Governor Lamont's Lead Poisoning Prevention Initiative

Lead Working Group Public Act 22-49

Lead Work Group Meeting 10/21/2022

In Attendance:

- Deputy Commissioner Heather Aaron (DPH)
- Lori Mathieu (DPH)
- Laura Fournier
- Howard Smith
- Patrick McCormack
- Claire Botnick
- Chloe-Anne Bobrowski
- Daniel Aubin
- Chris Corcoran
- Michael Santoro
- Rep. Jonathan Steinberg
- Owen Rood
- Margaret Flinter (CHC)
- Jennifer T. Haile
- Aisling McGuckin
- Ebony Jackson-shaheed
- Rafael Ramos
- Amanda Decew
- Katharine Berdy

Note Takers:

- Chris Silver
- Olivia Hine
- Jesus Blanco-Vazquez

- Work Group Report due by 12/1/22
    - Commissioner of Public Health shall report to the joint standing committees of the General Assembly having cognizance of matters relating to public health, education, and appropriations
- CGS Section 19a-111g(a)
    - Establishes a schedule for screening and testing to be followed by medical providers giving pediatric care. The pediatric medical provider shall comply with the following screening and testing, in accordance with the Advisory Committee on Childhood Lead Poisoning Prevention guidelines:
        - Age 9-35 months --> Test Lead at least annually
        - Age 36- 72 months --> Test Lead at least annually, children at elevated risk

        - Age 36- 72 months --> Test if not previously tested
        - Under 72 months --> Test if clinically indicated
        - Age 36- 72 months -->Medical Risk Assessment at least annually
        - Age 0- 36 months --> Medical Risk Assessment upon provider's determination
    - Prior to testing, the pediatric medical provider is required to provide the child's parent, educational material or anticipatory guidance information concerning lead poisoning and prevention
    - CGS Section 19a-111g(b) allows for a religious exemption
- CGS Section 19a-110(a) Reporting of Lead poisoning. Parental notification. Availability of information regarding lead poisoning
    - **Establishes reporting responsibilities of health care institutions and clinical laboratories who complete or receive a report of someone with a blood lead level (BLL) equal to or greater than 3.5 micrograms per deciliter of blood or any other abnormal body burden of lead**
    - It requires health care institutes and labs to report to DPH and the local health director no later than 48 hours after receiving or completing the report, certain data elements, including
        - Person's name, address, DOB, gender, race, ethnicity
        - Health care providers name, address, telephone number
        - Dates of sample collection of analysis
        - Type and blood lead analysis result
- 19a-110(d)
    - **Establishes the responsibilities of a local health department when a child is known to have a BLL equal to or greater than 3.5 mcg/dL.**
    - The elevated blood lead level may be known to the local health department via a confirmed venous blood lead level or through the reporting requirement pursuant to subsection (a)
    - The local health department shall provide or cause to be provided to the parent/ guardian of the child, information about the dangers of lead poisoning, prevention methods, Birth to Three intervention services, and laws and regulations concerning lead abatement
    - DPH is required to develop the information provided to parents/guardians. Local Healt Departments are only required to provide the information to the parent/guardian on one occasion after receipt of the initial report
- CGS Section 19a-110(e) Reporting Lead poisoning. Parental Notification. Availability of Information regarding lead poisoning.
    - **Establishes thresholds for requiring an on-site inspection conducted by the local health department for the purposes of identifying the lead source causing a child's elevated blood lead level and ordering remediation. The on-site is required to follow two venous blood lead levels taken at least 3 months apart. The thresholds are:**
        - Year 2023 --> BLL $\geq$ 10 mcg/dL < 15
        - Year 2024 --> BLL $\geq$ 5 mcg/dL < 10
        - This requirement is being phased out after 2024

Transcript

Lori Mathieu 0:00

Lead in schools and childcare centers reporting the results of the lead Tests and Tests and lead screening assessments to schools and childcare centers and health assessments for new students reporting additional data from a blood lead test laboratories and providers to the Department of Public Health and any other matters which and this is a phrase I like any other matters regarding lead poisoning prevention and treatment, which means that we can under these five items is a comprehensive list. Some of them are very pointed some in the last one it's very broad. So, our mission today is to walk through seas through the statutes that we had listed on the agenda and have a discussion. So, you there's 20 of you on and I would love it that all of you could turn your cameras on while we walk through this because I'd love seeing everyone's faces if you can that would be great. If you can't, that's fine too. But we want to have a group discussion. And there's a couple of points here, which I think are really very important items. Let's think about how to transition from being reactive to being proactive. I think we all recognize that the that the process needs some adjustment and change and to be more a modern approach where we're not utilizing children as the way to understand where we need to fix problems in our in our aging housing, but to be more proactive to think about how to do that, and what is important and also let's think about how we make sure that we are thinking about the child and the families while we while we think about these statutes so those are two things that I think are really very important DCA I was wondering if there's anything else you'd like to add to that while we start our launch into the statutes.

Heather Aaron 1:56

No, I think we should just jump right in. There's lots to do.

Lori Mathieu 1:59

Excellent, thank you. So, the previous statutes highlighted we heard last time from the State Department of Education, and we have the statutes listed there that clan had after the discussion had provided to us and we can list those in the chat with everybody to see those directly. And also, we can email those as well. And then a whole host of OECS, the Office of early childcare and a whole host of statutes that Laura had provided to us as well. So, thank you, Maura and clan for providing those statutory citations for us. And again, we can share all of those with you. So those are the previous but let's get right to slide to the next slide. And here's the list that I mentioned previously about the number of you know, it's not just three but there's quite a few statutes that are in our Department of Public Health statute book that that work on lead in within lead and the different recordings and the different levels of investigation. Also identifying educational program early diagnosis program, abatement of lead and drawings, and then testing and an assessment and then review the information and setup of regulations of recording of the poisoning prevention efforts that we that we undertake, and then

