Memo

To: GACEC, SCPD and DDC

From: Disabilities Law Program

Date: 2/12/2024

Re: February 2024 Policy and Law Memo

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

I. PROPOSED STATE REGULATIONS

- **Proposed Department of Health and Social Services (DHSS) Stroke System Regulation 4306, 27 Del. Register of Regulations 567 (February 1, 2024)**

With this regulation, the Department of Health and Social Services (DHSS), Division of Public Health (DPH) is proposing a Stroke System Regulation. Specifically, this regulation would establish and set forth how the Statewide Stroke System operates. Written comments, suggestions, compilations of data, testimony, briefs, or other materials are due by the close of business on March 4, 2024.

Before undertaking an analysis of this proposed regulation, a digression into the Emergency Medical Services Systems statute, 16 *Del. C.* §9701 *et. seq.*, that was the genesis of the regulation is beneficial. The stated purpose of Chapter 97 is "to establish and/or identify specific roles and responsibilities in regard to emergency medical services in Delaware in order to reduce morbidity and mortality rates for the citizens of Delaware and to ensure quality of emergency care services, within available resources, through the effective coordination of the emergency medical services system." 16 *Del. C.* §9701.

The statute created the Office of Emergency Medical Services as an agency within the Division of Public Health and which reports to the Director of Public Health. *Id.* at §9704(a), (b). Among other standing committees, the Director was directed to create a Stroke System Committee consisting of a broad base of membership. The membership included, *inter alia,* therapists with stroke rehabilitation experience; emergency department physicians; stroke neurologists; neurosurgeons; nurses providing stroke patient care; hospital administrators from acute health care facilities who have or intend to obtain a stroke center designation; Delaware Healthcare Association; and the state police aviation section. *Id.* at §9704(j).

The Stroke System Committee advises the Director[1] who then uses those recommendations as the basis for establishing a plan for "the basis for establishing a plan for the implementation and

[1] On:
"(1) Recommendations based on Delaware stroke data as determined by the Director of Public Health, and after review of Delaware data as analyzed by the Stroke System Committee, and input from the Committee, as to whether outcomes for Delaware patients will be improved by the adoption of a statewide stroke system. Such

maintenance of Delaware's inclusive statewide stroke care system." *Id.* at §9706(i). This plan must address each component of stroke care[2]; the Director also has the authority to promulgate rules "for the management of all components of Delaware's inclusive statewide stroke care system and shall seek input and review from the Stroke System Committee." Finally, the Director must maintain a system evaluation, including "a stroke data collection and registry system and a mechanism for evaluating and monitoring system performance throughout the continuum of stroke care." *Id.* at §9706(i).

Against this backdrop and enabling statute comes proposed 4306 Stroke System Regulation with the laudable goal "to ensure that every person who may be experiencing a stroke in Delaware receives the same high-quality care, thus decreasing morbidity and mortality from strokes." (1.0). The regulation establishes a comprehensive framework to accomplish the stated purpose. The key organizational components of the Stroke System of Care are the Stroke System Coordinator, who serves as administrator for the stroke system and related committees (3.1.1), and the Stroke System Committee[3] (mentioned above), whose role is to provide "coordination, oversight, and guidance for all components of the Stroke System in Delaware." (3.1.2).

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recommendations shall be made to the Director of Public Health no later than December 30, 2016. The Director of Public Health shall report the basis for the Directors' decision to the Chairs of the Health and Social Services Committees of the House and Senate.
(2) Rules governing the operation of Delaware's inclusive statewide stroke care system, which will be based upon national references and data based guidelines, as determined by the Director of Public Health with the advice of the Stroke System Committee.
(3) Recommendations for corrective action based on the reviews of the following:
a. Statewide stroke care system operations, including the monitoring for adherence to adopted policies, procedures, protocols and standards, the availability of appropriate resources and the periodic review of stroke hospital and freestanding emergency department participation (designation) criteria.
b. The delivery of emergency medical and hospital services by stroke care service providers to stroke patients.
(4) Recommendation for modifications of the policies, procedures and protocols of stroke care as a result of system-wide review."
16 Del. C. §9704(k).

