associated with the State's employee health benefit plan. Certain tasks currently being performed by third parties and paid for by the State could be performed by DHIN, likely at a cost savings to the State. DHIN intends to bid on those services in any RFP process, and to engage in a dialogue with the agency to determine whether there are any other areas in which DHIN could provide the State with replacement or enhanced services on a more cost-effective basis than possible with entities that do not share DHIN's status as a not-for-profit State instrumentality.

Status: 5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 7 with option.	DHIN also has begun conversations with DMMA with respect to data warehousing and analytics services that it contracts for in order to maintain and improve the State's Medicaid Program. Those conversations resulted in the IAPD project, discussed separately, that will both enhance the Health Care Claims Database and provide additional services to Medicaid at a reasonable (and federally-matched) cost. DHIN intends to continue to work with DMMA to determine if there are other areas where it currently contracts with third parties – especially in the areas of data warehousing and analytics – where DHIN could leverage the data in the HCCD and its status as a not-for-profit State instrumentality to provide more cost-effective services to other areas of the Medicaid program. Finally, DHIN believes that it can provide additional services to healthcare-related state agencies at a competitive cost, with the added benefit of diversifying DHIN's revenue stream and helping to ensure that the State-sanctioned provider of health information exchange services continues to thrive. DHIN will therefore be discussing with potential sponsors an extension of the current statutory language that permits certain divisions of state government to contract with DHIN for healthcare data warehousing and analytics services without going through the typical procurement process. The model for this legislation will Section 6904(m) of Title 29, which permits the Department of Education to contract directly with the University of Delaware, Delaware State University and Delaware Technical and Community College for any goods and services. Under DHIN's proposed statutory edits, the Department of Health and Social Services and Department of Insurance will be able to contract directly with DHIN for goods and services without going through the more onerous procurement process.

Recommendation & Status	**Progress Reporting**
Recommendation 8: Update Current Regulations DHIN shall update its regulations to reflect current operational procedures. Option: DHIN will report back to the JLOSC on progress of these efforts in January 2020. Status: 5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 8 with option.	**December Update:** DHIN has begun the process of re-drafting its regulations. Given the legislation that is being proposed as a result of this task force, DHIN has not finalized those regulations at this time. Once any legislation recommended by the task force becomes law, DHIN will finish the process of drafting updated regulations and will submit those regulations for public review and comment in the ordinary course. Currently, DHIN expects to be in a position to initiate the regulatory change process in the 3rd calendar quarter of 2020.
Recommendation & Status	**Progress Reporting**
Recommendation 9: Update Current HCCD Internal Procedures DHIN shall review and apply updates as needed to internal procedures involving HCCD operations. Areas of focus must include: a. Data staging, storage, and management. b. Reviewing and granting data access applications. c. Reviewing data access pricing. d. Reviewing and implementing marketing strategies and goals. Option: DHIN will report back to the JLOSC on progress of these efforts in January 2020. Status: 5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 9 with option.	**December Update:** DHIN embraces the ITIL frameworks of Best Practices in the provision of IT services. One ITIL process that exists throughout DHIN's operational culture is the Continual Service Improvement process. Consistent with that process, DHIN is always engaged in a process of self-reflection and examination, with a goal towards improving the quality of services it offers to end users. Specifically concerning the HCCD, DHIN consistently reviews (along with its vendors) the internal procedures with respect to the processes of obtaining, storing and providing access to data in the HCCD. DHIN's report to the Governor and General Assembly (Recommendation 4 above) discusses some of the immediate improvements DHIN is working on implementing, including improvements designed to streamline the way in which its most consistent users of the HCCD – State agencies – apply for and access data. DHIN management also has an internal goal of developing a three-year sustainability and business plan for the HCCD, and to present it to its Board for approval during this fiscal year. And finally, with respect to data access pricing in particular, DHIN's board approved a pricing paradigm earlier this fiscal year.

	As applications continue to come in – and as DHIN continues to speak to potential users and researchers who would like to access data in the HCCD – it intends to take any feedback on our pricing model and approach the Board with any recommended changes.
Recommendation & Status	**Progress Reporting**
Recommendation 10: Website Updates DHIN shall make the following updates to their website to advertise and promote the use of the HCCD to increase private funding opportunities associated with granting data access applications: a. Create a banner for the HCCD on the DHIN homepage. b. Include an icon on the DHIN homepage for the HCCD (current icons only include Patients, Healthcare Providers, and Data Senders).	**December Update:** Website updates are nearly complete. a. Banner has been added. b. Addition of banner makes this duplicative. c. HCCD added to dropdown menus for Providers and Data Senders, in addition to appearing as a banner on each individual page. d. "In the News" has been updated.

c. Add a specific webpage menu for the HCCD that would be included at the top of all DHIN webpages. d. Update the "in the news" section of the DHIN website and include recent news regarding the HCCD. The most recent news item was from August 2018. e. Create and include a HCCD brochure for the website. f. Redesign the HCCD webpage in order to adequately market the HCCD and attract data access applications. g. Make the HCCD data access application a fillable PDF document or fillable web form for easier submissions. h. Include a prominent link to the HCCD Committee's information including meeting agendas and minutes. Status: 5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 10.	e. Two HCCD videos have been created, posted to dhin.org and shared via social media. f. Redesign is underway. g. Data access application requires updates; fillable web form functionality will be added to the updated application. h. Link has been added. Additional website enhancements are planned per Recommendation 4, Future Plans.
<u>Recommendation & Status</u>	**<u>Progress Reporting</u>**
Recommendation 11: Release from Review or Hold Over <u>Option 1:</u> DHIN is released from review upon enactment of recommended legislation and any required reporting. - OR - <u>Option 2:</u> DHIN is held over and shall report to the Committee in January 2020. Status: 5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 11 with option 2.	**Progress Reporting not needed for this recommendation.**

The Delaware Health Care Claims Database:
2019 Annual Report

January 1, 2020

Jan Lee, MD
Chief Executive Officer, Delaware Health Information Network

CONTENTS

Appendices:

Executive Summary

Delaware Health Information Network (DHIN) is pleased to provide the Governor and General Assembly with a 2019 status report on the fully-operational Health Care Claims Database (HCCD).

At a Glance

Now at the end of its first year, the HCCD contains 495,000 unique records, **representing more than half of Delaware residents** (more to come as Medicare and Medicaid data are added), and includes **claims files from 2013 to 2018 from all required payers** (except one, who has since submitted and is in the testing phase).

Current Projects

DHIN has Memorandums of Understanding and Data Use Agreements with the following and is currently engaged in the studies listed:

- U.S. Centers for Disease Control and Prevention
    - Data extract – Perfluoronated compounds (PFCs) in drinking water
- Delaware Health Care Commission
    - Report – Delaware primary care total spend
    - Report – pending contract– cost transparency
    - Request in pipeline - Prevalence of certain diseases of interest
- Division of Public Health
    - Data extract - Lung cancer cost study
    - Request in Pipeline - data extract – HPV immunization prevalence
- Division of Medicaid and Medical Assistance (IAPD)
    - Data extract – supports various DMMA analytics
- Special Council for Persons with Disabilities
    - Brain trauma prevalence and geography
- Delaware Health and Social Services

Financial Sustainability

As documented in the March 2019 update to the Governor, the planning and implementation of the Delaware Health Care Claims Database was begun through federal grants. Nearly $2 million in federal support has been provided through DHIN's "Advance Interoperable Health Information Exchange" grant awarded by the Office of the National Coordinator and the State Innovation Model (SIM) Test grant awarded to the Delaware Health Care Commission by the Center for Medicare and Medicaid Innovation. The 149th Delaware General Assembly recognized the need for continued capitalization to allow the HCCD to mature and granted a one-time appropriation of $2 million to support the work.

At the time, the $2 million appropriation was expected to sustain the HCCD through June 2020. As previously outlined, DHIN has and continues to pursue funding strategies to address the longer-term need. We have researched the sustainability models of other state All Payer Claims Databases (APCDs) and developed a fee structure that will permit some cost recovery through that channel as non-State entities request access to data or reports derived from the data. **It is important to note that no APCD in any state is thus far sustainable through the sale of data products alone. All receive some combination of state, federal and grant funding.**

We have also worked closely with the Division of Medicaid and Medical Assistance (DMMA) on an Implementation Advance Planning Document (IAPD) that is expected to secure enhanced federal financial participation to enhance the HCCD in ways that will specifically benefit DMMA.

The Centers for Medicare and Medicaid Services (CMS) approved the IAPD in May 2019. In June, DMMA provided DHIN with its standard professional services agreement template, which DHIN modified to apply to the IAPD and provided back to DMMA on July 2. The draft contract remained with DMMA until October, when DMMA provided comments back to DHIN after approving the concept behind the contract in late September. Edits were made to the draft contract in October and November and on December 10, 2019 – after DMMA agreed to the final contract language – DHIN executed the contract and provided it back to DMMA.

As of the date of this document, DMMA has not counter-signed the agreement, having apparently sought additional assurances from CMS that the contract (which is based directly on the already-approved IAPD) is acceptable.

Currently, DHIN has spent more than 40% of the State's $2 million appropriation for FY20. (Because the enhanced federal financial participation, as outlined in the approved IAPD, is contingent upon a State match, this remaining amount will need to be carried over into FY21 to secure the federal funds.)

Enhanced federal financial participation can, under current regulations, be sustained in perpetuity, with new development matched at a 90/10 rate and maintenance and ongoing operations matched at a 75/25 rate.

Therefore, for future sustainability of the HCCD, DHIN requests a State financial commitment of 25% of the annual cost of operating and enhancing the HCCD. DHIN requests that this be included in the Governor's budget. In 2020 dollars, the total amount needed would be approximately $1.8 million, and thus an ongoing commitment of $450,000 in State funding is requested.

Strengths and Weaknesses

Among the HCCD's strengths, DHIN is proud of both the **breadth and quality of the data** contained in the HCCD. Currently, we hold data from Medicaid (FFS and MCO), Medicare FFS, Medicare supplemental, Qualified Health Plans, State Employee Benefits and commercial payers, spanning 1/13 – 10/19 and representing more than half of Delaware residents.

Our **collaboration with a diverse set of partners, vendors and agencies** is worth highlighting, specifically:

- Collaborative relationships with payer technical teams, providing prompt responsiveness to data issues and weekly working group meetings when necessary.
- Availability of consultant analytic resources, subject matter expertise and connections with the national body of knowledge for All Payer Claims Databases.
- Responsiveness and expertise of technology subcontractor keeping pace with biweekly (2x/week) action item progress.

DHIN's use of a **Cloud-based technology platform** maximizes the service's potential, enabling:

- Analytic access tools
- Quality and cost metrics for value-based health care assessments
- Secure access for interactive reporting tools

Our **privacy and security controls**, which follow recommendations for industry Best Practices.

As outlined above, DHIN is, however, concerned about the **financial sustainability** of the HCCD. The service is currently dependent on State appropriation and the pending IAPD for matching federal funds, and there is not yet a sustainable business model for the HCCD.

To date, DHIN has spent more than 40% of the State's $2 million appropriation for FY20. (Because the enhance federal funding through Medicaid is contingent on a State match, this remaining amount will need to be carried over into FY21.)

Data collection from self-funded payers is also an area of concern. Their participation is voluntary and comprises 35% of Delaware residents. While many analytic studies and reports and data extracts will not be significantly affected, some reports will have a population bias with under-representation of Delawareans employed by the state's largest employers.

DHIN's current analytic resources are a **contracted workforce**. This cannot be sustainable without steady, dedicated revenue. DHIN plans to hire its own staff to perform the analytics functions currently contracted (see Workforce below).

Status and Future Plans

Requests for access to HCCD data have included two applications, which were reviewed by the Data Access Committee. Of those, one, the CDC PFAS study data extract listed above, was approved, while a second, a commercial research project, was denied.

To date, we have received eight requests from State agencies:

- Division of Public Health: Lung cancer cost study (active)
- Special Council for Persons with Disabilities: Brain trauma presence and geography (active)
- Delaware Health Care Commission: Primary care spending (active)
- Delaware Health Care Commission: Cost transparency (pending)
- Division of Public Health: HPV rates (pending)
- Division of Medicaid and Medical Assistance: Data extract with IAPD work (pending)
- State Employee Benefits Committee: Two studies completed
    - Elective surgery cost study
    - RAND hospital transparency study

DHIN to plans to **grow its HCCD-dedicated workforce**. Currently the HCCD team includes a director and data quality analyst, with two subcontractors assigned to analytics/project management and hosting technology/data management.

In the first quarter of Calendar Year 2020, DHIN plans to add both a senior and junior analyst on a full-time basis and to maintain our current analytic subcontractors throughout the course of the work outlined in the Medicaid IAPD.

Additionally, DHIN plans to make enhancements to its application process, marketing efforts and the data itself, to include:

- Developing an application specific to State agencies
- Improving the public application for de-identified data
- Adding data statistics, current studies and readily accessible tools and instructions to the HCCD website
- Enhancing collected data with risk adjustments, a Master Provider Index, clinical and administrative groupers and a code and procedure library

Looking forward to the next Fiscal Year, 2021, DHIN plans to expand data access requests from extracts and reports to more self-service analytic tools, as well as to continue to collaborate with payers to improve both the quality and completeness of the data submitted.

Detailed Budget

A detailed budget for HCCD operations is attached.

Grant Applications

Grant applications and status for HCCD operational funding.
The pending IAPD referenced above goes through federal FY21 (i.e. until September 2021). It includes a 90% federal/10% State match for the design, development and implementation ("DDI") costs of new functionality. The first year of the contract is almost all DDI work (with the associated 90/10 federal match), and as the contract continues there will be a mix of DDI work and ongoing maintenance (which has a 75% federal/25% state match rate). Once the current contract expires, the IAPD can be renewed in perpetuity, but in order to do so the State will need to commit to provide 25% of the costs of such maintenance on an ongoing basis. In 2020 dollars, that match is expected to cost the State approximately $500K annually, assuming no further delays or difficulties in securing the federal match.

Status of contracts with vendors supporting HCCD operations.
Per a July 2018 agreement, Medicasoft provides hosting, data processing, security and database maintenance services for the HCCD. An additional agreement in July 2019 contracts with Medicasoft to also provide ongoing analytics support services for the HCCD. The contracts are in effect until either DHIN or Medicasoft chooses to end the contract. The combined cost of the two agreements is approximately $600K annually.

DHIN contracted with Freedman Consulting Group in January 2019 for Freedman to provide project management and analytics reporting consulting work at a cost of approximately $360K annually. The contract has an initial end date of 1/31/2020 with an option to extend up to an additional four years in increments to be determined by DHIN.

Number of data access requests submitted and granted.

- Two external (non-State agency) access requests submitted.
- One granted.

Freedman breakdown

	Monthly Total – By Task	Annual Total – By Task
Task 1: Project Management and Data Intake	**8,600**	**103,200**
Task 2: Quality Assurance and Data Validation	**10,100**	**121,200**
Task 3: Data Release Support	**1,750**	**21,000**
Task 4: Analytics and Medicaid Use Cases	**4,550**	**54,600**
	25,000	**300,000**

HCCD Operations and Maintenance

Monthly HCCD SaaS Charge		
Resources	**Monthly Price**	**Annual Price**
Couchbase Licenses	$935	$11,220
Hosting	$18,000	$216,000
Support	$12,000	$144,000
Total	$30,935	$371,220

Month of Task Review	Total # of Tasks	Total # of Hours
June	33	462
July	24	143
August	38	254
September	55	295
October	57	347
November	41	293
December 1-15, 2019 (partial month)	19	105
Total (Jun - Dec 2019)		

Analytic and Data Enhancement Support	% salary allocation
Executive Director	10%
Project Manager	95%
Data Quality Analyst	95%
Project Assistant	25%

Average monthly support
Average annual support

Some of these PM dollars are related to PM for Analytics
Data intake, operations, enhancements etc
Access Committee management and oversight
This line is variable and directly related to the Analytics for State requests.