financial systems and then some OSHA standards and abatement we're not going to go through all of these today. So, let's go to the next slide. But we want to let you know the list of statutes that are that are contained within our statute book in the department of public health that we are responsible for. So, let's get right to one of the first statutes of the three that we would like to that are focused in within the statute book for public health, and that's 19 a 111 G sub A. And, again, this was repealed and but replace effective January one of 2023. And look to Lisa to help me with this. As well as I don't know Dan, if he can let me know when Claire comes on. I don't know if she's on this moment. So, this is that Yep. Okay. Okay, great. So, this establishes a schedule for screening and testing to be followed by the medical providers giving pediatric care. The pediatric medical provider shall comply with the following screening and testing in accordance with the advisory committee and childhood lead poisoning. prevention guidelines. So, you see the bullets they're dependent upon the age. Um, you see the testing requirements. Again, this goes back to the pediatric medical provider shall comply with the following screening and testing. And these are the age groups and this is the requirement that you see under those particular six bullets. And prior to testing the pediatric medical providers required to provide to the child's parents slash Guardian educational material, or guidance information containing lead poisoning and prevention prior to testing. The pediatric medical provider is required to provide information educational material, and guidance concerning lead poisoning prevention. So, any thoughts on any of this here? I know we've had some discussion, in particular about the ages and about testing, requirements of testing and then how to how does all of this start? Are we sure that this is happening in every situation in case is this you know, are there as a question mentioned early with beginning the word gap, are there gaps are there concerns here and also in your, in your experience? Are there things that you know about that in your experience and your work, things that we should change or modify from your opinion? And Lisa, if you want to add anything at any point

Lisa Kessler 6:35

Well, I just I think, what's already been brought out and looked at past meetings was this first criteria thing, the first requirement of testing from age nine to 35 months, and there were discussions about the first test being done but then there's never a second test. So, I guess if there is need for the two tests within that age range, then possibly there'd be we might want to think about different wording there. And also, I guess, medical risk assessment, that's something that I don't know if it needs to be defined if that's something different from screening because at one point, I think the statutes use two terms medical risk assessment and screening to imply that they're two different things. So those are some of the you know the things that I recall being brought up and needing attention, but, you know, this is the opportunity for everybody to weigh in. Let us know what needs to be done.

Lori Mathieu 7:45

Thank you, and does anyone have their hand up? Or you can just speak up? If you have a question? Go ahead, Amanda.

Amanda Decew 7:51

I think that as a practicing clinician, the wording of age nine to 35 months tested at least annually is confusing to me. We tend to think of my terms of quality measures and so forth. You know, the child likes zero to 12 months and then 12 months to 24 months, so far, 24 months to 36 months, and that's how I sort of think of it with life. So, I think that is confusing typically at our practice, we will test at one year of age and two year of age and sometimes 18 months as well as what we have added. So, I think that needs to be clarified. What we mean and then in terms of required to provide the child's parent guardian educational material, anticipatory guidance. I think that's great. I think we should be doing that. I don't think that is happening always. And I think that that's an excellent addition. We should be doing that prior to starting to test the child whenever we started last year.

Margret Flinter 9:10

so strong agreement with Amanda's comments, thank you.

Lori Mathieu 9:25

Yes.

Heather Aaron 9:26

So, I just wanted to add to to the comment related to the nine to 35 months in a lot of the literature we've been reading. There's the issue with pregnant moms. So, I'm asking the physicians if mom who's pregnant, you know, has lead poisoning or undetected can this call into the literature this can go to the child shouldn't be waiting nine months to do the testing. That's just that's a question.

Lori Mathieu 10:10

Is there so is there a need to test the child sooner?

Margret Flinter 10:16

I thought there was a separate recommendation for screening and pregnancy that was somewhere within the whole package. We were looking at it was I correct on that? I mean, did you remember that? Is there a separate recommendation? Separate from the pediatric piece? Is there a separate recommendation coming up for screening and pregnancy?

Lori Mathieu 10:39

Yeah, there is a separate statute.

Lisa Kessler 10:41

Yeah, their recommendation but there is nothing in statute. Now. I think there's there might be something about the commissioner setting guidelines with other advisory groups to you know, to set the standard but there's nothing now that has that hasn't quite. I see.

Margret Flinter 11:04

What might be when you get to that point. I would certainly be in favor of that as a recommendation. But it's outside of this one, I guess. That we're looking at

Lori Mathieu 11:22

DC Aaron, I think your point is,

Heather Aaron 11:26

Now my point has to do with the child. I'm still indicating that we have a newborn that may be affected and is the recommendation to wait to nine months. That's the question regardless of whether we have separated or done with the mom.

Lisa Kessler 11:45

So, there is this requirement H zero to 36 months medical risk assessment cloud providers determination. So that would, I guess then but the next step is once you do that assessment, then would you be required to test and I don't see anything here on the 72 months tested clinically indicated. So, it is there. So, if I guess the mother did have high blood levels during pregnancy, then the clinician would do a medical risk assessment zero to 36 months. And then this guideline about under 72 months tested clinically indicated. I think those two things would cover that situation. It might be better to have language that may be highlights, you know that's its situation where a mother has a high blood level when she's pregnant.

Heather Aaron 12:50

And so, I think it would be helpful if that were just more highlighted within the scope of what we have for the child. And again, these are just thoughts for us to process.

As we look at the Emily have done a lot of work, I'm looking at the housing, I'm looking where children are harmed, and the see moms with kids and then there's another kid that's coming. Obviously, they're

in that same housing process. If we go back to the source, then we would see that everybody is at risk and it's an ongoing issue. So, the two are very tied together. Sir,

Lori Mathieu 13:43

is there anyone out there now that has experience with this medical risk assessment and how does it work? Actually, in practice?

Is that Amanda

Amanda Decew 14:07

There is a risk assessment that's put out by the AAP specific question. So, depending on the practice, they may have that incorporated into their note template. We don't do the full risk assessment we do screen for social needs and some housing questions but I can be quite lengthy. So, I think it depends on the practice and how they wish to address it. Because what I would say if they just want to have establish those regular screening intervals instead or if they're screening based on the medical risk assessment.