[2] "(2) The State Stroke System Plan shall address each component of stroke care as outlined in national references. These include, but are not limited to:
a. Prehospital care. — Standardized and statewide policies, procedure and protocols to be used by all emergency medical service providers and licensed personnel for the identification, treatment and transport of stroke patients.
b. Prevention. — Efforts to decrease the numbers and severity of strokes resulting in decreased demand for care.
c. Hospital care. — Standards and criteria for hospital personnel, equipment and designation that identify the necessary resources that hospitals must have in order to be recognized within Delaware's inclusive statewide stroke care system as a specified category stroke facility. These standards and criteria shall be consistent with those identified in national stroke system references produced by national accreditation and certification organizations. All expenses associated with utilizing a nationally recognized
d. *Rehabilitative care.* — Standards for the follow-up care for persons with disabilities resulting from injuries.
e. *Stroke continuing education.* — The ongoing stroke-related education for stroke care system personnel/providers to maintain knowledge and skills.
f. *Stroke care system evaluation.* — Monitor policies and procedures regarding the effectiveness/impact of stroke care systems.
Id. at §9706(i).

[3] "'**Stroke System Committee**' or '**SSC**' means the committee providing coordination, oversight, and guidance for all components of the Stroke System in Delaware as established in the Delaware code." (4.0 Definitions).

Although the Stroke System Committee is the "overarching standing committee," there are other committees. (5.4.2.1). The Stroke System Quality Evaluation Committee[4] "focuses on system performance improvement." (5.4.3.1). The Stroke System Education and Prevention Subcommittee "focuses on state-wide public education, awareness, and prevention" to lower the number of deaths and disabilities from suffering a stroke. (5.4.4.1.1 and 5.4.4.1.3). Ad-hoc Subcommittees can be established as needed. (5.4.5.1).

As part of the proposed regulation and 16 *Del. C.* §1013, the Secretary of Health and Social Services will designate hospitals in Delaware and upon request out-of-state hospitals that have received a certification from the Joint Commission[5] "or an equivalent certification by another nationally-recognized guidelines-based accrediting organization" as stroke centers. *Id.* at §1013(b); s*ee* 6.0.

Since the Division of Public Health has the ultimate responsibility for quality stroke care in the state, the proposed regulation establishes the Stroke System Performance Improvement Plan. (8.0). The plan is based on national studies and standards to aid the Division in meeting the goal of the plan: "'improv[e] stroke care by promoting consistent adherence to the latest scientific treatment guidelines, [as evidenced by] numerous published studies demonstrating the program's success in achieving measurable patient outcome improvements.'" (8.1). Improved care to stroke patients is achieved through "a collaborative approach with the appropriate facilities, services, and disciplines involved . . . ." (8.2.3). The Division can recommend "corrective action in all aspects of stroke care throughout the continuum from onset to rehabilitation" and can help stroke centers develop and implement their individual Stroke Performance Improvement Programs. (8.3.1).

As part of the Division's responsibilities under the State Stroke System Quality Improvement Program, the proposed regulation requires the Division to evaluate "the entire scope of care provided to stroke patients with the State of Delaware from stoke onset through rehabilitation." (8.6.1; 8.6.2.1). To aid the Division in the evaluation process, the Director is to appoint a Stroke System Medical Advisor and a Stroke System Committee Chairperson. (8.6.2.2). In addition, the proposed regulation establishes the state stroke registry. (8.7). All acute care hospitals that have treated stroke patients will be required to contribute data to the program (8.7.3.1), which will be used for improvement purposes and "research/prevention activities." (8.7.2.2).

This proposed regulation is a blueprint that establishes the rules and guidelines that must be followed regarding the treatment of strokes in the state. It identifies all the participants, including the Division of Public Health, the facilities involved, the personnel involved, and the committees involved, and specifies their roles, duties, and responsibilities. No public disclosure is required by the proposed regulation because the proceedings, reports, studies, and minutes are all confidential. (8.9).