Total Cost
$45,070
$14,405
$24,270
$28,445
$33,465
$28,235
$10,035
$183,925

$28,981.67
$347,780.04

Review of State Public Reporting Efforts

	Interactive Reports	Report Profiles	Report Snapshots	Full Report
Healthcare Cost and Utilization	Healthcare Utilization Report: Allows users to filter between various measures of utilization. Cost of Care Report: Allows users to view healthcare costs, stratified by inpatient, outpatient, pharmacy, and professional charges.	Potentially Preventable ER Visits: Profile of potentially preventable ER visits, including their cost, top 15 reasons for the visit, and the total burden on the healthcare system.	Epi Pen Cost Trends: average cost of an Epi Pen prescription in CO by year.	Spending and Use Among Maryland's Privately Fully Insured: Healthcare spending and utilization patterns for Maryland residents insured through the individual, small employer, and large employer markets.
	Inpatient Procedure Pricing Report: Inpatient costs for certain conditions by category (in production). Inpatient Admission Rate Report: Shows the number of inpatient visits per 1000 members, by payer.	Potentially Preventable Readmissions Related to Behavioral Health: Profile of potentially preventable BH-related ER visits.	Epi Pen Cost Trends: average cost of an Epi Pen prescription in AK by year.	Hospital Cost Comparison: A comparative analysis among ME's hospitals.
Population and Public Health	Disease Diagnosis Report: Number of people diagnosed with a disease or condition, by county, payer, age, and year. Breast Cancer Screening Rates: The number of women, within the appropriate age, who received preventive services. Cervical Cancer Screening Rates: The number of women, within the appropriate age, who received preventive services. Developmental Screening Rates: The number of children, within the appropriate age, who received a developmental screening.	Chronic Conditions in RI: Most common chronic conditions, including their cost and their impact on healthcare costs.	Fentanyl Prescription Trends in CO: Trends in Fentanyl prescriptions without a cancer diagnosis (intended use), including total spending. Impact of Firearm Injuries: Evaluating the incidence and total cost of firearm injuries, by intent, volume of injuries, and total paid amount.	*Not Applicable*
Healthcare Quality	CO Quality Measures Report: The number of people who received appreciate services for certain screenings. 30-Day Hospital Readmission Report: The rate of readmissions by payer. Adherence to Clinical Guidelines for Low Back Pain Imaging: Adults 18-50 with a primary diagnosis of low back pain who did not have an imaging study within 28 days of the diagnosis.	*Not Applicable*	*Not Applicable*	*Not Applicable*
Healthcare Coverage and Access	*Not Applicable*	*Not Applicable*	*Not Applicable*	Medicaid Baseline Statistics: Overview of the MassHealth population, with a focus on spending for members with Standard coverage in the Fee-For-Service (FFS).

Appendix II

PRICING SCHEDULE:

Monthly Ongoing Activities and Deliverables

A: Ongoing Monthly Activities

Task	Activity/Deliverable	Deadline	Acceptance Criteria	Monthly Price*	Total Annual Activity Price*
1) Project Management	1:1 Project Management	Ongoing	N/A - Status of ongoing monthly activities will be provided in the monthly progress reports that will accompany all monthly invoices	$ 7,677.08	$ 92,125.00
	1:2 Project Plan			$ 833.33	$ 10,000.00
	1:3 Project Team Meetings			$ 20,833.33	$ 250,000.00
	1:4 Data Submitter Management			$ 3,333.33	$ 40,000.00
	1:5 Subcontractor Oversight			$ 1,666.67	$ 20,000.00
2) Data Intake and Normalization	2:3 Monthly Data Collection and Aggregation			$ 26,308.33	$ 315,700.00
	2:5 Technical Support			$ 7,500.00	$ 90,000.00
	2:7 Data Configuration and Architecture			$ 5,266.67	$ 63,200.00
3) Application of Business Rules	3:2 Standard Business Rules			$ 12,916.67	$ 155,000.00
	3:3 New Business Rules			$ 7,916.67	$ 95,000.00
4) Integration with the Data Warehouse and DSS	4:1 Visioning and Design			$ 5,933.33	$ 71,200.00
5) Quality Assurance and System Testing	5:1 Data Quality Plan			$ 2,041.67	$ 24,500.00
	5:2 Level 1 DQ Checks			$ 13,958.33	$ 167,500.00
	5:3 Level 2 DQ Checks			$ 13,958.33	$ 167,500.00
FFY 2020 Total - Ongoing Monthly Activities				$ 130,143.75	$ 1,561,725.00

*** Not to Exceed**

B. Deliverables

Task	Activity/Deliverable	Deadline	Acceptance Criteria	Firm Fixed Price Upon Delivery
2) Data Intake and Normalization	2:1 Annual Registration	1/31/2020	Complete Annual Registration and Collect/Update DUA's. DHIN to provide Annual Registration Overview	$ 20,000.00
	2:2 Data Intake Portal (if necessary)	TBD	Stand up secure-web based portal for data submitters	$ 86,000.00
	2:4 Medicare Data Custodian	11/30/2019	Request additional Medicare data as it becomes available. DHIN to provide CMS cost invoice	$ 20,000.00
	2:6a Data Submission Guide	1/31/2020	DHIN to update Data Submission Guide, and provide copy to DMMA	$ 10,000.00
	2:6b: Data Dictionary	1/31/2020	DHIN to update Data Dictionary, and provide copy to DMMA	$10,000.00
3) Application of Business Rules	3:1 Master Person Index	12/31/2019	Acquire additional MPI's for new data. DHIN to provide Initiate invoice	$ 50,000.00
4) Integration with DW and DSS	4:2 Medicaid Data Extract	8/30/2020	Develop agreed upon data extract to transmit to the Medicaid data warehouse. DHIN to provide specifications document of final extract and frequency of transmission	$ 20,000.00
	4:3 Transmission of Extract	8/30/2020	DHIN to transmit the first data extract to Medicaid. DHIN to provide confirmation of transmittal	$ 5,700.00
5) Quality Assurance and System Testing	5:4 Level 3 DQ Checks	6/30/2020	DHIN to provide summary of Medicaid data within HCCD analytic environment, in collaboration with DMMA	$ 10,000.00
	5:5 DQ Report	7/30/2020	DHIN to produce data quality report showing the completeness of data included in transmission, and how it compares to data within DMES	$ 10,000.00
			FFY 2020 Total - Deliverables	**$ 241,700.00**

Appendix III

BUDGET

FFY2020 (10/1/2019 – 9/30/2020)

Expense	% FTE	Base Annual Salary	Benefits	Total Cost	%FFP	Federal Share	State Share
DHIN Project Staff							
Executive Director	10%	$ 260,000.00	30%	$ 33,800	90%	$ 30,420	$ 3,380
Project Manager	95%	$ 120,000.00	30%	$ 148,200	90%	$ 133,380	$ 14,820
Data Quality Analyst	95%	$ 90,000.00	30%	$ 111,150	90%	$ 100,035	$ 11,115
Project Assistant	25%	$ 65,000.00	30%	$ 21,125	90%	$ 19,013	$ 2,113
Systems Developer (NEW)	100%	$ 160,000.00	30%	$ 208,000	90%	$ 187,200	$ 20,800
Data Quality Anayst (NEW)	95%	$ 90,000.00	30%	$ 111,150	90%	$ 100,035	$ 11,115
DHIN Staff Subtotal				**$ 633,425**	**90%**	**$ 570,083**	**$ 63,343**
DHIN Subcontractors							
Project Management Vendor				$ 300,000	90%	$ 270,000	$ 30,000
Data Management Vendor				$ 800,000	90%	$ 720,000	$ 80,000
DHIN Subcontractors Subtotal				**$ 1,100,000**	**90%**	**$ 990,000**	**$ 110,000**
DHIN Additional Costs							
Additional MPI's				$ 50,000	90%	$ 45,000	$ 5,000
Data Acquisition Fees				$ 20,000	90%	$ 18,000	$ 2,000
DHIN Additional Costs Subtotal				**$ 70,000**	**90%**	**$ 63,000**	**$ 7,000**
Total DHIN NTE Cost FFY2020				**$ 1,803,425.00**	**90%**	**$ 1,623,082.50**	**$ 180,342.50**

Total DHIN invoices to DMMA in FFY2020 (monthly ongoing activities + deliverables) shall not exceed $1,803,424.00

Final Report

Joint Legislative Oversight and Sunset Committee
Task Force on the
Delaware Health Information Network

Established under the provisions of
Senate Resolution No. 9 of the 150th General Assembly

Respectfully submitted to the
Joint Legislative Oversight and Sunset Committee
January 2020

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Acknowledgements:

The Division of Research staff would like to sincerely thank all of those who were involved in the task force process which made this report possible.

Table of Contents

EXECUTIVE SUMMARY

- 11-member task force held a total of four meetings.
- Meeting discussion included JLOSC Recommendations 2, 4, and 6.
- DHIN provided PowerPoint presentations during meetings 2 and 3.
- Task force reviewed proposed legislative changes, including 7 draft bills.
    - Current items of support include:
        - Use of clinical data for research.
        - Sharing with DHIN important data, such as pharmacy, dental, and post-acute.
        - Gift of Life is excited to work with DHIN and wishes to have secure direct access to support their mission of coordinating organ and tissue donation and transplant efforts for Delaware.
            - DHIN information helped secure a life-saving liver transplant last year.
    - Current concerns received include:
        - Tabatha N. Offutt-Powell, Dr. P.H., M.P.H., DHSS, Division of Public Health.
            - Conflicts between access to HIV results, the current consenting process, and confidentiality.
            - Genetic tests and testing results have higher privacy and confidentiality standards and requirements.
            - Evaluation concerns regarding data requests for HIV and genetic test result data used for research purposes.
                - The requesting institution's Institutional Review Board (IRB) is not the data steward or owner.
        - Mike Records, Department of Corrections
            - The cost and use of data.
                - Interface upgrade costs.
                - Language regarding "summary of each visit" would charge DOC each time they viewed a patient, which would potentially increase their current costs.
                - DOC has policies in place that prohibit the use of offender data in research studies.
        - DHIN recognizes these concerns and agrees that proper measures need to be in place to ensure redisclosure rules are followed so that sensitive data is accessible only by those authorized.
        - The task force agreed that these areas of concern require further discussion prior to statutory changes.

INTRODUCTION

About JLOSC and the Review Process

The Joint Legislative Oversight and Sunset Committee ("JLOSC" or "Committee") is a bipartisan body comprised of five members of the Senate appointed by the President Pro Tempore and five members of the House of Representatives appointed by the Speaker of the House. JLOSC completes periodic reviews of agencies, commissions, and boards. The review's purpose is to first determine the public need for the entity and if need exists, to determine whether the entity is effectively performing to meet the need. JLOSC reviews aim to provide strength and support to entities that are providing a State recognized need. JLOSC performs its duties with support provided by the Division of Research's dedicated and nonpartisan staff in the form of two JLOSC analysts, a legislative attorney, a legislative fellow, and an administrative assistant.

During its 2019 review cycle, JLOSC reviewed the Delaware Health Information Network ("DHIN"). The review process included the completion of a draft report in April of 2019 which included information and performance questionnaire responses received from DHIN. The Committee held a public presentation meeting on April 15, 2019. DHIN presented information about their entity and the Committee received public comment. After the draft report and presentation meeting, the Committee reviewed, considered, and adopted eleven recommendations based on the information received throughout the review process. Four of the eleven recommendations related to proposed statutory changes to DHIN's governing statute. Three of these four recommendations required additional research and discussion to assist the Committee in making decisions on how to move forward with implementation. Recommendation number six included the bulk of the proposed statutory revisions and an option to create the JLOSC Task Force on DHIN ("task force") in order to further review them and report back to the JLOSC in January of 2020. This led to the creation, support, and passage of Senate Resolution 9 ("SR 9").[1] In June of 2019 the JLOSC analysts completed and released the JLOSC Final Report, which is accessible through the Committee's section of the Delaware General Assembly's website.

Creating this Task Force

JLOSC sponsored and created this task force through SR 9 for the sole purpose of reviewing and researching proposed statutory changes included in the JLOSC adopted recommendations. The acquisition of two new JLOSC analysts in March of 2019 condensed the 2019 review process. The idea behind this task force was to convene individuals with experience in the field to provide insight and assist in this discussion and review of DHIN's proposed statutory changes. JLOSC staff co-chaired the task force, performed its administrative duties, and produced the final report.

Structure of Meetings

The task force held a total of four meetings: an organization meeting, two meetings which discussed the recommendations, and a final report meeting.

The public comment period was open until December 4, 2019.

[1] See "SR 9" in Appendix F for the full resolution.

TASK FORCE MEMBERS

- **Holly Vaughn-Wagner, Esq.**, Division of Research Deputy Director and JLOSC legislative attorney, co-chair.
- **Amanda McAtee**, JLOSC analyst, co-chair.
- **Dr. Jan Lee**, Chief Executive Officer of DHIN.
- **Scott Perkins, Esq.**, General Counsel of DHIN.
- **Randy Farmer**, Chief Operating Officer of DHIN.
- **Meredith Stewart Tweedie, Esq.**, designee for the chair of DHIN Board of Directors.
- **Dr. Jonathan Kaufmann**, an individual who represents data senders, such as hospitals or labs, as designated by the DHIN Board of Directors.
- **Tanner Polce**, designee for the Lieutenant Governor.
- **Dr. Kathy Matt**, Dean of the University of Delaware's College of Health Sciences.
- **Elisabeth Scheneman**, designee for the Secretary of the Department of Health and Social Services.
- **Dr. Tabatha Offutt-Powell**, designee for the Director of the Division of Public Health.

TASK FORCE MEETINGS

- **First meeting**: Held on August 27, 2019.
- **Objective**: To review and research recommendations 2, 4, and 6.
- **Timeline**: To complete objective within 4 meetings.

- **Purpose:** JLOSC selected DHIN for 2019 review. DHIN's review resulted in recommendations that relate to statutory changes to DHIN's governing statute which required additional research and discussion.[2]
- **Meeting Documents:** Agendas, minutes, and other meeting documents posted online on the public meeting calendar under the JLOSC and on the General Assembly website.
- **Roles and Responsibilities of Task Force Members:** To bring expertise and knowledge to the discussion regarding proposed statutory changes within recommendations 2, 4, and 6.
- **Roles and Responsibilities of Consulting Members:** To work with JLOSC staff in providing resources and expertise in the recommendation topics.
- **Expected Work Product:** JLOSC staff will prepare a final report of task force findings, due January 2020.
- **Resources:** JLOSC staff posted, facilitated, and directed meetings. JLOSC analyst Amanda McAtee and legislative attorney Holly Vaughn Wagner served as task force co-chairs.

Quick Reference – Recommendations 2, 4, 6

Recommendation #2 Memorandums of Understanding ("MOUs") for Health Care Claims Database ("HCCD"): DHIN shall continue to work with the Department of Health and Social Services, Delaware Office of Management and Budget, Division of Public Health, Division of Medicaid and Medical Assistance ("DMMA"), and Delaware Health Care Commission to finalize MOUs permitting those collaborating state agencies to access data in the HCCD. **Option:** DHIN shall explore possible partnerships and develop MOUs with other agencies that will strengthen research and data for the HCCD. For example, DHIN could explore partnership with the Department of Correction ("DOC") and organ procurement organizations (such as the Gift of Life program) to identify ways in which DHIN data can be used to safely and quickly assist with organ donation suitability determinations.

Note: Recommendation 2 with option was adopted by JLOSC on May 13, 2019.

[2] Relevant sections of DHIN's governing statute found in Appendix D. A full listing of updated DHIN recommendations used in meeting #1 found in Appendix A.

DHIN Notes on Recommendation #2:

1. A potential partnership with the Gift of Life program would likely be for access to clinical data, not the HCCD. DHIN would need legislation explicitly permitting DHIN to provide data to the Gift of Life program regarding potential donors, which they would then use to supplement their work on suitability for donation. Recommendation number 6 includes an additional suggestion for proposed statutory updates.
2. While the DOC may be able to benefit from the use of claims data, DHIN believes a partnership with DOC with respect to the DOC providing DHIN with clinical data may be helpful to the DOC as well.