Lisa Kessler 14:55

So is the medical risk assessment just civil more comprehensive type of screening

Amanda Decew 15:06

I can try that and look it up for you when discussing. Thank you

Lori Mathieu 15:19

it'd be good to have more detailed information on how it is in practice and what does that entail? And as you mentioned, Amanda that it could be dependent upon the particular individual practice I think that that is as DC Aaron mentioned, and no it's that it starts with a mom starts when the mind is expecting the child and making sure that the mom has information that that she needs to know that this is that this is a risk and a risk to not only her but her child. Make sure that the educational information is there and prepared and provided and not only just provided but provided in a way that you know there's a level of understanding about what next steps need to be taken to protect the mom's health and the child's health. And so educational you know having the educational information and, in many languages, and in providing the guidance is important. Is early and we all know early detection early information early education is important through this process. I think Amanda anything you could share would be would be wonderful.

Lisa Kessler 16:48

Also just want to point out that this is really the only statute that talks about obligations of providers. So, if there is anything else that you know, I know what these talks about the testing guidelines and providing the educational information but there might be other ideas about what providers could do. And so, this would be the place where we would probably add it so if anybody has additional ideas aside from these two elements, you know what needs to be added to the statutes regarding providers responsibilities, just replace.

Laura Fournier 17:27

I wondered if we need to talk about those testing but what kind of testing, I know there was some discussion previously about inverse sticks versus being as testing and maybe there's some times where we don't want just a finger stick not a medical professional. So, I don't know I'm just raising that I think

Margret Flinter 18:06

I think for probably I don't know about all practices and I actually was wondering the same thing but for a different reason. The clear way to recruit an office screening test, I think is probably the dominant mode of what's being done with follow up venous testing for any elevations. If you had some reason to consider somebody very high risk like their sibling just got diagnosed with lead poisoning, you would probably you wouldn't be really doing the screening at that point you would probably amended anything to a mean it's tough just because you wanted immediately to know what those levels were. For officers that don't even have a clear read test. You know, I if I could just add a parenthetical question about the practicalities of getting this done. Do we think that lead screening, if done in a lab is a 100% covered preventive service under the rules for health insurance plans these days? It's just thinking this can get burdensome for parents. At the level of doing it frequently, so just something to think about. Bigger to know for parents, but I think most practices are doing clear wave tests in the office. Amanda is that true for Yeah, and you want to get the answers right away to the parents if you can.

Amanda Decew 19:31

Yeah, exactly. I mean, what we find is that if we're sending them to their lab, you know, like most people, they might just keep throwing the

Margret Flinter 19:40

exam room in the lab a lot can get lost

Heather Aaron 19:47

all the reimbursement is certainly something that we can bring to BSS. So, I know that question. I get regulatory interested in making sure that whatever reimbursement barriers they were that they will be addressed. So, it's a question that we can follow up on. Certainly, regarding the reimbursement for the test,

Margret Flinter 20:09

it may the venous ones may be covered for any plans because of the ACA but not everybody has one of those plans

Sue Dubb 20:21

and I just raise a point at Sue from Uncas. I've had several instances with capillary screaming in the offices, particularly with the lead care to machines, where we've had ridiculously elevated capillary levels reported to us only to find out that the venous follow up was literally less than three. So, I think there needs to be a real education piece of this for the people that are performing the lead care to testing there's a very specific protocol, including washing the child's hands before the test is done, which oftentimes when I enquire with parents, they're telling me that the nurse just wipes the child's finger or whoever does the test. Just wipe the child's finger with an alcohol wipe and that's not sufficient to move any lead off their fingers and I think that's why we get a lot of falsely elevated capillary levels. But when you get an elevated level, you're obligated to do something right away. And it's just a frankly, I'm a very busy person. And if I have to suddenly stop what I'm doing to investigate a capillary level of 22, that in reality is abusive to it's frustrating because it's a lot of work for I'm always happy that it's all for the child and the parent. But on our end when we're already kind of pushed to the limit. It's very frustrating. So there needs to be I guess, a more stringent education program for that screening process. Thank you.

Lori Mathieu 22:05

Good Comment.

Margret Flinter 22:09

Yes, good. Word for DPH to look at on their site visits to license practices and things to make sure they've got a really good policy and training protocol in place. Ebony

Ebony Jackson-Shaheed 22:26

I just have a quick question about CGS section at the bottom where it says allows for a religious exemption. I know I came out a little bit late but if someone could just explain that to me.

Sachin Patel 22:45

It allows let me just look at the language. exact wording. requirements of this section

Lisa Kessler 22:57

do not apply to any child whose parents or guardians object to blood testing as being in conflict with the religious tenants in practice.

Ebony Jackson-Shaheed 23:07

Okay, so as they, as they have some sort of a religion that says that they can't be tested and then we can't we can't do any lead testing.

Sachin Patel 23:24

Guess that would be exempt.

Ebony Jackson-Shaheed 23:29

I mean, the only reason why I'm asking about that is because you know how with the immunizations now in schools, there's no religious exemption for, you know, immunizations in schools and since this is like a preventative, you know, measure. I just don't understand why why there's a religious exemption. I mean, because it could, it could essentially let us know, you know, if a child is in danger, right. It's not like we're adding anything. We're not giving, you know, the child of any type of vaccination or giving them I mean, I just, I don't know, I think that one is, especially for our community, you know, as diverse as Bridgeport. We do have a lot of different religious communities, and sometimes that just becomes a default. Like, okay, well, it's against our religion to do you know, COVID vaccinations just against our, actually, it got so bad, you know, that. I know, for the Muslim community. I'm actually one of the like the high priests or the chefs from Saudi Arabia actually released something to the world, you know, worldwide during the pandemic, saying that it is not against all religions to take the vaccination, because that population has certain continents and countries were literally dying, because they thought that it was against our religion to take a vaccination. And so, I don't know, I just, I think that maybe that should really just be really thought because we don't do it for schools. And this has to do predominantly with children. So, I don't know I just feel like there may be a portion of the community that may opt out of it completely and just say, well, it's against my religion, and then we have children that may be damaged for life because of a preventative measure.

Lisa Kessler 25:21

Understand and we know it is based on an objection to blood testing and know if anybody we have so if it's there does allow that opt out. So, I guess maybe that's something that needs to be considered.