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[4] "'**Quality Evaluation Committee**' or '**QE Committee**' means the subcommittee of the Stroke System of Care that provides recommendations, advice, and assistance to DPH in its ongoing evaluation of the Delaware Stroke System. It evaluates data related to system metrics of success and quality of patient care and outcomes." (4.0 Definitions).

[5] "'**The Joint Commission**' or '**TJC**' means the national body that certifies or accredits various healthcare settings. The Joint Commission provides certification for stroke care centers." (4.0 Definitions).

The real question will be implementation of the requirements and responsibilities of the proposed regulation and an examination of the data collected to better improve stroke care and outcomes. The Stroke System Performance Improvement Plan is subject to a biennial review by the Division of Public Health and the Stroke System Quality Evaluation Committee, which should in large measure allay any apprehension over the lack of public disclosure of the proceedings, reports, studies, and minutes of the meetings. Nevertheless, Councils should ask that the biennial reviews conducted by the Division be posted on its website. This would allow Councils and others to see what progress is being made in the care and treatment of stroke patients in the state.

Recommendation: At this juncture, there is not much else to add to the proposed regulation. Councils may wish to support this regulation.

- **Proposed Department of Health and Social Services (DHSS) / Division of Public Health Regulation Governing the Childhood Lead Poisoning Prevention Act 4459A, 27 Del. Register of Regulations 570 (February 1, 2024)**

Here, DHSS /DPH re-publishes proposed revisions to 4459A Regulations Governing the Childhood Lead Poisoning Prevention Act. DPH amended the following provisions in the regulation for clarity:

> 10.3.3.2 30 calendar days from first entry into the ~~program or system~~ child care facility, public or private nursery school, preschool, or kindergarten.
>
> 10.6 The information sent to or received by a ~~program~~ child care facility, public or private nursery school, preschool, kindergarten or school shall be recorded and certified by a health care provider's signature on a form that includes the following:
> ….
>
> 3.6 In addition to the blood lead level screening and testing requirements in this section, a health care provider may order a lead screening or test at their discretion and these results must be reported to ~~DPH~~ the Division pursuant to Section 7.0.
>
> **5.0 Religious Exemption**
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> A religious exemption may be granted to a child if the blood lead level screening or testing conflicts with a genuine and sincere religious belief and not a belief based merely on philosophical, scientific, moral, personal, or medical opposition to blood lead level screening or testing. The ~~DPH~~ the Division affidavit of blood lead level screening or testing exemption for religious beliefs shall be signed and dated by the child's parent or guardian, notarized, and kept in the child's medical chart.
>
> 10.3.2 The ~~DPH~~ the Division affidavit signed by the parent or guardian stating that the blood lead level screening or test is contrary to the parent's or guardian's religious beliefs; or

DPH made revisions changing language from 60 days of notification of an elevated blood lead level to blood lead test with results at or above the blood lead reference level:

> 11.1 Within 60 days of receiving notification that a child has a blood lead level, at or above the reference level the Division shall determine: the child's residential address from birth through testing, the site of the child's lead exposure, and the property owner of the site at which the child became exposed to lead. Any documents that the Division creates or holds that contain confidential health

information shall be conspicuously marked and will not become public documents.

DPH made a change from age 6 to 18 with respect to age limits:

3.2 Unless a child's parent or guardian requests a blood lead level screening or test, a primary health care provider for a child who is 28 months old or older and younger than ~~6~~ 18 years old shall administer a blood screening or test for lead in the following circumstances:

DPH acknowledged Councils comments but does not make changes in response.

Recommendation: the changes made were not responsive to Councils' recommendations; however, further comments by Councils are unlikely to be productive.

- **Proposed Department of Health and Social Services (DHSS) Food Benefit Certification 9068, 27 Del. Register of Regulations 577 (February 1, 2024)**

With this publication, DHSS provides the public notice of revisions to the Delaware Social Service Manual (DSSM) regulations regarding Food Benefit Certification for Supplemental Nutrition Assistance Program (SNAP). DHSS proposes to amend DSSM section 9068 from a 24-month certification period to a 12-month certification period in households where all members are elderly or disabled, and from 12-month to 6-month certification periods for all other households. DHSS's proposal is contrary to federal SNAP policy that strongly favors longer certification periods, creates barriers to food equality, and significantly harms the very individuals that SNAP is designed to help - low-income households, especially families of color, facing food insecurity.