Recommendation 4 Annual HCCD Status Report: DHIN shall submit an annual status report, no later than January 1, to the Governor and General Assembly, regarding the HCCD. Reports shall include:

a. Analysis of strengths and weakness of HCCD.
b. Current status and future plans of HCCD.
c. Detailed budget for HCCD operations.
d. Grant applications and status for HCCD operational funding.
e. Status of contracts with vendors supporting HCCD operations.
f. Number of data access requests submitted and granted.

Option 1: The first report shall be submitted no later than January 1, 2020.
Option 2: The annual reports shall be included on the DHIN website.

Note: Recommendation 4 with options 1 and 2 was adopted by JLOSC on May 13, 2019.

Recommendation 6 Statutory Updates to Strengthen HCCD & Ensure DHIN's Continued Success: At DHIN's request, DHIN wishes to work with the Committee's legislative attorney to draft bills that will:

a. Maximize the number and types of claims that are submitted to the Delaware HCCD.
b. Permit more detailed reporting of claims related to sensitive diagnoses (by, for example, identifying DHIN as an appropriate holder of data associated with an HIV-related test (16 *Del. C.* § 717) or genetic testing (16 *Del. C.* § 1205)).
c. Maximize the number and types of entities that submit clinical information to the DHIN.
d. Permit use of clinical data for public health reporting and research.
e. Permit the use of de-identified clinical data for appropriate research purposes.
f. Ensure that pharmacy prescription fill data is provided to the DHIN.
g. Permit DHIN to provide data to the Gift of Life program on potential donors (this would be needed to establish a partnership between the two entities as referenced in recommendation number 2).

Option 2: Create a small JLOSC task force to discuss the proposed statutory amendments and report back to the JLOSC in January 2020. Task force membership will include DHIN's private counsel, the Committee's legislative attorney, and other members the Committee deems appropriate.

Note: Recommendation 6 with option 2 was adopted by JLOSC on May 13, 2019.

- Second meeting held on October 8, 2019.
- Brief discussion of recommendation #4 which JLOSC already adopted.
- DHIN presented a PowerPoint presentation and led discussion on the first three items of recommendation #6.[3] The following are the highlights from this discussion.

- DHIN operates as the state-sanctioned provider of health information exchange services.

- Discussion included information on how to maximize clinical data and data senders.
    - DHIN currently has data from the following:
        - Hospitals - 100%
        - Laboratories - 100%
        - Imaging Centers - ~95%
        - Neighboring State Health Information Exchange (HIE) – 5
            - MD, DC, WV, NJ, and 6 facilities in SEPA
        - Outpatient Practices (CCD) - ~12%
        - Urgent Care/Walk-In Facilities - 30%
        - Post-Acute Facilities (SNFs, home health) - 9%

    - DHIN currently does not have:
        - Pharmacy Data (except in claims)
        - Dental Data
        - Most Outpatient Practices
        - Most urgent care / walk-in Facilities
        - Most post-acute
        - Most telehealth encounters
        - Access to State managed data (social determinants of health)

    - Modify the “Mandatory Reporting Entity” definition to include the Department of Corrections and capture dental insurers.

    - Require pharmacy data to be submitted to DHIN.
        - Connection with pharmacies already exists with the Delaware Division of Professional Regulation for the Delaware Prescription Monitoring Program (PMP) which maintains, and monitors prescription data limited to controlled substances.
            - PMP statute would need an amendment for DHIN to work within their existing set-up.[4]

[3] Full PowerPoint presentation is in Appendix B.
[4] The JLOSC analyst attempted and was unable to obtain comments from the Division of Professional Regulation regarding this proposal.

- Senate Bill 171 is currently in the legislative process and would require urgent care facilities to enroll in DHIN as active users of the Community Health Record, provide primary care physicians with a notification of each visit (notifications could be sent through DHIN), and provide DHIN with a summary of care associated with each patient.
    - The model found in Senate Bill 171 could be applied to skilled nursing and long-term care facilities.

- DHIN proposed modifications to the telemedicine statute to remove the vague language and require telemedicine providers to send care summaries to DHIN.

- Amend the current statute in sections 717 and 1205 to allow DHIN to become the holder of HIV claims information and genetic testing data in accordance with the Health Care Claims Database.

- Meeting discussion included support for valuable data areas such as pharmacy, dental, and post-acute data.

- Concerns discussed involved privacy concerns involving HIV and genetic testing data.

- Third meeting held on November 20, 2019.
- DHIN presented a PowerPoint presentation and led discussion on the last four items of recommendation #6.[5] The following are the highlights from this discussion.
- Incorporated discussion of recommendation #2 into the meeting's discussion as it related to proposed draft bills.

- DHIN presented the following draft bills for discussion purposes:
  - Dental Claims Data:
    - Removes the statutory exemption for dental insurers from the Delaware Health Care Claims Database.
    - Dental care is an important indicator of overall health.
  - DOC Participation in DHIN:
    - Adds the DOC as a mandatory reporting entity within the Delaware Health Care Claims Database.
    - Addresses a gap in the coordination of care efforts involving incarcerated individuals.
  - Genetic Testing Data and Claims Information:
    - Adds permissions for DHIN to collect and disclose clinical genetic information and claims associated with genetic testing as permitted by DHIN's enabling statute.
  - HIV Testing Results and Claims Information:
    - Adds permissions for DHIN to hold clinical and claims data associated with HIV testing and to use the data as permitted by DHIN's enabling statute.
  - Long-term Care Facilities:
    - Requires long-term care facilities to enroll in DHIN and provide summaries of care in order to improve the quality and coordination of care within the State of Delaware.
  - PMP Data and DHIN:
    - Adds permissions to share prescription drug dispensing information with DHIN for inclusion in DHIN's clinical data repository so that participating providers and payers participating in the DHIN can access information regarding patients in their care, as permitted by DHIN's enabling statute.
  - Telemedicine and DHIN:
    - Adds requirement for telemedicine practitioners to enroll in DHIN and provide summaries of care to DHIN in order to improve the coordination of care.

[5] Full PowerPoint presentation is in Appendix C.

- Mike Records from Department of Corrections ("DOC") has concerns on the cost and use of data.
    - Concern with interface upgrade costs.
    - Concern with language regarding "summary of each visit" would charge DOC each time they viewed a patient, which would potentially increase their current costs.
    - DOC has policies in place that prohibit the use of offender data in research studies.

- The meeting's Power Point presentation included a positive discussion regarding the use of clinical data for research and amending DHIN's statutory enabling legislation to permit:[6]
    - De-identified data sets to be released for research purposes. Only released if the following apply:[7]
        - A Health Insurance Portability and Accountability Act ("HIPAA") compliant data agreement exists between the researcher and DHIN.
        - The researcher's agreement compliance is monitored by DHIN as if DHIN were a covered entity under HIPAA.
    - Individually identifiable health information for research only released if patient consent is received in writing compliant with HIPAA requirements.

[6] This information added after the meeting 4 final report review.
[7] Note: DHIN will need to modify data use agreements with its data senders.

Date: November 20, 2019

Objective: Approval of the Task Force Report

Vote to Approve Task Force Report:

- 8 Task Force members were physically present to vote.[8]

- After robust discussion, a motion was made to approve the report, contingent on the following:

    - The understanding that additional proofreading and technical or formatting changes would be made prior to submission to JLOSC.

    - The inclusion of information in the meeting 3 summary regarding proposed amendments to DHIN's statutory enabling legislation regarding the use of clinical data for research.
        - Meeting 3 discussion was supportive of the proposal, due to time restraints legislation was not drafted for task force discussion.

    - The inclusion of DHIN's response to concerns regarding genetic testing, HIV data, and DOC:

        - Any data received regarding genetic testing or HIV test results would not be available and accessible in the community health record and that is not the vision or intent with HIV or genetic information.

        - DHIN is seeking approval to have the claims data for HIV and genetics testing in the feeds the payers are required to send, wants the ability to provide aggregated reports that would not identify individuals but would be able to track what happens to people across time and institutions.

            - Currently, this cannot be tracked without the data. If DHIN was the lawful holder of the data, it would permit DHIN to do the analytics in order to provide data and

[8] One task force member participated in meeting conversation by phone, per FOIA did not count for quorum or meeting votes.

reports that do not identify individuals but provides useful information.

- Data would be subject to redisclosure restrictions.

- DHIN recognizes that necessary precautions would need to be in place and could insert language into the draft bill.

- DHIN is working on data security measures in this area of concern.

- DHIN anticipates additional conversations to take place with DOC, further conversations will be needed before moving forward with legislation involving DOC.

- Due to the points of concern raised by the Division of Public Health, the task force agreed that the discussion areas involving HIV and genetic testing data sets and DOC require further discussion.[9]

- The report was unanimously approved by a vote of 8.

Special Note:

- Because this page is a summary of what occurred at the Task Force's final meeting, it was not considered by the entire Task Force. The JLOSC staff who served as the Task Force co-chairs unilaterally drafted and included this page to serve as a summary of the final meeting.

    - Any additional information included in this report after Task Force consideration at its final meeting is indicated by footnote.

[9] Points of concern are included in the comments received from task force member Tabatha N. Offutt-Powell, Dr. P.H., M.P.H on page 26 of this report.

DRAFT LEGISLATION

SPONSOR:

DELAWARE STATE SENATE

174th GENERAL ASSEMBLY

SENATE BILL NO. ___

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO HEALTH AND SAFETY

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend § 10312, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 10312. Definitions.

For purposes of this chapter, unless amended, supplemented, or otherwise modified by regulations adopted under this chapter:

(3) "Health insurer" means as defined in § 4004 of Title 18 and providers of a dental plan or dental plan organization, as defined in § 3802 of Title 18. "Health insurer" does not include providers of casualty insurance, as defined in § 906 of Title 18; or providers of group long-term care insurance or long-term care insurance, as defined in § 7103 of Title 18~~; or providers of a dental plan or dental plan organization, as defined in § 3802 of Title 18~~.

SYNOPSIS

When the Delaware Health Care Claims Database was created in 2016, providers of dental insurance were exempted from the mandatory reporting requirements. Dental care, however, remains an important indicator of overall health and claims information related to dental care will help the Delaware Health Care Claims Database continue to provide value to the State and researchers to help advance the Triple Aim plus one. This Act removes the exemption for dental insurers from the statute.

Author:

SPONSOR:

DELAWARE STATE SENATE

174th GENERAL ASSEMBLY

SENATE BILL NO. ___

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO THE DEPARTMENT OF CORRECTION'S PARTICIPATION IN THE DELAWARE HEALTH INFORMATION NETWORK

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend § 10312, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 10312. Definitions.

For purposes of this chapter, unless amended, supplemented, or otherwise modified by regulations adopted under this chapter:

(4) "Mandatory reporting entity" means all of the following entities, to the extent permitted under federal law:

f. The Department of Correction, or any third-party entity contracted to provide health care services to individuals within the custody or care of the Department of Correction.

Section 2. Amend Chapter 89, Title 29 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 8916. Participation in the Delaware Health Information Network.

The Department of Correction, or any third-party providing medical care to individuals within its custody or care, must enroll in the Delaware Health Information Network as active users of the Community Health Record and enter into an agreement with DHIN to provide DHIN with a summary of each visit or episode of care in an electronic format established by DHIN.

SYNOPSIS

This Act aims to address a gap in care coordination efforts for individuals within the custody of the Department of Correction, by ensuring that appropriate health data regarding the care provided to those individuals and the cost of such care is provided to the Delaware Health Information Network for inclusion in that entity's clinical health data repository and the Delaware Health Care Claims Database, respectively. Such data will only be able to be accessed or used consistent with the DHIN's enabling legislation, Chapter 103 of Title 16.

Author:

SPONSOR:

DELAWARE STATE SENATE

174th GENERAL ASSEMBLY

SENATE BILL NO. ___

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO HEALTH AND SAFETY

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend § 1205, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 1205. Conditions for disclosure to others of genetic information.

(a) Regardless of the manner of receipt or the source of genetic information, including information received from an individual, a person shall not disclose or be compelled, by subpoena or other means, to disclose the identity of an individual upon whom a genetic test has been performed or to disclose genetic information about the individual in a manner that permits identification of the individual, unless:

(11) Disclosure is authorized in accordance with § 1201(4)c. of this title; ~~or~~

(12) ~~Disclosure is otherwise permitted by law~~. Disclosure is made by the Delaware Health Information Network, as permitted by Chapter 103 of this Title;

(13) Disclosure does not contain the results of any genetic test and is made by persons sending claims information to the Delaware Health Information Network pursuant to subchapter 2 of Chapter 103 of this Title; or

(14) Disclosure is otherwise permitted by law.

SYNOPSIS

This Act makes one clarification and one change. With respect to the former, the Act confirms that clinical genetic information that is provided to the Delaware Health Information Network as currently permitted by this section may be further disclosed by the DHIN as permitted by its enabling legislation. The Act also permits persons providing claims information to the Delaware Health Care Claims Database to provide claims associated with genetic testing to the DHIN, so long as those claims do not contain the results of the genetic tests at issue.

Author:

SPONSOR:

DELAWARE STATE SENATE

174th GENERAL ASSEMBLY

SENATE BILL NO. ___

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO HEALTH AND SAFETY

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend § 717, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 717. Confidentiality.

(a) No person may disclose or be compelled to disclose the identity of any person upon whom an HIV-related test is performed, or the results of such test in a manner which permits identification of the subject of the test, except to the following person:

(12) The Delaware Health Information Network, for inclusion in the clinical data repositories of that organization.

(b) No person to whom the results of an HIV-related test have been disclosed pursuant to subsection (a) of this section shall disclose the test results to another person except as authorized by subsection (a) of this section or, in the case of the Delaware Health Information Network, for uses permitted by Chapter 103 of this Title.

(c) The provisions in this section shall not interfere with the transmission of information as may be necessary to obtain third-party payment for medical care related to HIV infection or with the documentation of cause of death on death certificates. Nor shall the provisions in this section interfere with the transmission of information to the Delaware Health Information Network from persons sending claims information to the Delaware Health Care Claims Database as set forth in subchapter 2 of Chapter 103 of this Title.

SYNOPSIS

This Act adds the Delaware Health Information Network, the state-created instrumentality tasked with serving as the state's sanctioned provider of health information exchange services, as an entity that is permitted to hold clinical and claims data related to HIV testing. The Act requires the DHIN to use that data only as permitted by its enabling legislation.

Author:

SPONSOR:

DELAWARE STATE SENATE

174th GENERAL ASSEMBLY

SENATE BILL NO. ___

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO LONG TERM CARE FACILITIES AND THE DELAWARE HEALTH INFORMATION NETWORK

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Chapter 11, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 1119D. Coordination of Care.

(a) On or before January 1, 2021, each long term care facility must enroll in the DHIN as an active user of the Community Health Record.

(b) On or before January 1, 2021, each long term care facility that utilizes an electronic health record or electronic medical record must enter into an agreement with DHIN to provide DHIN with a summary of each episode of care in an electronic format established by DHIN.

SYNOPSIS

In an attempt to improve quality and coordination of care across the State, this Act requires long term care facilities to enroll in the Delaware Health Information Network and provide summaries of care to the DHIN.

Author:

SPONSOR:

DELAWARE STATE SENATE

174th GENERAL ASSEMBLY

SENATE BILL NO. ___

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO HEALTH AND SAFETY

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend § 4798, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 4798. The Delaware Prescription Monitoring Program.

(c) The Office of Controlled Substances shall establish and maintain a PMP program to monitor the prescribing and dispensing of all Schedule II, III, IV and V controlled substances by prescribers in this State, and to research the prescribing and dispensing of drugs of concern. The PMP must not interfere with the legal use of a controlled substance or drug of concern. The PMP may be used for the following purposes:

(5) Provide prescription drug data to the Delaware Health Information Network for inclusion in that entity's clinical data repositories and for uses permitted by Chapter 103 of this Title.