Lori Mathieu 25:41

Something clarify, it appears this reading the statute or the history it looks like that had been in the law for a while it's not new, it's not new that had been there

Claire Botnick 25:54

I think it's a great comment nd something to be really aware of, particularly in the current environment. I imagine that like political fleet feasibility of changing it through the legislature at this time would be a real I'm just getting just speaking in sort of real politics terms about what we would be able to do in this upcoming session. But I think that it's very, very important for us to note it in the report, so that we have a record of what challenges this poses for our local health departments. And I think we should definitely, you know, explore this topic. More I just, I think that if we were going to do something through the public health committee, I can only imagine that raising this would bring all kinds of attention to the changes that we would like to make substantively to the law at this time. And not just you know, of course, I think we all know the realities of what it means to work through the legislature. But I definitely think it's important to detail those real issues of like on the ground in our report, and of course, as a group, we can consider whether it would be appropriate to take any action on it. So, I thank you very much for raising it because it's obviously a critically important issue.

Amanda Decew 27:28

I'm not sure if this is the right time to raise this suggestion, but since we're talking about screening, I think it would be important for the federally qualified community health centers. We receive a Connecticut Husky Medicaid annual report on our quality measures, and that quality measure on lead does not match what is currently the state's recommendation of two tests before the age of three are these recommendations and so I think it's hard it was hard in my role as Director of Clinical Quality to advocate for more programs, more population health efforts. When it looked like we were doing exceedingly well on lead quality measurement.

Claire Botnick 28:15

That's a great point. And just as a reminder, this includes a slight change that we made to test children annually who are at an elevated risk so that will take effect this year going forward. So, for the pieces of the statute, that worksheets in the last session, you'll see that it says repealed and replaced effective January 1 2023 on the slide. So hopefully the change will help you aid you in your effort but also, I think that you're totally right and Lori and DC Aaron have kind of raised this repeatedly, which is that our Husky number looks very, very good. But doesn't explain why we still have such high caseload we must be missing kids. Right. So, I would be very open to hearing, you know, suggestions on how to kind of

increase the through the changes to the statute. Increase the catchment of children to make sure that we're actually living those numbers and that those numbers aren't just kind of a part of the system for lack of a better way of saying and that's one of the reasons why I love the idea based on clams, presentation of trying to use time entry into early childhood or for kindergarten as another opportunity to test kiddos. And, you know, I think we should just think creatively about you know, what the other opportunities are so that we could consider if we could make any additional additions

Lori Mathieu 30:05

So, I know it's a shame. I know that you had mentioned on on the text that maybe we should turn our cameras off because the bandwidth so she knows you all.

Dan Aubin 30:30

Lori, I think it was actually me who had mentioned that I'm getting a lot of interference today with driving the presentation. I think it's because the camera load depends on doing so.

Lori Mathieu 30:51

So Sachin is this better.

Sachin Patel 30:53

It should be good. I don't have any issue.

Lori Mathieu 30:59

I just I just lost the last few minutes of I just heard. I think what Claire was saying I didn't capture everything.

Sachin Patel 31:09

So, there's something wrong with the department.

Lori Mathieu 31:14

Okay so maybe we'll go to people raising their hands possibly. I usually like seeing everybody on their webcams. But maybe we should. Or we could put items in the chat. And then you could help and assist with that, if possible.

Dan Aubin 31:40

We could do that Laurie or if anyone has a question, maybe they could just turn on their camera and those who are silent or don't have a question could just keep theirs off. Maybe that would be the signal.

Lori Mathieu 31:50

Yeah, why don't we Why don't we do that? Why don't we do that? So, people have because I think you know, to Clare's point, one thing that we've talked about it very highest level is making sure that we're reaching all parents, all expecting moms. At a time when it's important to do these laws cover that as well as cover each child and that we are not missing a child that that he serves screening to make sure that our statutes like your SP those items, because they are concerned that children might be might be this or these leads are not happening for all of our kids. So is there is there anything else that people would like to raise on the screening anything else education materials, anything further about trying to you know, fill the gap on making sure it's screening happenings, making sure that the information is being provided. And what how the statute could be written to, you know, to make sure that that phrase follows through, maybe there's items that the department needs to do more on to make sure that materials are provided. Maybe there needs to be more. I think there needs to be more consistent education for all people, including the practitioners in providing information because everyone's quite busy, but to make sure that all of these items that we're talking about that are very important to you know at the start of this process is is how that starts and catching the children and the moms early in the process is very important.

Chloe-Anne Bobrowski 33:58

For you can I make a comment? It's Chloe. I wanted to just echo what Claire had mentioned before about making sure that we have some sort of documentation on a child who's entering kindergarten. I know in previous workgroups we've talked about how sometimes we don't have a history of children that have been tested or screened for lead. If they've moved in, they you know, just don't have that information but to make sure that there's at least maybe addressing the time when they come to school for the first time. Even though the five that we make sure that we do have that screening available and on the health assessment that's provided to the school. I don't know if we could you know, just have that so that is addressed. And we're not missing an opportunity to have a screening result on a tile that may or may not have been screened previously or they haven't we just don't have the results.

Lori Mathieu 35:02

Yes. Good Points. And Laura on the for the for OEC. And in your within your statutes is their produce speak to any particular requirements for the younger children in the childcare,

Laura Fournier 35:31

it is on the health screening. You know the medical form but it's not something that's specific in our regulations that has to be filled in so it's not a violation if it's blank. If that helps. No, that's

Lori Mathieu 35:48

No that's good to know.

Lisa Kessler 35:56

Sorry, this school board can require it but I think it's you know, at the discretion of the school medical adviser and the school board, so it can vary from you know, the different school districts

Chloe-Anne Bobrowski 36:11

and I can tell you from the State Health Assessment forms that are provided to early childhood, they are as strict as being mandated to be got it there has to have documentation, but on the blue form which is still being submitted to the schools when their child enters kindergarten. It is not an asterix section so I think having that to be Asterix, which means it's mandated to have some kind of result would make a difference. Thank you. I think it would,

Lori Mathieu 36:49

I think that's a great comment and tightening up those processes and making sure the statutes are connected

Lori Mathieu 37:06

exactly what the commissioner spoke of identifying the gaps Claire,

Claire Botnick 37:12

I just wanted to add a recall Doctor making this comment previously about you know, if we add in five-year-old screening, we wouldn't necessarily put insights and tips when it happened in the preceding years. And so, I like the idea that this kind of responds to do that by making it more trackable right would hopefully be touching that one, too. Then upon entry entry into early childhood and then finally again in kindergarten, which I think is an improvement from where we are Dr. Hale, I don't know if I've categorized stuff. That comment from a few weeks back, but it didn't stick in my head.