In 2021, SNAP helped 12% of the state's population, approximately 115,500 Delaware residents[6]:

- more than 66% of SNAP participants are in families with children;
- **almost 38% are in families with members who are older adults or have disabilities**;
- almost 46% are in working families.

A certification period is a review at which the SNAP family is required to report certain changes in income, living arrangements and family composition.7 C.F.R. § 273.l0(f) addresses certification periods and states "State agencies must assign the longest certification period possible based on the predictability of the household's circumstances." Currently DHSS adheres to this policy by allowing 24-month recertification periods with a periodic review at month 12 for households where all members are elderly or disabled, and for 12- month certification periods with a periodic review at month 6 for other households based on their circumstances.

Delaware's proposed changes will result in many eligible families losing SNAP benefits and runs counter to the federal government's stated policy goals of increasing enrollment by streamlining application and renewal processes and generally trying to reduce unnecessary churn (when a household exits SNAP and then re-enters the program within 4 months). See for example 87 Fed. Reg. 54760 (Sept. 7, 2022) (proposing multiple changes to simplify Medicaid applications and renewals).

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[6] Center on Budget and Policy Priorities (April 25, 2022), available at https://www.cbpp.org/research/food-assistance/a-closer-look-at-who-benefits-from-snap-state-by-state-fact-sheets# Delaware.

The Proposed rule will also increase the administrative burden on both SNAP recipients and the State by doubling the number of reviews that must be conducted.

Making SNAP benefits more accessible is a racial justice issue. It is well established that families of color bear the brunt of hunger in America. Adopting polices that restrict or reduce eligibility will have a disproportionate effect on those families. Food insecurity also plays an important role in physical and mental health. Delaware should not adopt policies that only worsen food insecurity. Indeed, a recent report, co-authored by Center for Law and Social Policy (CLASP) in collaboration with the Community Partnership Group (CPG) recommends longer certification periods. It also addresses the consequences of short certification periods: "These short certification periods add burden and create more opportunities for human error, causing families to lose their benefits. One year renewal periods - nothing less - should be the national standard."[7]

SNAP is the nation's largest mechanism to fight hunger and is 100% federally funded. Delaware should be seeking to increase not decrease enrollment of eligible families. The proposed changes will do precisely the opposite.

Recommendation: Councils may wish to oppose the proposed changes to the frequency of the review periods and recommend that DHSS maintain 24-month certification / 12-month certification periods.

- **Proposed Delaware Board of Dentistry and Dental Hygiene Regulation 1100, 27 Del. Register of Regulations 584 (February 1, 2024)**

The Delaware Board of Dentistry and Denal Hygiene, pursuant to 24 **Del. C.** 1106(a)(1), proposes to revise its regulations to clarify that limited licensees are subject to general supervision while training, and to eliminate redundancies in supervision. To address these redundancies, edits have been made to Section 5.0, relating to supervision. These proposed changes are not substantive and serve to eliminate redundant language that is used in the previous sections of the regulation. Beyond the proposed changes made in Section 5.0, the proposed regulation remains the same.
However, of note, Section 6.0 addresses Continuing Professional Education (CPE) and Renewal. Section 6.3 states that "[a]ll persons licensed to practice dentistry in the State of Delaware shall be required to acquire fifty (50) hours of continuing professional education (CPE) credit every two (2) years." Per Section 6.3, two of the credit hours must be courses covering infection control, and evidence must be provided every two years that a licensee has completed a cardiopulmonary resuscitation (CPR) course.
There are no accessibility training recommendations or requirements in Section 6.0. The absence of accessibility training is problematic for individuals with disabilities. One study reported on in the *New York Times* several years ago held focus groups with doctors and specialty health care providers. In that anonymous format, the providers admitted to broad disability discrimination, including refusing new patients because of their disabilities, to avoid having to: accommodate