(l) The Office of Controlled Substances shall maintain procedures to ensure that the privacy and confidentiality of patients and patient information collected, recorded, transmitted, and maintained is not disclosed, except as provided for in this section.

(3) The Office of Controlled Substances may provide data in the prescription monitoring program to the DHIN as permitted by this Section.

SYNOPSIS

This Act permits the Office of Controlled Substances to provide data in the prescription drug monitoring program to the Delaware Health Information Network for inclusion in the DHIN's clinical data repository. The inclusion of that data within DHIN will provide medical providers and payers participating in DHIN with the ability to access prescription drug dispensing information regarding patients in their organization. Such data can only be accessed or used consistent with the DHIN's enabling legislation, Chapter 103 of Title 16.

Author:

SPONSOR:

DELAWARE STATE SENATE

174th GENERAL ASSEMBLY

SENATE BILL NO. ___

AN ACT TO AMEND TITLE 24 OF THE DELAWARE CODE RELATING TO TELEMEDICINE AND THE DELAWARE HEALTH INFORMATION NETWORK

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend § 1769D, Title 24 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 1769D. Telemedicine and telehealth.

(e) Telemedicine shall include, at such time as feasible and when appropriate, utilizing the Delaware Health Information Network (DHIN) in connection with the practice. In order to ensure compliance with this provision and to ensure the appropriate coordination of care:

(1) On or before January 1, 2021, any physician treating a patient through telemedicine must enroll in the DHIN as an active user of the Community Health Record.

(2) On or before January 1, 2021, any provider at which physicians treat patients through telemedicine must enter into an agreement with DHIN to provide DHIN with a summary of each telemedicine visit or episode of care in an electronic format established by DHIN.

SYNOPSIS

In an attempt to improve coordination of care and ensure compliance with existing statutory language, this Act requires physicians and practices providing telemedicine services to enroll in the Delaware Health Information Network and provide summaries of care to the DHIN.

Author:

COMMENTS RECEIVED

Comments received from:
Tabatha N. Offutt-Powell, Dr. P.H., M.P.H.
State Epidemiologist and Section Chief
Epidemiology, Health Data, and Informatics
Delaware Department of Health and Social Services
Division of Public Health

HIV-test results

The main concern is **access to** HIV results because a consenting process still exists for HIV testing and the test and associated results are held to stricter privacy rules than other test results. A secondary concern is **using HIV test result data for research purposes** and the process in place to evaluate data requests/research projects not relying solely on the requesting institution's IRB since the requesting IRB isn't the data steward or data owner.

1. If clients are still required to consent to HIV testing (no such consent process exists for other testing such as metabolic panel, cell count, liver enzymes, etc.), then the expectation is that there is a higher level of privacy for HIV results vs other test results.

2. The HIPAA Minimum necessary rule should be followed. People with access to DHIN do not necessarily have a need or right to have access to HIV results. Many EMR's have an additional safeguards for HIV results compared to other results. Also, many processes force the patient to call for results and do not allow a passive resulting process via phone or mail as counseling may be needed regardless of result. https://www.hhs.gov/hipaa/for-professionals/faq/207/how-are-covered-entities-to-determine-what-is-minimum-necessary/index.html

    - Because there are other non-healthcare providers or healthcare providers who access the DHIN who do not have a need to know the HIV results, given the consenting process associated with HIV testing, availability of the HIV results in the Community Health Record would violate HIPAA minimum necessary rule and the statute.

3. (Inadvertent or not) Redisclosure of the HIV tests results from the non-ordering provider to the patient and potential redisclosure of an HIV test result of a minor 12 years and older to a parent or guardian is a concern.

4. There are instances in which informed consent was not obtained (Title 16 Chap 7 §715(d)(1), (4), and (5)) in which redisclosure could be a concern or in cases where a court order was in place and an alias was used.

5. Because of the emotional nature of learning the test results, Title 16 Chap 7 §715(f) states that "at the time of learning the test result, the subject of the test or the subject's legal guardian shall be provided with counseling or coping with the emotional consequences of learning the result, for understanding the interpretation of the test result, for understanding the measures for preventing infection to others, to urge the voluntary notification of sexual and needle sharing partners or the risk of infection and the availability of any appropriate healthcare services including mental healthcare and social and supportive services."

    - Thus, access to and knowledge of these results requires a greater level of care and privacy than other results as described in the statute.

6. Title 16 Chap 7 §717 Confidentiality

    - (a) states that no person may disclose or be compelled to disclose the identity of any person upon an **HIV related test** (referring not only to the result but to the fact that a test was actually performed) or **the results of such test** in a manner which permits identification of the subject of the test. The exception that I want to bring attention to is under (3). The concern that is being raised is twofold (1) the healthcare facility or healthcare provider is authorized to obtain the results (2) more importantly "the agent has a medical need to know such information to provide healthcare to the patient." Again, not every healthcare provider or person who has access to the DHIN's clinical database/community health record has a need to know this information; furthermore, not everyone is a healthcare provider who has access to the DHIN's clinical database/community health record.

    - (b) no person whom the results of an HIV-related test have been disclosed pursuant to subsection (a) shall disclose the rest results to another person except as authorized.

        - Again, concerns regarding the risk associated with having the HIV test and testing results in DHIN given the confidentiality and consents that exist for HIV testing and the appropriate legal handling of the HIV test results.

Summary: As such, HIV results need to be treated differently - if patients no longer need a separate consent process for HIV testing and confidentiality of HIV testing and test results is changed, then there may be implications that HIV testing and test results are considered of equal privacy and confidentiality as for other results.

Genetic test and test results

The main concern is **access to** genetic tests and test results, which require a consenting process that differs from other medical testing and as such held to a higher privacy and confidentiality standard and requirements. A secondary concern is **using genetic test result data for research purposes** and the process in place to evaluate data requests/research projects not relying solely on the requesting institution's IRB since the requesting IRB isn't the data steward or data owner.

1. If clients are required to consent to genetic testing, the expectation is that there is a higher level of privacy for genetic testing and genetic test results compare with other medical testing; therefore, these test results should be held to a higher privacy standard than other information contained within medical records and claims databases. Title 16 Chap 12 §1202. How will informed consent be managed for all genetic tests that are conducted and information restricted by the patient?

2. Title 16 Chap 12 §1205: Conditions for disclosure to others of genetic information.

    a. States "regardless of the manner of receipt or the source of genetic information including information received from an individual, a person shall not disclose or be compelled to disclose the identity of an individual upon whom a **genetic test has been performed** (so just having the test result listed in the HCCD – would be concern even without the test result) or to disclose genetic information about the individual in a manner that permits identification of the individual.

        - The exception that is concern is the one that states (5) disclosure is authorized by obtaining informed consent of the tested individual describing the information to be disclosed and to whom
            - How will this be addressed if results are available in the DHIN for any genetic test result?
            - Having genetic tests even without the test result would not be allowed in the Healthcare Claims Database under this exception because there is no way for the payers to be able to know informed consent details for each test since claims are related to billing and informed consent details aren't captured in billing systems.

Summary: (1) Based on the existing law, genetic tests performed, or test results cannot be stored in the HCCD given the requirements for informed consent for disclosure of this information (see below). (2) There is a requirement for informed consent to disclose genetic test results through DHIN that is not necessarily captured for every genetic test performed. Newborn screening is an exception already listed in the statute.

Research use of HIV and genetic data

Data received from DPH and stored in the Community Health Record or HCCD

1. DPH is considered the stewards of these data.
2. Any DPH data cannot be used for marketing purposes.
3. Use of protected health information described under Title 16 §1211, legitimate public health purpose applies to identifiable AND **nonidentifiable** health information.
4. These data, if being requested in aggregate/summary, limited, or protected forms, must be reviewed by the DPH Privacy Board
5. The data request must be reviewed by the DHSS Human Subjects Review Board if any research is being conducted regardless of whether there is another IRB review on record.
6. Are subject to the HIPAA and other related privacy and confidentiality state laws.

From: Christopher Graham
To: "Scott Perkins"
Cc: McAtee, Amanda A (LegHall); Shannon Kaminski; Jacqueline Giuffrida; Stephen
Subject: Tornone RE: Gift of Life access to DHIN
Date: Monday, November 18, 2019 6:06:07 PM

Hi Scott,

Very happy to receive your update this morning! Thank you for your continued work on our behalf. Please let me know if I can be of any assistance to you moving forward.

Amanda,

I'm sure that Scott has shared our story. We are excited and hopeful that we can secure direct access to DHIN, so that we may better support our mission of coordinating Delaware's organ & tissue donations and transplants. When a patient is transferred to Christiana from one of Delaware's smaller hospitals, for instance, comprehensive medical records rarely come with them. DHIN has the potential to be a powerful tool to provide the most accurate information to our transplant surgeons. Working through physicians at Christiana last year, DHIN information literally was the difference between a case being canceled and a patient receiving a life-saving liver transplant!

I look forward to working with you in any way you may need.

Sincerely,
Christopher J. Graham

One organ and tissue donor can save or improve the lives of more than 75 other people. Learn more about how Mary's son Eric saved Arlinda's life at www.donors1.org/hero

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From: Scott Perkins
Sent: Monday, November 18, 2019 9:06 AM
To: Christopher Graham
Cc: McAtee, Amanda A (LegHall)
Subject: Gift of Life access to DHIN

Chris,

I'm writing to give you a "heads up" and provide an introduction. I have copied Amanda McAtee, who works for the Delaware General Assembly. DHIN is currently involved in a legislative process to update and modernize our statute, and one of the things that we raised was our desire to provide Gift of Life clinical staff with access to the Community Health Record in situations where that would be helpful to you to identify suitability for organ and tissue donation.

This Wednesday, November 20, DHIN will be proposing to a task force that it recommend changing DHIN's statute to allow that access to go forward. Amanda asked me to provide an introduction so that she could answer any questions you may have. I also am available to discuss.

Thanks,
Scott

Scott W. Perkins
General Counsel
DelaWare HealtH InformatIon n etWork

APPENDIX A
UPDATED DHIN RECOMMENDATIONS

Delaware Health Information Network: Recommendations

Recommendation	Status
Recommendation 1: Continue or Terminate Under §10213(a), Title 29, the Committee must determine whether there is a genuine public need for an agency under review. To meet this requirement, the Committee may select one of the following options. Option 1: DHIN shall continue, subject to any further recommendations that JLOSC adopts. - OR - Option 2: DHIN is terminated and the Committee will sponsor legislation to implement this recommendation.	5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 1 with option 1. No updates required from DHIN for this recommendation.
Recommendation	**Status**
Recommendation 2: MOUs for HCCD DHIN shall continue to work with the Department of Health and Social Services, Delaware Office of Management and Budget, Division of Public Health, Division of Medicaid and Medical Assistance (DMMA), and Delaware Health Care Commission to finalize MOUs permitting those collaborating state agencies to access data in the HCCD. Option: DHIN shall explore possible partnerships and develop MOUs with other agencies that will strengthen research and data for the HCCD. For example, DHIN could explore partnership with the Department of Correction (DOC) and organ procurement organizations (such as the Gift of Life program) to identify ways in which DHIN data can be used to safely and quickly assist with organ donation suitability determinations.	5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 2 with option. 10/31: October update from DHIN is due. 12/30: December update from DHIN is due. DHIN Notes: 1. A potential partnership with the Gift of Life program would likely be for access to clinical data, not the HCCD. DHIN would need legislation explicitly permitting DHIN to provide data to the Gift of Life program regarding potential donors, which they would then use to supplement their work on suitability for donation. Recommendation number 6 includes an additional suggestion for proposed statutory updates. 2. While the DOC may be able to benefit from the use of claims data, DHIN believes a partnership with DOC with respect to the DOC providing DHIN with clinical data may be helpful to the DOC as well.

Recommendation	Status
Recommendation 3: Continued Federal Funding Initiatives DHIN shall continue their work with DMMA to leverage their previously-appropriated state funding for the HCCD by seeking a federal match through the Implementation Advance Planning Document (IAPD) process. Option: Should the IAPD process be unsuccessful for any reason, DHIN shall work with JLOSC to ensure that the $2 million already appropriated funds remain available to DHIN for its work setting up and maintaining the HCCD.	5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 3 with option. 10/31: October update from DHIN is due. 12/30: December update from DHIN is due.
Recommendation	**Status**
Recommendation 4: Annual HCCD Status Report DHIN shall submit an annual status report, no later than January 1, to the Governor and General Assembly, regarding the HCCD. Reports shall include: a. Analysis of strengths and weakness of HCCD. b. Current status and future plans of HCCD. c. Detailed Budget for HCCD operations. d. Grant applications and status for HCCD operational funding. e. Status of contracts with vendors supporting HCCD operations. f. Number of data access requests submitted and granted. Option 1: The first report shall be submitted no later than January 1, 2020. Option 2: The annual reports shall be included on the DHIN website.	5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 4 with options 1 and 2. 10/31: October update from DHIN is due. 12/30: December update from DHIN is due.
Recommendation	**Status**
Recommendation 5: Statutory Update & Technical Corrections JLOSC will sponsor a bill to make technical corrections to DHIN's entire governing statute, Chapter 103, Title 16.*	5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 5. No updates required from DHIN for this recommendation.

* The Committee's legislative attorney will draft any legislation resulting from approved recommendations, unless otherwise noted.

Recommendation	Status
Recommendation 6: Statutory Updates to Strengthen HCCD & Ensure DHIN's Continued Success At DHIN's request, DHIN wishes to work with the Committee's legislative attorney to draft bills that will: a. Maximize the number and types of claims that are submitted to the Delaware HCCD. b. Permit more detailed reporting of claims related to sensitive diagnoses (by, for example, identifying DHIN as an appropriate holder of data associated with an HIV-related test (16 *Del. C.* § 717) or genetic testing (16 *Del. C.* § 1205)). c. Maximize the number and types of entities that submit clinical information to the DHIN. d. Permit use of clinical data for public health reporting and research. e. Permit the use of de-identified clinical data for appropriate research purposes. f. Ensure that pharmacy prescription fill data is provided to the DHIN. g. Permit DHIN to provide data to the Gift of Life program on potential donors (this would be needed to establish a partnership between the two entities as referenced in recommendation number 2). Option 1: Create a small JLOSC subcommittee to will discuss the proposed statutory amendments and report back to the JLOSC in January 2020. Subcommittee membership will include DHIN's private counsel, the Committee's legislative attorney, and other members the Committee deems appropriate. Option 2: Same as Option 1, but create a task force instead of a JLOSC subcommittee. - OR - Option 3: The Committee's legislative attorney will work with DHIN's private counsel to draft proposed bills and report back to the JLOSC in January 2020.	5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 6 with option 2. 8/27: First task force meeting scheduled.

Recommendation	Status
Recommendation 7: Reduce Overlap and Duplicated Efforts At DHIN's request, DHIN shall identify areas of overlap between its capabilities and those separately contracted for or provided by State agencies, and work with those agencies to eliminate overlap or redundancies. As a part of these efforts, DHIN shall explore whether it can reasonably be the "single point of contact" for delivery of health data on Delaware residents to assist state and federal public health efforts. By statute, DHIN is the "State's sanctioned provider of health information exchange (HIE) services" (16 *Del. C.* § 10301). Option: DHIN will report back to the JLOSC on progress of this research in January 2020.	5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 7 with option. 10/31: October update from DHIN is due. 12/30: December update from DHIN is due.
Recommendation	**Status**
Recommendation 8: Update Current Regulations DHIN shall update its regulations to reflect current operational procedures. Option: DHIN will report back to the JLOSC on progress of these efforts in January 2020.	5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 8 with option. 10/31: October update from DHIN is due. 12/30: December update from DHIN is due.
Recommendation	**Status**
Recommendation 9: Update Current HCCD Internal Procedures DHIN shall review and apply updates as needed to internal procedures involving HCCD operations. Areas of focus must include: a. Data staging, storage, and management. b. Reviewing and granting data access applications. c. Reviewing data access pricing. d. Reviewing and implementing marketing strategies and goals. Option: DHIN will report back to the JLOSC on progress of these efforts in January 2020.	5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 9 with option. 10/31: October update from DHIN is due. 12/30: December update from DHIN is due.