Dr. Jennifer Haile 37:54

Yeah, no. Yeah, it was more of it. And I can clearly see where someone had said it earlier this morning. And I apologize. I was late at a meeting prior to this. But yeah, the idea that you know, sometimes the multiple pediatricians prior to prior to the physicians completing their school form, and you might not have those records, or that lead level, so you know, it's hardly if it's available, obviously be completed. But if we don't, yes, the statute is Isn't that one between 36 and 72. But I think that's where a lot of practices don't realize that statute and that would catch those tips

Lori Mathieu 38:48

thank you Dr. Haile.

Margret Flinter 38:49

We supposed to be raising our hands going on camera the

Lori Mathieu 38:56

camera on and to go ahead Margret if you'd like, you know, the

Margret Flinter 39:01

this thing of having the information from previous visits is such an important issue and I believe and get on and correct me. If I'm wrong, it is the sort of the downside of doing the in office screening test right we may get the procedure code that we did a lead screen but we don't actually know the result from the in-house clear wave test. I'm thinking about Connie and the new system that's going to let us look things up and get the results of labs and pharmacies which is so exciting. I think really looking forward to that. But I think that's the downside of the in house testing that we just have to recognize. And Amanda and Jen correct me if I'm wrong, but I don't think we get the clear wave tests that it was done and result on the on the feeds like Connie was tiny but

Claire Botnick 40:01

I needed I mean, it's it's it is to be reported to the state auditor capillary levels are reported to the state or they're supposed to be by your office. So, and that will happen to it does go into the lead Maven reportable lead data and I don't know much about Connie and animals that were both connect to get that data, but the capillary tests are reported to this state by offices. So those are everything is there. Not a concern, but am I good?

Amanda Decew 40:35

I just wanted to follow up on a point you made earlier and I think I misunderstood misspoke. At some of our sites we use the clear wave in other sites we actually go through quest is still a point of care test. But I do think it is a huge problem. For us the cost and the fact that you know, the point of care testing is quite costly. And that has prevented us expanding our screening intervals at one site where we don't have quest is able to process on site. And it's a very large pediatric site in New Haven our largest so I think we made $2 or

Margret Flinter 41:11

something like that per

Amanda Decew 41:13

expensive

Margret Flinter 41:16

Thank you, Amanda, for raising that. We just we just do it but as you know, in the FQHCs we can't build any anything additional. It's just the flat rate. So that's a 15 off the off the visit reimbursement internally. thank you

Sue Dubb 41:32

Lori, I was just going to mention that there's definitely I noticed at the local level a gap between you know, I usually get the first year the second-year result, but often times I don't get another result on a child until they're in kindergarten. So, these kids kind of go on the missing list. And I've tried working with you know, at least the federal daycares like early head start. This this child enrolled in your program; I need to get in touch with the parents because I do notice that there's a lot of moving of families, they kind of go from address to address so I get the letters returned to me but no follow up address. And oftentimes, as has been mentioned earlier, they're changing providers as well. So, I usually lose track of people somewhere between age two and five. And once they register for the school system, then I have another opportunity to kind of reach out to these families. But that that gap in between would be really helpful because we are directly notified of the results through the Maven system and might be able to at least get updated information about where the families living in who the most recent provider has been. So

Lori Mathieu 42:59

I think again, as we mentioned at the at the onset, you know, following the child, following the child isn't to your point is really very important to having the information not only for you know for the child for the childcare that that that child is going to be in but once the child is in school as well, so really very important to keep track and have the information in the system.

Claire Botnick 43:26

I just wanted to circle back to the FQHC comment about expense and make sure that I understood that so or is that an expense that's not reimbursable under husky?

Margret Flinter 43:42

Sorry, correct, because it's the all-inclusive rate for F Tracy's one rate period. No matter what you do or what expenses you incur in the course of providing defense. It's so it's significant. We do it, but it's just no thanks. Got it.

Claire Botnick 44:02

Amanda, you want to add anything to that?

Amanda Decew 44:06

No Did I said like we have a large pediatric practice in New Haven. And at one site we do not have labs on site. And so, as I said that has prevented us from expanding our screening interval as we talk about the screening intervals at that site because the cost is so high. And so, what are other sites? I think we scraped were able to screen more point of care testing in those sites because of that, and I think we need to note that and it should be addressed.

Claire Botnick 44:42

Okay, thanks for raising, I just want to make sure I understood.

Lori Mathieu 44:45

Thank you, Dr. Haile, and you had your hand up.

Dr. Jennifer Haile 44:48

Yeah, I just I just wanted to add to kind of piggyback off of what what Sue was saying and kind of just capillary versus Venus piece is. I think we've talked about, you know, the screening of one versus the

screening and who's getting the first I mean, according to the 2020 data we are, you know, 100% of the kids have gotten one screen, which is crazy. That's awesome. But only 53 has gotten both. And I think we're talking about kind of two different populations. And we're talking about the population that keeps moving and we can't, you know, we can't get our pulse on that. But we're also talking about the population of families that are in more of a private practice setting that just don't want to bring their kids for the bloodwork again right. So, you have a capillary, you have a you have a capillary in your office, those offices, the screening rates are great. If you're telling the families and ordering their lead levels and sending them to the lab. They're not going. So, we just recently moved sites we're having that problem. Patients are walking right past the lab because they don't want to get, they don't want to stick their child again. And so, a lot of this is back to what we talked about. The original one is I think a big piece of this is education, right? Because, you know, a pediatrician can do everything correct to try to follow these statutes and they're required to do this better than the other but if the family doesn't understand the importance, and there's 1000 Things you need to track a lot of that well child visit, they're not going to go and so, you know, it's hard to say you know, again, as you know, I just think this is an important part I think educating the families and especially not focusing on and it's certainly nice when I finally we work in that same population that Hartford that I was, but I think we're also we would be remiss to not talk about the rest of the state that we're I think the reason why our screenings are so low is it's those private practices and not at any fault of the pediatricians. But, you know, we're leaving the office to the lab slip and you don't want to hear your kid cry because they're too now they're harder to hold one that's easy, too. And there, you've done that and you don't want to do it again and I hear it all the time. So, I think you know, somehow getting that education piece to families and not going to spare them but I want to educate them and I think that's something we need to focus on. And that's, I think, one of the biggest barriers to that second screen and in general, the, the screening rates and it's that at VSP, so we're lucky if you can get a capillary but if you can't, you know, it's really hard and the percent