[7] Center for Law and Social Policy, "A Community-Driven Anti-Racist Vision for SNAP," (September 2022), available at https://www.clasp.org/publications/report/brief/a-community-driven-anti-racist-vision-for-snap/

them, figure out how to communicate with them, or give theme extra time (because they believed they were going to take more time than non-disability patients).[8]
Considering this, it is unsurprising that per the American Institute of Dental Public Health, "many [individuals with disabilities] do not seek routine dental care as a result of […] barriers and challenges, and when they do seek dental care, it's often because of expensive emergencies that could have been easily prevented."[9] Accessibility to dental care varies on an individual basis. "Communication, physical, and behavioral barriers are often invisible or devalued by healthcare providers. Impaired communication limits the ability of people with disabilities to describe their feelings or needs, and, in many cases, to comprehend instructions."[10] Without accessibility training, dental professionals in Delaware may unknowingly fortify these invisible barriers and contribute to a disability dental divide.
It's important to understand that the Americans with Disabilities Act (ADA)[11] *requires* dental professionals to provide people with disabilities the same level of service that they provide all patients. Indeed, the American Dental Association modified its own code of conduct "to align with the ADA act of 1990."[12] Without regular and robust accessibility training for dental professionals, Delaware dental providers are at risk of unknowingly (or knowingly, as was shown with the *NY Times* article discussed above) discriminating against individuals with disabilities. This puts Delawareans at risk for poor health outcomes, and potential legal actions against the dental providers.
In terms of legal outcomes for dental providers – noncompliance can result in significant damages. In October of 2022, the U.S. Department of Justice resolved a complaint against a dental clinic that failed to provide interpretation services to a patient who is deaf; the clinic agreed to undertake improvements and pay the complainant almost $50,000 in compensation for the discrimination she endured.[13] In February of 2013, a Virginia dental office was made to pay $10,000 after requiring a patient with HIV to "schedule all future appointments as the last appointment of the day." The dental office also had to train its staff on the ADA and develop an anti-discrimination policy.[14]

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[8] *These Doctors Admit They Don't Want Patients with* Disabilities, NEW YORK TIMES, October 19, 20233, https://www.nytimes.com/2022/10/19/health/doctors-patients-disabilities.html

[9] *Disabilities and Dental Care: Why More Must Be Done to Improve Access,* AM. INST. OF DENTAL PUB. HEALTH, Jun. 26, 2023, https://aidph.org/disabilities-and-dental-care-why-more-must-be-done-to-improve-access/.

[10] Orrin Devinsky, Danielle Boyce, Miriam Robbins & Mariel Pressler, *Dental health in persons with disability,* 110 Epilepsy and Behavior, Sept. 2020.

[11] See also Delaware's ADA comparable law, the Delaware Equal Accommodations Law; Section 504 of the Rehabilitation Act and the Affordable Care Act also require nondiscrimination in services offered by covered entities.

[12] *Revisiting the Equal Opportunity Law for People with Disabilities*, BENCO DENTAL, Aug. 2, 2021, https://www.benco.com/benco-dental-u/article/revisiting-the-equal-opportunity-law-for-people-with-disabilities-9-questions-and-answers-about-the-americans-with-disabilities-act/.
[13] Press Release, United States Attorney's Office, DOJ and Des Moines, Washington, dental clinic resolve complaint over Americans with Disabilities Act (ADA) violation (Oct. 18, 2022), https://www.justice.gov/usao-wdwa/pr/doj-and-des-moines-washington-dental-clinic-resolve-complaint-over-americans.

Required up-to-date training could help protect the disability community from discrimination and physical harm, and dental providers from unknowingly violating the law. Disability is not "one size fits all." As seen in the examples above, the needs of dental patients with disabilities will vary greatly. Training for dental professionals would be a valuable educational tool.
For example, accessibility training could be required comparable to the requirements of infectious disease training: two (2) credit hours every two years. This would not be overburdensome to dental professionals but would keep the topic of accessibility relevant and ensure that accessibility training is ongoing and evolving.
Recommendation: Beyond the non-substantive changes made in Section 5.0, Councils should consider educating the Division of Professional Regulation about the benefits of the inclusion of two (2) credit hours of accessibility training for dental professionals every two (2) years.