Recommendation	Status
Recommendation 10: Website Updates DHIN shall make the following updates to their website to advertise and promote the use of the HCCD to increase private funding opportunities associated with granting data access applications: a. Create a banner for the HCCD on the DHIN homepage. b. Include an icon on the DHIN homepage for the HCCD (current icons only include Patients, Healthcare Providers, and Data Senders). c. Add a specific webpage menu for the HCCD that would be included at the top of all DHIN webpages. d. Update the "in the news" section of the DHIN website and include recent news regarding the HCCD. The most recent news item was from August 2018. e. Create and include a HCCD brochure for the website. f. Redesign the HCCD webpage in order to adequately market the HCCD and attract data access applications. g. Make the HCCD data access application a fillable PDF document or fillable web form for easier submissions. h. Include a prominent link to the HCCD Committee's information including meeting agendas and minutes.	5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 10. 10/31: October update from DHIN is due. 12/30: December update from DHIN is due. As of 5/13/19 - DHIN's webpage menu included: • Home • Patients • Healthcare Providers • Data Senders • About DHIN • Contact Us • Search Icon
Recommendation	**Status**
Recommendation 11: Release from Review or Hold Over Option 1: DHIN is released from review upon enactment of recommended legislation and any required reporting. - OR - Option 2: DHIN is held over and shall report to the Committee in January 2020.	5/13: First consideration of this recommendation 5/13: JLOSC adopted recommendation 11 with option 2. No updates required from DHIN for this recommendation.

APPENDIX B

DHIN PRESENTATION MEETING 2 OCTOBER 8, 2019

Senate Resolution 9 Task Force Meeting #2

JLOSC Recommendations 6(a)-6(c)

Dr. Jan Lee
Chief Executive Officer
Delaware Health Information Network
October 8, 2019

JLOSC Recommendation #6

DHIN instructed to work with the committee and report back with proposed legislation that will:

A. *Maximize the number and types of claims that are submitted to the Delaware Health Care Claims Database.*
B. *Permit more detailed reporting of claims related to sensitive diagnoses.*
C. *Maximize the number and types of entities that submit clinical information to the DHIN.*

How can we maximize data provided to HCCD?

Current scope (from 16 *Del. C.* § 10312(4)):

(4) "Mandatory reporting entity" means all of the following entities, to the extent permitted under federal law:

a) The State Employee Benefits Committee and the Office of Management and Budget, under each entity's respective statutory authority to administer the State Group Health Insurance Program in Chapter 96 of Title 29, and any health insurer, third-party administrator, or other entity that receives or collects charges, contributions, or premiums for, or adjusts or settles health claims for, any State employee, or their spouses or dependents, participating in the State Group Health Insurance Program, except for any carrier, as defined in § 5290 of Title 29, selected by the State Group Health Insurance Plan to offer supplemental insurance program coverage under Chapter 52C of Title 29.

b) The Division of Medicaid and Medical Assistance, with respect to services provided under programs administered under Titles XIX and XXI of the Social Security Act [42 U.S.C. §§ 1396 et seq. and 1397aa et seq.].

c) Any health insurer or other entity that is certified as a qualified health plan on the Delaware Health Insurance Marketplace for plan year 2017 or any subsequent plan year, except for any health insurer or other entity that is not otherwise required to provide claims data as a condition of certification as a qualified health plan on the Delaware Health Insurance Marketplace for plan year 2017 or any subsequent plan year.

d) Any federal health insurance plan providing health-care services to a resident of this State, including Medicare and the Federal Employees Health Benefits Plan.

e) Any health insurer providing health-care coverage to a resident of this State.

How can we maximize data provided to HCCD?

Practical effect: What does HCCD not contain?

- Veterans Affairs, Indian Health Service, TriCare, Department of Correction
- Workers Compensation
- Federal Employees Health Benefit Plan
- Uninsured or Private Pay
- Small Private Insurers*
- Self-funded plans that are not publicly-funded (e.g. ERISA plans)
- Dental claims

* DE Regulations require participation of health plans with 1,000 DE covered lives or more

How can we maximize data provided to HCCD?

Proposed areas of improvement:

- Modify definition of “Mandatory Reporting Entity” to include the Department of Correction (or any contracted private party providing health care to individuals within the care of DOC).
- Modify definition of “Mandatory Reporting Entity” to capture dental insurers.
- Group discussion: Are there ways that the State could encourage ERISA plans to provide data to the HCCD voluntarily? How about VA, DoD, federal employees, and Bureau of Indian Affairs plans?
  - Ex: Maryland – requires *providers of care* (at least hospitals) to submit claims data, rather than just the payers.

How can we permit more detailed reporting of claims?

- DHIN is currently operating as the state-sanctioned provider of health information exchange services.
- In that role, DHIN holds, maintains, and provides appropriate access to a myriad of protected health information, consistent with state and federal laws and regulations.
- The more complete the information provided to DHIN, the better that DHIN will be able to ensure that the HCCD is as successful as intended by the General Assembly.
  - In particular, lack of identifiable HIV data is a problem – limits ability to track an individual across time and determine costs and quality of care as they potentially move between payers and providers.

How can we permit more detailed reporting of claims?

Reduce Delaware-specific limitations

- Title 16, Section 717: Confidentiality of HIV-related tests
  - Limits the potential recipients of information regarding the identity of any person upon whom an HIV-related test has been performed, and the results of any such test.
    - The legislation contains a number of exceptions, including for health-care providers "providing medical care to the subject of the test, when knowledge of the test results is necessary to provide appropriate emergency care or treatment" and the transmission of information necessary to obtain third-party payment for medical care (i.e., a claim).
    - The legislation does not permit identifiable data related to that claim to be provided to DHIN, nor does it permit DHIN to make the clinical results of such a test available to health care providers who have a need to access the information for the purposes of the patient's emergency or treatment.

How can we permit more detailed reporting of claims?

Reduce Delaware-specific limitations

- Title 16, Section 1205: Disclosure of Genetic Information
  - Limits the ability of any individual who has access to the information from disclosing "the identity of an individual upon whom a genetic test has been performed or to disclose genetic information about the individual in a manner that permits identification of the individual."
  - Contains a number of exceptions, including for disclosures that are "otherwise permitted by law" and for situations where a notice explicitly indicates that the information will be available to individuals who will have access to DHIN.
    - With an appropriate notice to patients and authorization, this means that providers can provide clinical information to the DHIN that will be available to other care providers in DHIN's community health record. There is no similar exemption for claims data associated with genetic testing.

How can we permit more detailed reporting of claims?

Proposed Areas of Improvement:

- Amend Section 717
  - Permit DHIN to be a steward of HIV-related claims information (which will not include the results of tests) for purposes consistent with the HCCD legislation
  - Permit DHIN to be a steward of HIV-related clinical information
- Amend Section 1205
  - Explicitly include DHIN as an entity to whom claims data associated with genetic testing can be provided, to be used in accordance with the HCCD legislation and associated regulations.
- Issue for discussion: should there be a statutory requirement that anyone who wants to access *identifiable* claims data with respect to HIV or genetic information obtain actual patient consent?

How do we maximize clinical data and data senders?

What We Have

Hospitals – 100%

Laboratories – ~100%

Imaging Centers -- ~ 95%

Neighboring State HIE – 5
(MD, DC, WV, NJ, and 6 facilities in SEPA)

Outpatient Practices (CCD) -~12%

Urgent Care/Walk-In Facilities – 30%

Post-Acute Facilities (SNFs, home health)– 9%

What We Don't Have

Pharmacy Data (except in claims)

Dental Data

Most Outpatient Practices

Most urgent care / walk-in Facilities

Most post-acute

Most telehealth encounters

Access to State-managed data (social determinants of health)

How to maximize clinical data and data senders?

Proposed Areas for Improvement:

- Require pharmacy data to be submitted to DHIN.
  - Discussion: limit to prescription drug monitoring program data, or should DHIN receive all pharmaceutical fill information? If the former, just amend PDMP statute; if the latter, likely need to amend Title 24 to require connection and provision of information to DHIN as a part of licensure, or could require pharmacies to submit all fill information to PDMP, and allow DHIN to pull that data into its own network to aggregate with clinical data.
- Increase number of specialty and urgent care practices required to coordinate care with primary care doctors.
  - Make participating in DHIN a way in which the specialty or urgent care practice can comply with its care coordination efforts.
  - Example: SB 171 (currently pending), requires urgent care facilities (as a care coordination effort) to (i) enroll in the DHIN as active users of the Community Health Record; (ii) provide DHIN with summaries of care associated with each of their patients; and (iii) provide primary care physicians with notifications of each visit – which notifications can be made through DHIN.
  - Apply SB 171 model to Skilled Nursing and Long Term Care facilities.

How to maximize clinical data and data senders?

Proposed Areas for Improvement:

- Require DOC (or its third party contractor) to access and provide care summaries to DHIN's clinical record database.
  - Requires an amendment to DOC enabling legislation.
- Amend telemedicine statute
  - Currently requires telemedicine practitioners, "at such time as feasible and when appropriate" to utilize DHIN.
  - Take out the vagueness – require telemedicine providers to send care summaries to DHIN, which will add value to care coordination efforts.

How to maximize clinical data and data senders?

Proposed Areas for Improvement:

- Support DHSS grant-funding initiative for primary care connectivity
  - DHIN fees to access the CHR are very low -- $400 per year (if practice is not a data sender) or $200 per year (for practices that are also sending DHIN data).
  - DHIN leveraged grant funding to establish connections with 9 major EMRs used in Delaware. By utilizing that funding, DHIN is able to allow practices to provide information to DHIN *without an integration fee*. For entities that are not using one of those 9 EMRs, DHIN may charge an integration fee commensurate with its costs. EMRs, on the other hand, typically charge fees to practices to connect to DHIN.
- Discussion: How best to authorize stage agencies holding data pertaining to social determinants of health to work with DHIN and allow providers using DHIN's services to access that data.
  - E.g., My Healthy Community tool created by DHSS (https://myhealthycommunity.dhss.delaware.gov/)

Thank you

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APPENDIX C
DHIN PRESENTATION
MEETING 3
NOVEMBER 20, 2019

Senate Resolution 9 Task Force Meeting #3

JLOSC Recommendations 6(d)-6(g)

Dr. Jan Lee
Chief Executive Officer
Delaware Health Information Network
November 20, 2019

JLOSC Recommendations 6(d)-(g)

DHIN instructed to work with the committee and report back with proposed legislation that will:

D. Permit use of clinical data for public health reporting and research.

E. Permit the use of de-identified clinical data for appropriate research purposes.

F. Ensure that pharmacy prescription fill data is provided to the DHIN.

G. Permit DHIN to provide data to the Gift of Life program on potential donors.

How can DHIN permit use of clinical data for research?

DHIN's ability to use clinical data in its possession is governed by at least three sources:

- HIPAA and associated regulations.
  - Identifiable data may be released without patient consent for purposes of "treatment, payment and operations."
  - Permits use of patient data for research in identified circumstances.
- DHIN's enabling legislation (16 *Del. C.* §10307(a)).
  - "The DHIN shall by rule or regulation ensure that patient specific health information be disclosed only in accordance with the patient's consent or best interest to those having a need to know."
- Data Use Agreements with data senders.
  - Earlier agreements are more restrictive than those executed in recent years

How can DHIN permit use of clinical data for research?

Practical effect: What is happening now?

- Limited instances of clinical data used for research:
  - De-identified data is used to identify practices with a concentration of possible clinical trial candidates; the practice recruits patients
  - De-identified data may be used for research *if* permitted by the data sender.
    - Agreements with outpatient data providers and one hospital explicitly permit the research use case
    - Agreements with other hospitals and most labs allow use of their data for Treatment, Payment, Operations, as required by law or regulation, and by patient consent or patient request.
    - Agreement with Quest restricts permitted data uses to treatment, and explicitly disallows use of even de-identified data for secondary purposes
    - Currently working on project with the CDC to supplement HCCD data it has been permitted to obtain with matching clinical data – requires amended agreements with three hospitals and two reference laboratories.

How can DHIN permit use of clinical data for research?

Proposed areas of improvement:

- Amend DHIN's enabling legislation to explicitly permit:
  - Release of de-identified data sets for research purposes
  - Release of limited data sets for research purposes ONLY IF:
    - DHIN enters into a HIPAA-compliant data use agreement with a researcher; and
    - DHIN monitors the researchers compliance with the agreement as if DHIN were a covered entity under HIPAA.
  - Release of individually identifiable health information for research ONLY IF the patient consents, in a writing compliant with HIPAA
- NOTE: DHIN will still have to seek amendments to its data use agreements with data senders.

How can DHIN obtain prescription fill data?

- Discussed generally at task force meeting #2.
- Currently have a proposal to transfer data from the Prescription Drug Monitoring Program to DHIN.
- *Discussion question*: Should pharmacies be required to provide *all* fill data to PDMP, rather than just controlled substances and drugs of interest?

How can DHIN provide Gift of Life with access to appropriate clinical data?

Gift of Life Donor Program

- Hospitals are currently required to provide Gift of Life with appropriate clinical information when organ or tissue donation becomes a possibility.
- Portions of the Delaware code explicitly require hospitals to notify and provide this information.
- Gift of Life has contacted DHIN.
  - In certain circumstances, DHIN has information that would be helpful to Gift of Life in determining whether certain organs or tissues are suitable for donation.

How can DHIN provide Gift of Life with access to appropriate clinical data?

Proposed area of improvement:

- Require DHIN to provide Gift of Life clinicians with access to the Community Health Record.
- Access would be limited to the same circumstances that trigger a hospital's duty to provide information to Gift of Life.
- Access would be audited and reviewed pursuant to existing DHIN policies and procedures.

Thank you

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APPENDIX D
RELEVANT DHIN STATUTES

TITLE 16

Health and Safety

Regulatory Provisions Concerning Public Health

CHAPTER 7. Sexually Transmitted Diseases

Subchapter II. HIV Testing and Counseling

§ 714 Definitions.

For purposes of this subchapter the following definitions shall apply:

(1) “AIDS” shall mean Acquired Immunodeficiency Syndrome, a stage of HIV illness.

(2) “Approved laboratory” shall mean a laboratory approved by the Department for the purpose of performing standard tests for HIV as recognized as such by the Department.

(3) “Clinical setting” shall mean prenatal clinics, hospital emergency departments, urgent care clinics, inpatient services, substance abuse treatment clinics, public health clinics, nursing homes, community clinics, correctional health-care facilities, blood banks, blood centers, sperm banks, primary care settings, and other public or private settings as defined by the Division.

(4) “Health-care provider” shall mean any nurse, physician, dentist or other dental worker, optometrist, podiatrist, chiropractor, laboratory or blood bank technologist or technician, phlebotomist, dialysis personnel, emergency health-care provider (including any paramedic, emergency medical technician, law-enforcement personnel or firefighter), others whose activities involve contact with patients, their blood or corpses, and other public or private providers as defined by the Division.

(5) “Health facility” shall mean a hospital, nursing home, clinic, blood bank, blood center, sperm bank, laboratory, or other health-care institution.

(6) “HIV” shall mean the Human Immunodeficiency Virus, a virus that can be transmitted sexually and that is identified as the causative agent of AIDS.

(7) “HIV-related tests” shall mean HIV tests, CD4 cell count tests, viral load tests, or any other tests related to HIV.

(8) “HIV test” shall mean a test to detect HIV infection.

(9) “Informed consent” means consent of the subject of the test or subject’s legal guardian to the performance of HIV testing by a health-care provider who has informed the subject or the subject’s legal guardian both verbally and in writing, to an extent reasonably comprehensive to general lay understanding, of the nature of the proposed testing and of the risks and alternatives to testing which a reasonable person would consider material to the decision whether or not to undergo testing.