Lori Mathieu 47:28

so how do you think that you know, I know bringing my children and doing that well visit was really very important. You always wanted to go take care and make sure you did everything, and they made sure that they the vaccines, they brought the vaccines into the office, and that was scary, right for the children and if the screenings can happen right there and then I think that that's important instead of going to the lab because you're busy or bringing children all over the place and they're already screaming, especially if you have more than one. Right. So what would you say is the best? Or one of the solutions that you could think of?

Dr. Jennifer Haile 48:10

I don't think there's one solution. The problem is is that it you know, I think it's just that education piece. I mean, you can't require any family to do this, you know, but, and again, the amount of information that needs to be covered during you know, visits with your pediatrician are very long.

But, you know, again, in an educational campaign something you know, that's going to reach parents not in the context necessary in addition to the context of the well child visit. He doesn't mean there I can't tell you what to do. Let me so many people who talk about letting know that so exists, it's a yes, yes, it does. People just don't know and don't understand why. And they just see it as well. Again, like you said, my kid isn't lying. I don't want to bring them unless not a big deal anymore. So, I think that to me, is the piece is just getting that education who's out there as it lead is not gone. It is not going anywhere, unfortunately, and we need to protect our children and these are reasons why. Because I think a lot of it falls on that and you know, like I said if they don't go, they don't go and it's you know, it's frustrating from a statistical standpoint when you see those numbers but a lot of it's not the pediatricians, I won't say all of it because there are some pediatricians who don't believe in it and don't report on the levels and that's fine. But, you know, a lot of that is going to fall on the families and the parents. So somehow finding a way to get them and like I said, not necessarily to scare them, but it's a big deal, and they don't think it is and that's really hard. Frustrating.

Lori Mathieu 49:54

So, I know that it is it is so that that is a significant gap. To thank you for that. I know that Jessica has had an item and just kind of want to speak, if you can. Or Dan who can help me with her question. Particular Can you hear me?

Sachin Patel 50:22

On your laptop,

Jessica Kristi 50:26

sorry, I'm having a lot of tech issues today. Is that better? Yes. Okay. And this kind of ties into what we were just talking about, you know that the education component is really, really important. Both for our providers, but also for our parents. And what I put in the comment was that, you know, these education materials really need to be standardized, and they need to be consistent because we know that material is created all the time that scratches the surface, some is really comprehensive, but we need to make sure that we're providing consistent materials throughout and that we're really emphasizing the why so that that loop is closed and if we really emphasize the why and I think someone said it earlier, not as a scare tactic, but really, to get the point across it was really important for the child safety. I think that can can make a difference, but it's going to take some standardization and I think on both ends of the spectrum for you know, in our last presentation we heard about some providers may be not as proactive with, you know, testing or education. So, we want to make sure that we're consistent across the board but that especially those parents or guardians are getting a really kind of emphasis on the need and the importance of following up and if it was possible to do that screening at the Wellchild you know, instead of referring out, I think that's amazing, you know, making things more efficient and easier. is, you know, the goal but coming from a non-provider viewpoint. I know that's easier said than done. So, I just wanted to throw that in that from a public health standpoint, is that education is being done. I'm sure

we would love to be looped in on that as well. So that we can make sure that we know what exactly the providers are being educated on and then what is given to those parents up front and how we can re-emphasize those points when we're communicating with our constituents. Thank you

Lori Mathieu 52:51

Thank you, Jessica. Sorry, I muted myself. I never do that. Dr. Haile, you turn your camera like the Yeah, no, I

Dr. Jennifer Haile 52:58

just I agree with that comment. And I think you know, not to be so the amount of information that you take home from a well child visit is a stack of paper that no family actually reads because it's 25 pages of like, don't forget to you know, childproof your home and use your vaccine you know, and that's why I just I feel like we need to figure out a different way to educate these families. Like I said, I mean, anyone who has kids knows we go to those visits, and it's like a bombardment of information and you only listen to, you know, and you only absorb like half of it. And you just say you're going to give them I agree needs to be sneezed to be standardized. 100% But, you know, to, you know, to give them an additional piece of paper, they're not going to read it and that's why I just I'm at a loss for suggestion, but to find a different way to communicate and educate these parents,

Jessica Kristi 54:01

what about starting in prenatal care, so you're not waiting for that wild child visit or you know, once the child was born, but you start that education, education during pregnancy. So, it's already in the backburner. You know, getting the mother thinking about that, knowing that it's coming, anticipating that more information or screenings or testings may occur, once the child is born, I don't I don't know. I'm not a mother myself. So, I haven't gone through prenatal or maternal care, so I don't know if those conversations are happening in prenatal.

Sue Dubb 54:41

If I can add to that. One of the things that we were doing before the pandemic happened was these community showers if you will, and the hospital Baptist Hospital here in Norwich, with bringing in different vendors from our area that provide services for pregnancy and delivery. And one of the things that I always brought with me was number one of the TDR programs are completing, but also information about lead poisoning and reminding parents that I know you've got a lot on your plate right now and you know, things are going to happen very quickly. But I want you to keep this really important thing in the back of your mind. You know, think about the house that you're living in right now. And I kind of talked about the risk factors in furniture hands, you know, handed down are you living in an older home that you're renovating? All of those kinds of things that place them at greater risk, so that at least I planted the seed. But I think the other piece that Dr. Hale had mentioned about having somebody

at the table here from OB to kind of have their say in what they're doing, because just like a pediatrician, there's a lot of information that gets thrown at pregnant women as well. To kind of process and think through and try to prioritize, but I think early in the pregnancy, we're doing that with the oldies and then as they're approaching their delivery time. We can have the conversation with them about thinking about as your child is young and different things resources available. They at least think oh my gosh, if the subject of blood comes up, I can call my pediatrician or I can call my local health department so that they at least know where to go to get the information when they're suddenly told oh my goodness, I never even thought about this. I just got a call from a family parent who bought a house two months ago and she just got a lead level back from her child and she had no idea. She said I didn't know the questions to ask they sweet talk me into buying the house. It was such a good deal and now my child is poisoned. And I'm stuck with a house because with the homeowners she has to do with eight-month process so he's about education about buyer beware for the parents that are trying to find a good home for their children. And then suddenly in this situation. There are so many things to consider in that educational piece early on.