II. Final State Regulations

- **Delaware Department of Education (DDOE) Final Residential Child Care Facilities and Day Treatment Programs 105, 27 Del. Register of Regulations 599(February 1, 2024)**

In response to Councils' comments, DDOE stated that "in the future, OCCL will invite the GACAC and SCPD to participate on task forces when regulations are being revised." DDOE did not make other changes in response to Councils' comments.

Recommendation: Councils may wish to thank DDOE for the future invitations to participate on task forces when regulations are being revised, and note that Councils' other concerns with the amendments remain.

III. State Bills

- **HB 293**

House Bill 293 seeks to add a provision to Chapter 2 of Title 15, Elections, requiring the Department of Elections (DOE) to ensure that polling places are accessible. Currently there is a vague provision at 15 Del Code § 4512 which generally requires that polling places be "readily accessible."[15] Of course, federal law (the Americans with Disabilities Act and Help America Vote Act, among others) currently requires that the DOE provide accessible polling places and accessible voting equipment. DLP has conducted surveys which suggest that about 25% to 30% of polling places are not fully accessible on any given election day.[16]

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[14] Press Release, Justice Department Reaches Settlement with Virginia Dental Office to Stop HIV Discrimination (Feb. 12, 2013), https://www.justice.gov/opa/pr/justice-department-reaches-settlement-virginia-dental-office-stop-hiv-discrimination.
[15] **4512. Polling places; designation and preparation.**
(b) The Department shall designate only conveniently located and readily accessible polling places for each election district.

[16] The DLP's report on our 2022 Polling Place Survey can be found here: http://www.declasi.org/clasi-disabilities-law-program-report-finds-widespread-accessibility-violations-at-delaware-polling-places/

House Bill 293 adds a more specific requirement for accessibility of polling places, although it places it in Chapter 2 of Title 15, which covers general provisions relating to the authorities of the DOE. Councils may want to query about this placement, and whether it does not make more sense to place it in Chapter 45.

In any case, in proposed Section 221(a), the bill requires the DOE to ensure that polling places have adequate and accessible spaces and that all polling places in the state be accessible to persons with disabilities, in compliance with the ADA. Subsection (b) makes exceptions in two circumstances: first, in an emergency, and second, if the Commissioner of Elections determines that all polling places in a polling area have been surveyed and none are accessible or can be made accessible, and that any voter in that polling area has been reassigned to an accessible polling place or has been given an alternative means of voting.

We have the following observations:

1. Emergency is not defined. Councils may wish to suggest that emergency be defined, either as a situation where the Governor has issued an Order declaring an emergency, or when a specific polling place is unusable on Election Day due to circumstances beyond the DOE's control and that cannot be remediated.
2. There is no enforcement provision in this bill. Councils may wish to suggest, at a minimum, that language be added providing for a complaint process or some type of judicial enforcement. Language could be added either providing a mechanism to file a complaint for relief to Superior Court, or that complaints can be filed under the Equal Accommodations statute. Another alternative may be something filed through the Architectural Accessibility Board.
3. DLP has noted that there have been occasions when accessible locations, often schools, are not accessible on Election Day because a particular feature, such as an accessible door or ramp, has not been made available. Councils may wish to suggest that language be added that requires any polling location make its accessible features fully available on Election Day, or that the DOE makes this a requirement of any contract or agreement that the DOE makes with the owner or operator of a polling place.

Generally speaking, HB 293 should improve accessibility by being much more explicit about what the DOE must do. The bill requires that the DOE ensure that polling places are ADA compliant. The only exception, other than in an emergency, is if the DOE has literally surveyed every potential location and hasn't been able to identify one that can be made accessible. The chances of this occurring are exceedingly small.

Recommendation: **Consequently, councils may wish to endorse or otherwise support the bill, with the suggestions 1-3, found above.**