(10) “Invasive medical procedure” shall mean any procedure involving surgical entry into tissues, cavities, or organs.

(11) “Legal guardian” shall mean a person appointed by a court to assume legal authority for another who has been found incompetent or, in the case of a minor, a person who has legal custody of the minor.

(12) “Manner known to transmit HIV” shall mean parenteral exposure to blood or blood products including but not limited to injection through the skin, sexual exposure, or exposure as otherwise determined by the Division.

(13) “Nonclinical setting” shall mean community-based organizations (CBO), outreach and education settings, mobile vans, and other settings as defined by the Division.

(14) “Person” shall mean any natural person, partnership, association, joint venture, trust, public, or private corporation, or health facility.

(15) “Prevention counseling” shall mean an interactive process of assessing risk, recognizing specific behaviors that increase the risk for acquiring or transmitting HIV, and developing a plan to take specific steps to reduce risks.

(16) “Release of test results” shall mean a written authorization for disclosure of test results, which is signed, dated and specifies to whom disclosure is authorized and the time period during which the release is to be effective.

(17) “Routine/opt-out testing” shall mean that the general consent for medical care shall encompass testing for HIV and that testing may be performed as a part of routine care unless it is declined and that declination is noted in the medical record. A separate consent for HIV testing is not required.

(18) “Test counseling” shall include information that includes an explanation of the testing process/procedure, the meaning of possible test results, and provision of resources for additional information about relevant infections. The information may be provided orally or in writing and the subject of the counseling given the opportunity to ask questions.

66 Del. Laws, c. 336, § 1; 71 Del. Laws, c. 458, § 1; 78 Del. Laws, c. 277, § 2.;

§ 715 Consent for HIV testing.

(a) A health-care provider or other person who performs HIV testing services in a clinical setting may provide routine/opt-out testing provided that the following occurs:

(1) The subject is informed, orally or in writing, that routine/opt-out HIV testing is

encompassed by the general consent for medical services.

(2) The subject is given the opportunity to refuse consent to HIV testing at each instance of testing. Documentation of such refusal shall be noted in the subject's medical record.

(3) The subject is provided HIV test counseling, orally or in writing, at the first instance of testing and by request thereafter.

(b) The health-care provider or other person who performs HIV testing services in a nonclinical setting must obtain written documentation of informed consent at each instance of HIV screening.

(1) Informed consent to an HIV test in a nonclinical setting shall consist of a voluntary agreement executed by the subject of the test or the subject's legal guardian.

(2) At each instance of testing, the subject of the test must be offered HIV test counseling and prevention counseling prior to consent for HIV testing.

(c) Notwithstanding any other provision of law, a minor 12 years of age or older may consent or refuse consent to be a subject of HIV-related testing and to counseling relevant to the test. The consent or refusal of the minor shall be valid and binding as if the minor had achieved majority, and shall not be voidable, nor subject to later disaffirmance, because of minority.

(d) Notwithstanding subsection (a) of this section the provisions of subsections (b) and (c) of this section do not apply when:

(1) Knowledge of such test results is necessary for medical diagnostic purposes to provide appropriate emergency care or treatment and the subject of the test is unable to grant or withhold consent.

(2) The testing is done for the purposes of research; provided that the test is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher.

(3) A health-care provider or health-care facility procures, processes, distributes or uses:

a. Blood;

b. A human body part donated for a purpose specified under the Uniform Anatomical Gift Act (Chapter 27 of this title); or

c. Semen provided prior to July 11, 1988, for the purpose of artificial insemination, and such test is necessary to assure the medical acceptability of such gift or semen for the purposes intended.

(4) The health of a health-care worker has been threatened during the course of a health-care worker's duties, as a result of exposure to blood or body fluids of the patient in a manner known to transmit HIV.

(5) It is necessary to control the transmission of HIV infection as may be allowed pursuant to this chapter as it relates to sexually transmitted diseases, or § 6523(b) of Title 11 as it relates to the Department of Correction.

(6) Testing is ordered by a court of competent jurisdiction within the confines of civil or criminal litigation where the results of an HIV-related test of a party, or a person in the custody or under the legal control of another party, is relevant to the ultimate issue of culpability and/or liability. Said order must be issued in compliance with the following provisions:

a. No court of this State shall issue such order unless the court finds that there is a compelling need for such test results, which cannot be accommodated by other means. In assessing compelling need, the court shall weigh the need for testing and disclosure of the test results against the privacy interest of the test subject and the public interest, which may be disserved, by disclosure which deters future testing or which may lead to discrimination.

b. Pleadings pertaining to ordering of an HIV-related test shall substitute a pseudonym for the true name of the subject of the test. The true name shall be communicated confidentially, in documents not filed with the court.

c. Before granting any such order, the court shall provide the subject of the test with notice and a reasonable opportunity to participate in the proceedings if the individual is not already a party.

d. Court proceedings as to disclosure of test results so ordered shall be conducted in camera unless the subject of the test agrees to a hearing in open court or unless the court determines that a public hearing is necessary to the public interest and the proper administration of justice.

(e) Any person on whom an HIV-related test was performed without first having obtained informed consent pursuant to paragraphs (d)(1), (4) and (5) of this section shall be given notice promptly, personally and confidentially that a test sample was taken and the results of such test may be obtained upon request.

(f) At the time of learning the test result, the subject of the test or the subject's legal guardian shall be provided with counseling for coping with the emotional consequences of learning the result, for understanding the interpretation of the test result, for understanding measures for preventing infection to others, to urge the voluntary notification of sexual and needle-sharing partners of the risk of infection and the availability of any appropriate health-care services, including mental health-care and appropriate social and supportive services.

66 Del. Laws, c. 336, § 1; 70 Del. Laws, c. 186, § 1; 77 Del. Laws, c. 109, § 1; 78 Del. Laws, c. 277, § 2.;

§ 716 HIV testing of pregnant women.

(a) A perinatal care provider may provide routine/opt-out testing pursuant to § 715(a) of this title.

(1) In addition to the provisions of this subsection, a licensed health-care provider who renders the primary prenatal care for a pregnant woman must offer HIV testing upon intake to perinatal services, during the third trimester, and at intake into labor and delivery if the result of previous test are not available or documented in the patient's chart.

(2) In addition to the provisions this subsection, a licensed health-care provider who renders the primary prenatal care for a pregnant woman must also counsel a pregnant woman that is found to be HIV-infected, orally or in writing, about the dangers to her fetus and about the treatment options for maintaining her health and reducing chances of transmission of HIV to her fetus.

(b) A pregnant woman shall have the right to refuse consent to testing HIV infection at any instance of testing and to refuse any recommended treatment. Documentation of such refusal shall be maintained in the patient's medical record. All other provisions of this subchapter shall apply to such counseling, testing, and disclosure, which take place pursuant to this section.

70 Del. Laws, c. 520, § 1; 70 Del. Laws, c. 186, § 1; 71 Del. Laws, c. 458, § 1; 75 Del. Laws, c. 434, § 1; 77 Del. Laws, c. 109, § 2; 78 Del. Laws, c. 277, § 2.;

§ 717 Confidentiality.

(a) No person may disclose or be compelled to disclose the identity of any person upon whom an HIV-related test is performed, or the results of such test in a manner which permits identification of the subject of the test, except to the following person:

(1) The subject of the test or the subject's legal guardian.

(2) Any person who secures a legally effective release of test results executed by the subject of the test or the subject's legal guardian.

(3) An authorized agent or employee of a health facility or health-care provider if the health facility or health-care provider itself is authorized to obtain the test results, the agent or employee provides patient care or handles or processes specimens of body fluids or tissues, and the agent or employee has a medical need to know such information to provide health-care to the patient.

(4) Health-care providers providing medical care to the subject of the test, when knowledge of the test results is necessary to provide appropriate emergency care or treatment.

(5) When part of an official report to the Division as may be required by law or regulation.

(6) A health facility or health-care provider which procures, processes, distributes or uses:

a. Blood;

b. A human body part from a deceased person donated for a purpose specified under

the Uniform Anatomical Gift Act [Chapter 27 of this title]; or

c. Semen provided prior to July 11, 1988, for the purpose of artificial insemination.

(7) Health facility staff committees or accreditation or oversight review organizations which are conducting program monitoring, program evaluation or service reviews, including the Child Death Review Commission conducting reviews pursuant to Title 31.

(8) Pursuant to Chapter 9 of this title as it relates to investigation of child abuse.

(9) Pursuant to subchapter I of this chapter as it relates to sexually transmitted diseases and their control.

(10) A person allowed access to said record by a court order which is issued in compliance with § 715(d)(6) of this title. Upon the issuance of an order to disclose test results, the court shall impose appropriate safeguards against unauthorized disclosure, which shall specify the persons who may have access to the information, the purposes for which the information shall be used and appropriate prohibitions on future disclosures.

(11) Pursuant to Chapter 12A of this title as it relates to notification of emergency medical care providers.

(b) No person to whom the results of an HIV-related test have been disclosed pursuant to subsection (a) of this section shall disclose the test results to another person except as authorized by subsection (a) of this section.

(c) The provisions in this section shall not interfere with the transmission of information as may be necessary to obtain third-party payment for medical care related to HIV infection or with the documentation of cause of death on death certificates.

66 Del. Laws, c. 336, § 1; 68 Del. Laws, c. 415, § 2; 70 Del. Laws, c. 186, § 1; 75 Del. Laws, c. 361, § 3; 78 Del. Laws, c. 277, § 2; 80 Del. Laws, c. 187, § 3.;

§ 718 Enforcement of subchapter.

(a) Any person aggrieved by a violation of this subchapter shall have a right of action in the Superior Court and may recover for each violation:

(1) Against any person who negligently violates a provision of this subchapter, damages of $1,000 or actual damages, whichever is greater.

(2) Against any person who intentionally or recklessly violates a provision of this subchapter, damages of $5,000 or actual damages, whichever is greater.

(3) Reasonable attorneys' fees.

(4) Such other relief, including an injunction, as a court may deem appropriate.

(b) Any action under this subchapter is barred unless the action is commenced within 3 years after the cause of action accrues. A cause of action will accrue when the injured party becomes aware of an unauthorized disclosure pursuant to § 717 of this title, or that an HIV-related test has been conducted without informed consent pursuant to § 715 of this title.

(c) The Attorney General may maintain a civil action to enforce this subchapter in which a

Court may order any relief authorized by subsection (a) of this section.

(d) Nothing in this subchapter shall be construed to impose civil liability or criminal sanction for disclosure of an HIV-related test result in accordance with any reporting requirement by the Division.

66 Del. Laws, c. 336, § 1; 70 Del. Laws, c. 520, § 1; 71 Del. Laws, c. 458, § 1; 78 Del. Laws, c. 277, § 2.;

TITLE 16

Health and Safety

Regulatory Provisions Concerning Public Health

CHAPTER 12. Informed Consent and Confidentiality

Subchapter I. Genetic Information

§ 1201 Definitions.

As used in this subchapter:

(1) "Genetic characteristic" means any inherited gene or chromosome, or alternation thereof, that is scientifically or medically believed to predispose an individual to a disease, disorder or syndrome, or to be associated with a statistically significant increased risk of development of a disease, disorder or syndrome.

This includes, but is not limited to, information regarding carrier status, information regarding an increased likelihood of future disease or increased sensitivity to any substance, information derived from laboratory tests that identify mutations in specific genes or chromosomes, requests for genetic services or counseling, tests of gene products and direct analysis of genes or chromosomes.

(2) "Genetic information" means information about inherited genes or chromosomes, and of alterations thereof, whether obtained from an individual or family member, that is scientifically or medically believed to predispose an individual to disease, disorder or syndrome or believed to be associated with a statistically significant increased risk of development of a disease, disorder or syndrome.

(3) "Genetic test" means a test for determining the presence or absence of an inherited genetic characteristic in an individual, including tests of nucleic acids such as DNA, RNA, and mitochrondrial DNA, chromosomes or proteins in order to identify a predisposing genetic characteristic associated with disease, disorder or syndrome.

(4) "Informed consent"

a. For the purpose of obtaining genetic information, means the signing of a consent form which includes a description of the genetic test or tests to be performed, its purpose or purposes, potential uses, and limitations and the meaning of its results, and that the individual will receive the results unless the individual directs otherwise;

b. For the purpose of retaining genetic information, means the signing of a consent form which includes a description of the genetic information to be retained, its potential uses and limitations;

c. For the purpose of disclosing genetic information, means the signing of a consent form which includes a description of the genetic information to be disclosed and to whom or a notice that the information will be available to individuals who have access to Electronic Medical Records (EMR) or to the Delaware Health Information Network (DHIN).

d. For the purpose of obtaining insurance, there may be a single signing which shall allow the obtaining, retaining and disclosure of genetic information, which, in addition to the requirements of paragraphs (4)a. and b. of this section, shall:

1. Be written in plain language;

2. Be dated;

3. Name or identify by generic reference the persons authorized to disclose information about the individual;

4. Specify the nature of the information authorized to be disclosed;

5. Name or identify by generic reference the person to whom the individual is authorizing information to be disclosed, or subsequently redisclosed;

6. Describe the purpose for which the information is collected;

7. Specify the length of time such authorization shall remain valid; and,

8. Be signed by:

A. The individual;

B. Such other person authorized to consent for such individual, if such individual lacks the capacity to consent; or;

C. The claimant for the proceeds of an insurance policy.

71 Del. Laws, c. 458, § 2; 78 Del. Laws, c. 277, § 3; 80 Del. Laws, c. 126, § 1.;

§ 1202 Informed consent required to obtain genetic information.

(a) No person shall obtain genetic information about an individual without first obtaining informed consent from the individual.

(b) The requirements of this section shall not apply to genetic information obtained:

(1) By a state, county, municipal or federal law-enforcement agency for the purposes of establishing the identity of a person in the course of a criminal investigation or prosecution;

(2) To determine paternity;

(3) Pursuant to the DNA analysis and data bank requirements of § 4713 of Title 29;

(4) To determine the identity of deceased individuals;

(5) For anonymous research where the identity of the subject will not be released;

(6) Pursuant to newborn screening requirements established by state or federal law; or

(7) As authorized by federal law for the identification of persons.

71 Del. Laws, c. 458, § 2; 78 Del. Laws, c. 277, § 3.;

§ 1203 Authorization to retain genetic information and samples from which genetic information is derived.

(a) No person shall retain an individual's genetic information without first obtaining informed consent from the individual unless:

(1) Retention is necessary for the purposes of a criminal or death investigation or a criminal or juvenile proceeding;

(2) Retention is necessary to determine paternity;

(3) Retention is authorized by order of a court of competent jurisdiction;

(4) Retention is made pursuant to the DNA analysis and data bank requirements of § 4713 of Title 29;

(5) Retention of information is for anonymous research where the identity of the subject will not be released; or

(6) Retention is pursuant to newborn screening requirements established by state or federal law.

(b) The sample of an individual from which genetic information has been obtained shall be destroyed promptly unless:

(1) Retention is necessary for the purposes of a criminal or death investigation or a criminal or juvenile proceeding;

(2) Retention is authorized by order of a court of competent jurisdiction; or

(3) Retention is authorized by the individual; or

(4) Retention is for anonymous research where the identity of the subject will not be released.

71 Del. Laws, c. 458, § 2; 78 Del. Laws, c. 277, § 3; 80 Del. Laws, c. 96, § 2.;

§ 1204 Genetic information access by the subject.

An individual promptly upon request, may inspect, request correction of and obtain genetic information from the records of that individual.

71 Del. Laws, c. 458, § 2; 78 Del. Laws, c. 277, § 3.;

§ 1205 Conditions for disclosure to others of genetic information.