Lori Mathieu 57:26

Thank you Sue much your hands up. So, Aisling and Margaret.

Aisling McGuckin 57:33

Thank you. Good morning, everybody. I so I'm a maternal and child health care expert training and when I worked in Texas, managing is about calorie reduction program. We invested really heavily in the text for baby program, which is a free, a free program that parents can sign up for during pregnancy. It's actually we enter your baby's expected due date and you get messages that are timed to the stage that you are in pregnancy all the way through. I believe the baby's second birthday now and the messages include the service provider and so we as the state of Texas, were able to include the mother receives the parents receive two messages a week and an optional third message. Third messages can be anything from emergency preparedness. To issues that are going to come up later. So, if, you know if the state of Connecticut invested in, you know, contract with which is just an MLA with text for baby, parents could sign up for that and the third message could be specific specifically about lead and introducing that at a stage early in the pregnancy and then prove the baby's development so that there's regular reminders and it's targeted. We can craft those messages yourself. I just it's there's a website that goes we did into Russian Spanish. It's a very good tool. It used to be there used to be a public funding component to it and I'm not sure if that still exists, but it is still a service and if the state of Connecticut was promoting it universally, and then doing I mean, this is something I think I've mentioned before that all of this increased emphasis have led and parents that are going to be getting these letters from their local health department saying your child had positive led tests and not have the contextual information to interpret how serious is this? You know, there's some parents who are going to be like, Yeah, another piece of junk mail. There are other parents at the other end of the spectrum that are going to be like freaking out. And the more we do to proactively inform parents to a public awareness campaign, leading up to the implementation of those changes in guidelines. I think it will save us. It will save us a lot of phone calls from parents and future, but also help parents again, be informed

participants in their own health care. And not receivers of health care handed down to them. Thank you. I dropped the link in the chat so

Lori Mathieu 1:00:25

I'm just going to ask. Thank you. Very good. Margaret. You're next and then Dr. Haile.

Margret Flinter 1:00:31

big fan of text for baby. So, appreciate that. But I think what I wanted to ask was in the sort of appropriation around the love word, if there's funding for any marketing, PSA advertising, because I don't think it should be. Ideally not just the mom who gets this message. It's perfectly fine with me if it's brother in law's sister, Father, whatever. The level of awareness I think is really down over where it might have been years ago and whether it's the size of buses, Spanish English radio stations, public service announcements, any way that DPH could contribute to yes lead is still a problem and we can reverse the damage. So let us you know, well maybe you don't want to do that too scary but we need we've got to do the screening. Something that gets that message across will be really helpful.

Lori Mathieu 1:01:26

And I think you know, in in our business here there's, we certainly can take more DPH more proactive approach on a consistent basis. All of you to think about you'll see the homework at the end on view to think about what you all could do in your areas because I think it's blanketing this information toward a single point, maybe a webpage so that parents can take a look at this information on a consistent and I think that comment about education, consistent education across all of our spectrums is really very important to you know not not confuse people about what this actually is and define it for parents so that parents have and guardians and everyone have an understanding of what we're talking about in plain language. Dr. Haile

Dr. Jennifer Haile 1:02:20

it was common just make me

Lisa Kessler 1:12:28

The lab identifier. And then Subsection C is a is just some guidance when the testing is referred to another lab and who is responsible for the reporting. And then the following section is the local health director's responsibilities, which

Lori Mathieu 1:12:55

Oh, they all go to the next slide. So that's to your point, that's D.

Lisa Kessler 1:13:00

And the reason why I'm kind of hurrying through everything is because I think that this is probably the most important right now. I think this is one of the more problematic sections. So, and this I don't know Laurie if you want to take over.

Lori Mathieu 1:13:17

Sure. Or Claire, I know you turn your camera on. If you want to speak on this or we just walked through it.

Claire Botnick 1:13:25

I was just going to add for B and A B and see if folks could help us to identify if there are any off ramps and that those sections, especially maybe as a follow up to this call that you've observed in your practice, then it would be I think really helpful just in terms of helping the group to think about ways to tighten reporting

Lori Mathieu 1:13:51

as well. So, I just don't want that to get lost in the conference. Player. I know in our hustle for this a in particular, you know making efforts to get the information to the parent guardian of an elevated result is really important. But what it talks about their it says reasonable efforts, some people could take liberty and what reasonable efforts actually means. So, sort of tightening, tightening that up as Claire mentioned and some of the gaps that you all see and maybe in B and C but going back to where we are here on the on the reporting of blood red lead results in parental notification really very important responsibilities of local health department. So, I see that Sue has turned her camera on, Sue if you'd like to speak.

Sue Dubb 1:14:35

So, one of the things that I have come across, thankfully not on a frequent basis, but from time to time. There is a delay in reporting from the physician office to our office. And the excuse that I'm given is that from the nurse, while we're not allowed to send lab results anywhere without the doctor signing off on it. Well, this was a child that had a lead level of venous level of 23. And it sat on a doctor's office on their desk for eight days. Because they had been signed off. So, I think there's education with the nursing staff, medical assistants, whoever is I guess receiving those reports and kind of getting ready to give to the provider. Maybe there needs to be a little bit more education around triaging reports for lack of a better term but you know, I certainly educated on the spot when you see a lead level of 23 You need to

walk that into the doctor and have them sign it and then send it to me immediately. Because if that's an internal procedure that they have, they have to understand that there's going to be exceptions to waiting till the doctor signs if they need to recognize it themselves as being something that needs to be acted on immediately.

Lisa Kessler 1:16:00

Can I just have clarification so the results were from they weren't coming from a lab. This lab is supposed to be reporting directly to the local health director.

Sue Dubb 1:16:12

Nope. It was a quest report that we were told when it goes when it gets reported to the state. It's considered also reported to the local level. And so, the paper copy of it showed up eight days and I got the paper copy I looked in Maven, it wasn't there. And so, I called the doctor's office and said, what's going on? Like, why do I have a report of 23 and it was collected eight days ago, and I'm just finding out about it now. So, like I said those incidences are rare, but they do happen. And I'm not sure I don't get any paper reports now of lab reports unless the doctor's office faxes or something, because they're all electronically reported into me.

Lisa Kessler 1:17:03

Okay, and there's no alerts the system doesn't have like an ability to alert well.

Sue Dubb 1:17:10

I don't get any direct alert so many labs. Thank you so welcome.

Lori Mathieu 1:17:23

I think that is sure that there is in the reporting and all the hands that this needs to move forward through the need for as Sue mentioned, the need for urgency when the child is found at a certain level and following through all of the pieces and parts about reporting to the local health reporting to to the Department of Health, moving those results quickly through the process, but it also goes along hand in hand with the educational piece and knowing what those results are but also educating the parents and guardians about the importance of moving forward quickly when there is an elevated blood level. So, I we are at 1025 So we have five minutes. I know that we are on D but there's a there's another course there is there's another sub division of this particular statute. Let's move on to that. So, slide 11, please, which is E and this is reporting of lead poisoning results parental notification availability of information regarding lead poisoning, establishing thresholds or requiring an onsite inspection. Now, this is where it goes from, from we're going from the screening and the education early on to you know what you're

finding to how you report it and who you report it to how quickly you can move that information and provide all the education around all of that now the trigger is the requiring an on-site inspection to be conducted by local health departments. So, you can tell that how important it is the timing is important here. And there seems to be a lot of items where we could help through the whole system. Make sure that when we get to this level and the need for onsite inspection is important and to be conducted by the local health department for the purposes of identifying the lead source causing a child's elevated blood level and ordering remediation. The on-site inspection is required following to venous blood lead levels taken at least three months apart. And there are the thresholds of the years and what the law has been changed and adjusted due to you know the public act passed this of this May. And again, this this is being phased out after the year 2024. So, you see that if if all of the information doesn't flow through the system in a timely manner, and you don't have the two venous blood levels take at least three months apart. Certain things do not happen in this particular statute. So, if there are many gaps in the information and the flow of information, you cannot get to this point in a timely fashion or it may be if ever, so if there's anybody, I know that we have three minutes left, and we walk through these, not walk but I feel like we ran through these very important statutes and all these subdivisions very quickly. So, I see Ebony.

Ebony Jackson-Shaheed 1:20:25

Yeah, I just had a quick question. The last sentence where it says this, this requirement is being phased out after 2024. Can you just explain that a little bit to me? What do they mean by that?

Lori Mathieu 1:20:38

So, in the statute change I believe that is what was added last.

Claire Botnick 1:20:49

It was me today muted. We did a bunch of investigating into how the epidemiological versus onsite inspections were being handled and our learnings were that many of the departments or experts in this space had different viewpoints on what was required for each and we had a lot of difficulty zeroing in on what those differences were. So, we collapsed the category of environmental investigation after 2024 but we wanted to give Eclipse time to adapt to the new change. So, there will just be one type of investigation that's required going forward some people said that onsite investigation was the more rigorous investigation. Others said that environmental investigation was the more rigorous so there was it just seemed like there was a lot of confusion was the feedback that we got from the field when we spoke to folks across the state.

Ebony Jackson-Shaheed 1:21:54

Okay, thank you.

Lori Mathieu 1:21:58

I think that's an important point and one that we wanted to point out here now we have about a minute and a half. Let's go to the last slide where we wanted to, I know we're going to skip over some of our other slides about process flow. We can come back to that at our next gathering. But if we go down to the end where we would like for all of you were asking your assistance and I noticed there's barely a very small text but so the idea here, Claire and Lisa and Dan is to ask all of you for your potential suggestions based on what you heard today. And all the great ideas that we you brought forward about your experiences, knowing you know what we walked through or sort of ran through the last pieces and went yeah, we can bring this back again and spend more time if we need to, but let's get started by you all, looking at the statute, knowing what we walked through today and what you all brought to the table and giving us your potential suggestions or identified ideas and practices that we should change the least if you wanted to.

Lisa Kessler 1:23:18

Yeah, no, that's, I think, explanation just you know, we this is the report needs to focus on statutory changes. So, anything that you think that you know, will help with, you know, prevention or the guidelines as far as anything here that should be noted as potential statutory change. If you could just review and include that that would be very helpful.

Lori Mathieu 1:23:50

And I know that we spend a lot of time on education and process in practice and in reporting and parental notification, I would love to get your input and your insight. So, when that I know that it's 1031 and I know that I believe that Deputy Commissioner had there Aaron is on and we could close out and say a few words.

Heather Aaron 1:24:20

So, this has been an excellent discussion. I am looking forward to see what everyone responds to on this package that we're going to send out to you. It is very important for us to have your input so that this is a collaborative process and the statutes become yours, and not something that we have designed so we really want to get your input and we thank you so much for the time and the interest and the enthusiasm. So back to you.

Dan Aubin 1:24:57

Are you muted?

Lori Mathieu 1:25:01

I never mute myself so sorry. Isn't Thank you. Thank you, Deputy Commissioner Aaron. As a reminder, our next meeting our sixth meeting is Wednesday, November 2 at 930 to 11. We will continue on but we really want to hear from you as DC Aaron mentioned, it really is important that we get your input your ideas, your ideas about the gaps, and that you've heard today we've discussed today. Today was a very meaningful discussion. I really appreciate all of these thoughts. And again, when we come back together on November 2 that we continue on with this discussion and bring your thoughts to the table and we'll send this chart out and Dan, that will be sent out today. I believe we'll get it out to all the working group members. So, with that, have a great rest of your day and have a great rest of your Friday and a great weekend. So, thank you very much for being on I appreciate it very much. Take care everyone.

Lisa Kessler 1:25:59

Very good meeting. Thank you so much. Bye. Thank you, everybody. Bye. Thanks, everyone. Thank you