(a) Regardless of the manner of receipt or the source of genetic information, including information received from an individual, a person shall not disclose or be compelled, by subpoena or any other means, to disclose the identity of an individual upon whom a genetic test has been performed or to disclose genetic information about the individual in a manner that permits identification of the individual, unless:

(1) Disclosure is necessary for the purposes of a criminal or death investigation or a criminal or juvenile proceeding or to protect the interests of an issuer in the detection or prevention of fraud, material misrepresentation or material nondisclosure;

(2) Disclosure is necessary to determine paternity;

(3) Disclosure is authorized by order of a court of competent jurisdiction;

(4) Disclosure is made pursuant to the DNA analysis and data bank requirements of § 4713 of Title 29;

(5) Disclosure is authorized by obtaining informed consent of the tested individual describing the information to be disclosed and to whom;

(6) Disclosure is for the purpose of furnishing genetic information relating to a decedent for medical diagnosis of blood relatives of the decedent;

(7) Disclosure is for the purpose of identifying bodies;

(8) Disclosure is pursuant to newborn screening requirements established by state or federal law;

(9) Disclosure is authorized by federal law for the identification of persons; or

(10) Disclosure is by an insurer to an insurance regulatory authority;

(11) Disclosure is authorized in accordance with § 1201(4)c. of this title; or

(12) Disclosure is otherwise permitted by law.

(b) This section shall apply to any subsequent disclosure by any person after another person has disclosed genetic information or the identity of an individual upon whom a genetic test has been performed.

71 Del. Laws, c. 458, § 2; 78 Del. Laws, c. 277, § 3; 80 Del. Laws, c. 126, § 1.;

§ 1206 Subchapter applicability.

This subchapter applies only to genetic information or samples that can be identified as belonging to an individual or family. This subchapter does not apply to any law, contract or other arrangement that determines a person's rights to compensation relating to substances or information derived from a sample of an individual from which genetic information has been obtained.

71 Del. Laws, c. 458, § 2; 78 Del. Laws, c. 277, § 3.;

§ 1207 Parental rights.

This subchapter does not alter any right of parents or guardians to order medical and/or

genetic tests of their children.

71 Del. Laws, c. 458, § 2; 78 Del. Laws, c. 277, § 3.;

§ 1208 Violations, penalties for unlawful disclosure of genetic information, jurisdiction.

(a) Any person who wilfully retains an individual's genetic information or retains an individual's sample in violation of this subchapter shall be punished by a fine of not less than $1,000 nor more than $10,000.

(b) Any person who wilfully obtains or discloses genetic information in violation of this subchapter shall be punished by a fine not less than $5,000 nor more than $50,000.

(c) Any person who wilfully discloses an individual's genetic information in violation of this subchapter, shall be liable to the individual for all actual damages, including damages for economic, bodily or emotional harm which is proximately caused by the disclosure.

(d) The Superior Court shall have jurisdiction over all violations of this subchapter.

71 Del. Laws, c. 458, § 2; 78 Del. Laws, c. 277, § 3.;

TITLE 16

Health and Safety

Delaware Health Information Network

CHAPTER 103. Delaware Health Information Network

Subchapter II. The Delaware Health Care Claims Database

§ 10311 The Delaware Health Care Claims Database — Findings; purpose; creation.

(a) The General Assembly finds that:

(1) The establishment of effective health-care data analysis and reporting initiatives is essential to achieving the "Triple Aim" of the State's ongoing health-care innovation efforts: improved health, health-care quality and experience, and affordability for all Delawareans.

(2) The ongoing work of the Delaware Center for Health Innovation to transform the State's health-care system from a fee-for-service system to a value-based system that rewards health-care providers for quality and efficiency of care is a worthy effort, and, to that end, the General Assembly supports the establishment of a health-care claims database that would assist in the State's efforts to achieve the Triple Aim.

(3) Claims data is an important component of population health research and analysis, and that appropriate access to claims data can facilitate the development of value-based health-care purchasing and the study of the prevalence of illness or injury across the broader population of Delaware and in particular communities or neighborhoods.

(4) Providers and other health-care entities accepting financial risk for managing the health-care needs of a population, including the State as a self-insured employer, should have access to claims data as necessary to effectively manage that risk.

(b) The purpose of this subchapter is to create a centralized health-care claims database to enable the State to more effectively understand utilization across the continuum of health care in Delaware and achieve the Triple Aim.

(c) The DHIN, assisted by the Department of Health and Social Services and the Delaware Health Care Commission as necessary, shall administer a centralized health-care claims database, known as the "Delaware Health Care Claims Database."

(d) The Delaware Health Care Claims Database is created within the DHIN to facilitate data-driven, evidence-based improvements in access, quality, and cost of health care and to promote and improve the public health through increased transparency of accurate health-care claims data and information. The DHIN shall collect and maintain claims data under this subchapter.

80 Del. Laws, c. 329, § 5.;

§ 10312 Definitions.

For purposes of this chapter, unless amended, supplemented, or otherwise modified by regulations adopted under this chapter:

(1) "Claims data" includes required claims data and any additional health-care claims information that a voluntary reporting entity elects, through entry into an appropriate data submission and use agreement under this subchapter, to submit to the Delaware Health Care Claims Database.

(2) "Health-care services" means as defined in § 6403 of Title 18.

(3) "Health insurer" means as defined in § 4004 of Title 18. "Health insurer" does not include providers of casualty insurance, as defined in § 906 of Title 18; providers of group long-term care insurance or long-term care insurance, as defined in § 7103 of Title 18; or providers of a dental plan or dental plan organization, as defined in § 3802 of Title 18.

(4) "Mandatory reporting entity" means all of the following entities, to the extent permitted under federal law:

a. The State Employee Benefits Committee and the Office of Management and Budget, under each entity's respective statutory authority to administer the State Group Health Insurance Program in Chapter 96 of Title 29, and any health insurer, third-party administrator, or other entity that receives or collects charges, contributions, or premiums for, or adjusts or settles health claims for, any State employee, or their spouses or dependents, participating in the State Group Health Insurance Program, except for any carrier, as defined in § 5290 of Title 29, selected by the State Group Health Insurance Plan to offer supplemental insurance program coverage under Chapter 52C of Title 29.

b. The Division of Medicaid and Medical Assistance, with respect to services provided under programs administered under Titles XIX and XXI of the Social Security Act [42 U.S.C. §§ 1396 et seq. and 1397aa et seq.].

c. Any health insurer or other entity that is certified as a qualified health plan on the Delaware Health Insurance Marketplace for plan year 2017 or any subsequent plan year, except for any health insurer or other entity that is not otherwise required to provide claims data as a condition of certification as a qualified health plan on the Delaware Health Insurance Marketplace for plan year 2017 or any subsequent plan year.

d. Any federal health insurance plan providing health-care services to a resident of this State, including Medicare and the Federal Employees Health Benefits Plan.

e. Any health insurer providing health-care coverage to a resident of this State.

(5) "Pricing information" includes the preadjudicated price charged by a provider or facility to a reporting entity for health-care services, the amount paid by a patient or insured party, including copays and deductibles, and the postadjudicated price paid by a reporting entity to a provider for health-care services.

(6) "Provider" means a hospital or any health-care practitioner licensed, certified, or authorized under state law to provide health-care services and includes hospitals and health-care practitioners participating in group arrangements, including accountable care organizations, in which the hospital or health-care practitioners agree to assume responsibility for the quality and cost of health care for a designed group of beneficiaries.

(7) "Reporting date" means a calendar deadline, to be scheduled on a regularly recurring basis, by which required claims data must be submitted by a mandatory reporting entity to the Delaware Health Care Claims Database.

(8) "Required claims data" includes the basic claims information that a mandatory reporting entity is required to submit to the Delaware Health Care Claims Database by the reporting date, including all of the following:

a. Basic demographic information, including the patient's gender, age, and geographic area of residency.

b. Basic information relating to an individual episode of care, including the date and time of the patient's admission and discharge; the identity of the health-care services provider; and the location and type of facility, such as a hospital, office, or clinic, where the service was provided.

c. Information describing the nature of health-care services provided to the patient in connection with the encounter, visit, or service, including diagnosis codes.

d. Health insurance product type, such as HMO or PPO.

e. Pricing information.

(9) "Third-party administrator" means as defined in § 102 of Title 18.

(10) "Voluntary reporting entity" includes, except as prohibited under applicable federal law, any of the following entities, unless such entity is a mandatory reporting entity:

a. Any health insurer.

b. Any third-party administrator.

c. Any entity, which is not a health insurer or third-party administrator, when such entity receives or collects charges, contributions, or premiums for, or adjusts or settles health-care claims for, residents of this State.

80 Del. Laws, c. 329, § 5; 81 Del. Laws, c. 79, § 32; 81 Del. Laws, c. 392, § 3.;

§ 10313 Submission of required claims data by mandatory reporting entities; submission of claims data by voluntary reporting entities.

(a) Requirements for submission of required claims data by a mandatory reporting entity.

(1) A mandatory reporting entity shall submit required claims data to the Delaware Health Care Claims Database by the reporting date.

(2) The DHIN, subject to the provisions of this subchapter and regulations promulgated under this subchapter, shall collect the required claims data from mandatory reporting entities by the reporting date.

(3) The DHIN shall, under § 10306 of this title, promulgate a template form for a data submission and use agreement for the submission of required claims data by a mandatory reporting entity.

(4) The DHIN and each mandatory reporting entity shall execute a mutually acceptable data submission and use agreement. Such agreement shall include procedures for submission, collection, aggregation, and distribution of claims data and shall provide for, at a minimum, all of the following:

a. The protection of patient privacy and data security under provisions of this chapter and state and federal privacy laws, including the federal Health Insurance Portability and Accountability Act [P.L. 104-191]; Titles XIX and XXI of the Social Security Act [42 U.S.C. §§ 1396 et seq. and 1397aa et seq.]; and the Health Information Technology for Economic and Clinical Health (HITECH) Act [42 U.S.C. §§ 300jj et seq. and 17901 et seq.], and all other applicable state and federal laws relating to the privacy and security of protected health information.

b. The identification of any claims data, in addition to required claims data, that the mandatory reporting entity elects to submit to the Delaware Health Care Claims Database.

c. A detailed summary of how claims data submitted by the mandatory reporting entity may be used for geographic, demographic, economic, and peer group comparisons.

d. A representation and warranty that the DHIN shall, abide to the fullest extent possible, by nationally recognized data collection standards and methods, including the standards promulgated by the APCD Council or successor organization, to establish and maintain the database in a cost-effective manner and to facilitate uniformity among various health-care claims databases of other states and specification of data fields to be included in the submitted claims, consistent with such national standards, allowing for exemptions when submitting entities do not collect the specified data or pay on a per-claim basis.

(5) *Exclusions from required claims data reporting requirement.* — The required claims data reporting requirements under this subchapter, and any rules and regulations promulgated under this chapter, do not apply to required claims data created for any

employee welfare benefit plan or other employee health plan that is regulated by the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat. 829, as amended, 29 U.S.C. § 1001 et seq., unless otherwise permitted by federal law or regulation.

(b) *Submission of claims data by a voluntary reporting entity.* — (1) The DHIN shall collect claims data from voluntary reporting entities under the terms and conditions of the applicable data submission and use agreement.

(2) The DHIN may promulgate regulations to clarify the types of claims data that may be submitted by a voluntary reporting entity.

(3) The DHIN and any voluntary reporting entity that elects to submit claims data to the Delaware Health Care Claims Database shall execute a mutually acceptable data submission and use agreement. The DHIN shall publish a template form data submission and use agreement that includes the required data submission and use agreement provisions under paragraph (a)(4) of this section.

(c) Unless modified or supplemented by regulations promulgated under this chapter, in instances where more than 1 entity is involved in the administration of a policy, a health insurer shall be responsible for submitting the claims data on policies that it has written, and the third-party administrator shall be responsible for submitting claims data on self-insured plans that it administers.

80 Del. Laws, c. 329, § 5.;

§ 10314 External and public reporting of claims data.

(a) The DHIN shall provide Delaware health-care payers, providers, and purchasers with access to the Delaware Health Care Claims Database for the purpose of facilitating the design and evaluation of alternative delivery and payment models, including population health research and provider risk-sharing arrangements.

(1) Claims data provided to the Delaware Health Care Claims Database shall only be provided to a requesting party when a majority of the DHIN Board of Directors, or of a subcommittee established under the DHIN's bylaws for purposes of administering the Health Care Claims Database, determines that the claims data should be provided to the requesting party to facilitate the purposes of this subchapter or to the Delaware Health Care Commission.

a. The determination under this paragraph (a)(1) shall be reduced to writing and provided to the requesting party.

b. The determination under this paragraph (a)(1) shall be final and not subject to appeal, and there is no private right of action to a requesting party against the DHIN or any other party to enforce the requirements of this section.

(2) The DHIN shall, in consultation with the Delaware Health Care Commission, promulgate rules and regulations regarding the appropriate form and content of an application to receive claims data, providing examples of requests for claims data that will generally be deemed consistent with the purposes of this subchapter.

(b) Claims data provided to a requesting party under this section shall be provided under the DHIN's existing confidentiality and data security protocols and in compliance with all applicable state and federal laws relating to the privacy and security of protected health information, including compliance, to the fullest extent practicable consistent with the purposes under this subchapter, with guidance found in Statement 6 of the Department of Justice and Federal Trade Commission Enforcement Policy regarding the exchange of price and cost information. Individually identifiable patient health information shall be maintained by providers and purchasers in accordance with all applicable state and federal laws relating to the confidentiality and security of protected health information and any additional privacy and security requirements set forth in regulations promulgated under this chapter.

(c) The Office of Management and Budget, State Employee Benefits Committee, Division of Public Health, State Council for Persons with Disabilities, and Division of Medicaid and Medical Assistance shall have access to all claims data reported by the Delaware Health Care Claims Database under this subchapter at no cost for the purposes of public health improvement research and activities. These entities are authorized to enter into appropriate agreements with the DHIN to allow the Delaware Health Care Claims Database to perform data warehousing and analytics functions that have been performed pursuant to the existing statutory authority of the Office of Management and Budget, the State Employee Benefits Committee, State Council for Persons with Disabilities, or the Department of Health and Social Services.

(d) The DHIN may promulgate regulations to make available to the public certain nonindividually identifiable data extracts and analyses, as the DHIN determines is consistent with, and necessary to, achieve the goals and policies of this subchapter. Prior to the release of such data extracts and analyses, the same processes identified in subsection (e) of this section shall be completed.

(e) The DHIN shall promulgate regulations to notify a mandatory reporting entity or voluntary reporting entity when claims data submitted by the mandatory reporting entity or voluntary reporting entity may be released for a purpose permitted under this subchapter and provide the mandatory reporting entity or voluntary reporting entity with an opportunity to comment on the data release request prior to its release. Any comments received from a mandatory reporting entity or voluntary reporting entity during the comment period shall be reviewed, considered, and responded to by DHIN prior to the data release. If a party requesting the release of data is identified by a mandatory reporting entity or voluntary reporting entity as a potential competitor of the reporting entity, the DHIN shall limit disclosure of any pricing information that includes postadjudicated claims data, to the fullest extent practicable and consistent with the purposes of this subchapter, to a summary format that allows for analysis without revealing contracted pricing information.

(f) The DHIN shall promulgate regulations to ensure confidentiality, privacy, and security protections of health-care data and all other information collected, stored, or released by DHIN, subject to all applicable state and federal health-care privacy, confidentiality, and data security laws.

80 Del. Laws, c. 329, § 5; 81 Del. Laws, c. 392, § 4; 82 Del. Laws, c. 156, § 1.;

§ 10315 Funding of Delaware Health Care Claims Database.

(a) The DHIN may not require any mandatory reporting entity, voluntary reporting entity, or provider to pay any cost or fee to submit or verify the accuracy of claims data or otherwise to enable the operation of the Delaware Health Care Claims Database with respect to required claims data submissions.

(b) The DHIN may enter contracts under § 10303(a)(11) of this title with individuals and entities who voluntarily subscribe to access the database.

(c) The DHIN, with the assistance of the Department of Health and Social Services, shall develop short-term and long-term funding strategies for the creation and operation of the Delaware Health Care Claims Database that may include public and private grant funding, subscriptions for access to data reports, access fees, and revenue for specific data projects, subject to the limitations of this section.

80 Del. Laws, c. 329, § 5.;

APPENDIX E
SENATE BILL 171

SPONSOR: Sen. Poore & Rep. Griffith
Sens. Hansen, Lockman; Reps. Briggs King, Jaques, Michael Smith

DELAWARE STATE SENATE
150th GENERAL ASSEMBLY

SENATE BILL NO. 171

AN ACT TO AMEND TITLE 16 OF THE DELAWARE CODE RELATING TO URGENT CARE FACILITIES.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE (Three-fifths of all members elected to each house thereof concurring therein):

Section 1. Amend Title 16, of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows and adding a new Subchapter 10B as follows:

§ 1001B Purpose.

To establish standards with respect to safety and sanitary conditions of urgent care facilities as defined in § 1002B of this subchapter and to investigate and inspect any such urgent care facility for unsafe or unsanitary conditions upon receipt of a complaint by a patient or current urgent care facility employee in accordance with this subchapter or upon the occurrence of any adverse event in connection with any such facility.

§ 1002B Definitions.

As used in this Chapter, the following terms mean:

(1) "Adverse event" means:

a. The death or serious injury of any patient at an urgent care facility;

b. A reasonable determination by the Department that death or serious injury may result from any unsafe or unsanitary condition at an urgent care facility; or

c. The initiation of any criminal investigation arising out of, or relating to, any diagnosis, treatment or other medical care at an urgent care facility.

(2) "Approved Accrediting Body" means those accrediting organizations approved by the Department pursuant to criteria that may be further outlined by regulation.

(3) "Complaint" means a complaint filed by a patient or current facility employee in writing, in such format as the Department shall require.

(4) "Patient" means a person who has received diagnosis, treatment, or other medical care at an urgent care facility or such person's spouse, as well as any parent, legal guardian, or legal custodian of such person who is under 18 years of age or any legal guardian or legal custodian of such person who is an adult.

(5) “Urgent Care Facility” means a facility that provides urgent care services, such as, without limitation, facilities known as “walk-in” clinics or centers or “urgent care centers.”

(6) “Urgent Care Services” means a model of episodic care for the diagnosis, treatment, management, or monitoring of acute and chronic disease or injury that is: (i) for the treatment of illness or injury that is immediate in nature but does not require emergency services and (ii) otherwise holds itself out to the public as a facility that provides immediate medical care for non-emergency conditions outside of the customary primary care office setting.

§ 1003B Regulations.

(1) The Department shall promulgate regulations in accordance with the Administrative Procedures Act, 29 Del. C. § 10101, *et seq.*, to further outline the parameters of its inspection and enforcement authority and to further establish the operational protocols contemplated in paragraphs (a) through (h) of this Section, consistent with the limitations as set forth in this subchapter. Specifically, at a minimum, the Department shall develop, establish, and enforce regulations:

a. Governing the operation of urgent care facilities to protect and promote the public health and welfare;

b. Setting forth criteria the Department will utilize in assessing whether a facility may be offering urgent care services without a license to operate as an urgent care facility, including whether the facility holds itself out to the public as a provider of immediate medical care for non-emergent conditions that provides care outside of the customary primary care office setting or relationship on a walk-in basis and outside of routine primary care business hours;

c. Governing the criteria for which organizations shall be designated as an approved accrediting body;

d. Governing when reports, documentation, and proof required by this subchapter shall be provided to the Department;

e. Setting forth criteria under which the Department shall investigate and inspect any urgent care facility upon receipt of a complaint by a patient or current facility employee or upon occurrence of any adverse event in connection with any such urgent care facility;

f. Governing whether and under what circumstances and conditions a facility fee may be charged or added to the costs of services provided to a patient by an urgent care facility;

g. Governing patient care coordination, including working with the Delaware Health Information Network (“DHIN”) and other necessary stakeholders, to establish procedures for appropriate notifications to primary care providers of urgent care utilization by the primary care provider’s assigned or attributed patients; and

h. Revoking any existing Department regulations or sub-regulatory guidance or documents that conflict with the requirements of this subchapter, including the requirements set forth in 16 Del. Reg. § 4404 that prohibit

or otherwise restrict the use of the name or title "urgent care" by any facility that is not licensed by the Department as a free standing emergency center.

§ 1004B Licensing By Accreditation Requirement.

(1) To provide urgent care services and operate in this State, an urgent care facility must obtain a license, whether provisional or regular, from the Department.

(2) The Department shall issue a provisional license, which shall be valid for no more than 9 months from the date issued, to any existing or new urgent care facility when such facility provides the Department with the following:

a. An application made on a form prepared by or approved by the Department and published by regulation; and

b. Proof satisfactory to the Department that the existing or new urgent care facility is seeking accreditation from an approved accrediting body.

Provided both subsections (a) and (b) of this subsection (2) are satisfied, the Department shall issue a provisional license to such facility within 10 business days of the urgent care facility submitting its application. A provisional license may only be renewed one time.

(3) The Department shall issue a regular license, which shall be valid for no more than twenty-four months from the date issued, to any existing urgent care facility or any urgent care facility holding a provisional license when such facility provides the Department with the following:

a. An application made on a form prepared by or approved by the Department and published by regulation; and

b. Proof satisfactory to the Department that the existing urgent care facility or urgent care facility holding a provisional license has been accredited by an approved accrediting body.

Provided both subsections (a) and (b) of this subsection (2) are satisfied, the Department shall issue a regular license to such facility within 10 business days of the urgent care facility submitting its application.

(4) All urgent care facilities must submit proof of accreditation to the Department at regular intervals as the Department may proscribe. After each survey of any facility hereunder by an approved accrediting body, the facility must submit the approved accrediting body's survey report to the Department within 30 days.

(5) If the facility fails to maintain current accreditation or if the accreditation is revoked or is otherwise no longer valid, the license of that urgent care facility shall immediately cease to operate. The Department shall also revoke the license granted to the urgent care facility

(6) An approved accrediting body shall report to the Department, at a minimum, all of the following regarding urgent care facilities the organization has accredited under this subchapter:

a. Findings of surveys; and

b. Findings of complaint and incident investigations;

Each approved accrediting body shall makes these reports to the Department at regular intervals as the Department may proscribe. Documents provided under this section are not public records under the Freedom of Information Act, Chapter 100 of Title 29.

(7) If an urgent care facility holds a current certification for participation in either Medicare or Medicaid through an affiliated hospital, such certification shall be deemed to be the equivalent of being accredited by an approved accrediting body provided the urgent care facility provides proof satisfactory to the Department that the urgent care facility holds, through an affiliated hospital, a current certification for participation in either Medicare or Medicaid. Such proof shall be provided to the Department at regular intervals as the Department may proscribe.

(8) The Department shall charge a fee of up to two thousand dollars ($2,000) per facility that shall accompany the application for licensure of an urgent care facility. The fee shall be used to offset the costs of administering the licensing requirements set forth in this subchapter.

§ 1005B Other Department Authority.

(a) The Department can make and enforce such orders as it deems necessary to protect the health and safety of the public hereunder. Without limitation of the foregoing, if the Department determines during the course of any investigation or inspection that any facility hereunder poses a substantial risk to the health or safety of any person, the Department may order that such facility be closed until such time as it no longer poses a substantial risk.

(b) The Department shall share information regarding facilities with the Department of State, Division of Professional Regulation.

§ 1006B Coordination of Care.

(a) No later than January 1, 2020, each urgent care facility must enroll in the DHIN as active users of the Community Health Record and enter into an agreement with DHIN to provide DHIN with a summary of each visit or episode of care in an electronic format established by DHIN.

(b) If the patient has a primary care provider, the urgent care facility must notify the patient's primary care provider of the urgent care visit. Such notifications may be made through DHIN’s Electronic Notification Service.

§ 1007B Enforcement.

(1) Any person constructing, managing, or operating any urgent care facility without complying with the procedures set forth in this Chapter shall be fined by the Department no more than $5,000 for the first offense and no more than $10,000 for each subsequent offense. Each day of a continuing violation shall be considered a separate offense.

Section 2. This Act shall become effective at the earlier of 180 days following enactment or 90 days after final regulations specified under Section § 1003B are published in accordance with the Administrative Procedures Act.

SYNOPSIS

This Act establishes a new subchapter of Title 16 regulating urgent care facilities. It requires such facilities, existing and new, to obtain a license from DHSS, which requires the urgent care facility to either be accredited by an approved accrediting body or be seeking such accreditation. If the urgent care facility is seeking accreditation, it can operate on a provisional license for nine months. If accreditation is not obtained, the urgent care facility can apply once for a renewal of a provisional license. Operating without a license or accreditation will subject urgent care facilities to fines. The Act grants DHSS the power to promulgate various regulations to enforce the Act. DHSS can also make and enforce orders to protect the public health and share information with the Division of Professional Regulation. The Act requires each urgent care facility in the State to enroll in the Delaware Health Information Network ("DHIN") and to notify a patient's primary care provider through DHIN to facilitate the coordination of care.

Author: Senator Poore

APPENDIX F
SENATE RESOLUTION 9

SPONSOR: Sen. Lockman
Sens. Delcollo, Hansen, Lopez, Walsh

DELAWARE STATE SENATE
150th GENERAL ASSEMBLY

SENATE RESOLUTION NO. 9

ESTABLISHING A TASK FORCE TO RESEARCH, DISCUSS, AND MAKE FINDINGS AND RECOMMENDATIONS REGARDING THE JOINT LEGISLATIVE OVERSIGHT AND SUNSET COMMITTEE'S REVIEW OF THE DELAWARE HEALTH INFORMATION NETWORK.

WHEREAS, the Joint Legislative Oversight and Sunset Committee ("JLOSC") reviewed the Delaware Health Information Network ("DHIN") in 2019; and

WHEREAS, DHIN's review resulted in 4 recommendations that relate to statutory changes to DHIN's governing statute, Chapter 103 of Title 16 being presented for JLOSC's consideration; and

WHEREAS, 3 of the 4 recommendations require additional research and discussion among interested agencies and citizens to assist JLOSC in making decisions whether to adopt the recommendations; and

WHEREAS, JLOSC expressed its desire to create a task force, comprised of JLOSC staff, relevant agencies, and members of the public, to address the implementation of the 3 recommendations and report back to JLOSC in January 2020.

NOW, THEREFORE:

BE IT RESOLVED by the Senate of the 150th General Assembly of the State of Delaware that the Joint Legislative Oversight and Sunset Committee Task Force on the Delaware Health Information Network ("Task Force") is established.

BE IT FURTHER RESOLVED that the Task Force research, discuss, and make findings regarding Recommendations 2, 4, and 6 of the JLOSC's 2019 review of DHIN, and report its findings and recommendations to the JLOSC. The Task Force may find that the JLOSC should consider additional recommendations that the Task Force identifies.

BE IT FURTHER RESOLVED that the Task Force is composed of 11 members. A member who serves by virtue of position may appoint a designee to serve in that member's stead and at that member's pleasure. Membership is comprised as follows:

(1) One JLOSC Analyst.

(2) One JLOSC Legislative Attorney.

(3) The Chief Executive Officer of DHIN.

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(4) General Counsel of DHIN.

(5) Chief Operating Officer of DHIN.

(6) The Chair of the DHIN Board of Directors.

(7) An individual who represents data senders, such as hospitals or labs, as designated by the DHIN Board of Directors.

(8) The Lieutenant Governor, or the Lieutenant Governor may appoint a designee from the Behavioral Health Consortium.

(9) The Dean of the University of Delaware's College of Health Sciences.

(10) The Secretary of the Department of Health and Social Services.

(11) The Director of the Division of Public Health.

BE IT FURTHER RESOLVED that at least 5 individuals serve as consultants to the Task Force. A consultant who serves by virtue of position may appoint a designee to serve in that consultant's stead and at that consultant's pleasure. A consultant does not vote or have any duties or powers reserved for a Task Force member. Consultants are comprised as follows:

(1) One analyst from the Controller General's Office.

(2) The Chief Information Officer of the Department of Technology and Information.

(3) The Chief Executive Officer of the Gift of Life Program.

(4) The Bureau Chief of the Bureau of Correctional Healthcare Services.

(5) An individual who specializes in pharmacy data, selected by the Task Force members.

(6) Any other organization or individual that the Task Force may determine helpful in meeting its duties.

BE IT FURTHER RESOLVED that a member or consultant may appoint a designee. A member or consultant who appoints a designee must provide the designation in writing to the chair. A designee has the same duties and rights as the member or consultant the designee represents.

BE IT FURTHER RESOLVED that the JLOSC Analyst and JLOSC Legislative Attorney serve as co-chairs of the Task Force.

BE IT FURTHER RESOLVED that the co-chairs of the Task Force are responsible for guiding the administration of the Task Force by doing, at a minimum, all of the following:

(1) Notifying all Task Force members of their selection to serve on the Task Force and all consultants of their selection to serve as consultants.

(2) Setting a date, time, and place for the initial organizational meeting.

(3) Supervising the preparation and distribution of meeting notices, agendas, minutes, correspondence, and reports of the Task Force.

(4) Sending, after the first meeting of the Task Force, a list of the members of the Task Force and the person who appointed them to the Joint Legislative Oversight and Sunset Committee and the Director of the Division of Research of Legislative Council.

(5) Providing meeting notices, agendas, and minutes to the Director of the Division of Research of Legislative Council.

(6) Ensuring that the final report of the Task Force is submitted to the Joint Legislative Oversight and Sunset Committee with a copy to DHIN, the Director and the Librarian of the Division of Research of Legislative Council, and the Delaware Public Archives.

BE IT FURTHER RESOLVED that the Task Force must hold its first meeting no later than August 31, 2019.

BE IT FURTHER RESOLVED that a quorum of the Task Force is a majority of its members. A vacant position is not counted for quorum purposes.

BE IT FURTHER RESOLVED that:

(1) Official action by the Task Force, including making findings and recommendations, requires the approval of a majority of the members of the Task Force.

(2) The Task Force may adopt rules necessary for its operation. If the Task Force does not adopt rules or if the adopted rules do not govern a given situation, *Mason's Manual of Legislative Procedure* controls.

BE IT FURTHER RESOLVED that the Division of Research is responsible for providing reasonable and necessary support staff, materials, and meeting locations for the Task Force.

BE IT FURTHER RESOLVED that the co-chairs must compile a report containing a summary of the Task Force's work regarding the matters assigned to it in lines 14 through 17 of this Resolution, including any findings and recommendations adopted by the Task Force, and submit the report to the JLOSC and the Director and the Librarian of the Division of Research of Legislative Council no later than January 10, 2020.

BE IT FURTHER RESOLVED that this Resolution expires on the date the Task Force submits its findings and recommendations

SYNOPSIS

The Joint Legislative Oversight and Sunset Committee ("JLOSC") reviewed the Delaware Health Information Network ("DHIN") in 2019. As a result of that review, 4 recommendations relating to statutory changes to DHIN's govnering statute were presented for JLOSC's consideration. JLOSC determined that a task force should be created to research, discuss, and report back to JLOSC its findings on the implementation of 3 of the 4 recommendations. JLOSC decided to form the task force through a simple resolution.

This Resolution establishes the Joint Legislative Oversight and Sunset Committee Task Force on the Delaware Health Information Network ("DHIN"). In addition to the 11 members of the Task Force, several consultants are also named, to share their expertise with the Task Force. The Task Force must hold its first meeting by August 31, 2019, and submit a final report of its findings and recommendations to JLOSC by January 10, 2020.

The Task force will not approve the implementation of a recommendation or authorize or require a change in any statute, policy, or practice. The Task Force is designed, authorized, and limited to do only the following:

- Research the background of and relevant information relating to JLOSC's Recommendations 2, 4, and 6.
- Discuss the merits and concerns of each recommendation.
- Report back to JLOSC on what the Task Force found in its research and discussions.

Consultants are specified to ensure their participation in the Task Force, while the number of members is kept limited in the interest of meeting quorum and scheduling requirements more easily.

Author: Senator Lockman