Governor Lamont's Lead Poisoning Prevention Initiative

Lead Work Group Meeting 11/2/2022

In Attendance:

- DCA (DPH)
- Lori Mathieu (DPH)
- Laura Fournier
- Howard Smith
- Patrick McCormack
- Chloe-Anne Bobrowski
- Daniel Aubin (DPH)
- Chris Corcoran
- Michael Santoro
- Rep. Jonathan Steinberg
- Owen Rood
- Margaret Flinter (CHC)
- Jennifer T. Haile (Pediatrician)
- Aisling McGuckin
- Ebony Jackson-shaheed
- Rafael Ramos – New Haven Health
- Amanda Decew
- Katharine Berdy

Note Takers:

- Chris Silver
- Olivia Hine
- Jesus Blanco-Vazquez

Lori Mathieu:

Dr. Erin Nozetz

- Challenges
    - Test is being ordered but is not being follow up on
- Possible Solution
    - Point of Care Testing for all

Venous Level of 3.5 or >

- Challenges
    - Having Multiple responsible parties

    - What if a Family cannot be reached?
    - Educational materials, inspection, abatement
    - Landlords
    - Contractors (Trained)
    - Section 8 Housing
- Possible Solutions
    - Team of Inspectors and Lead Outreach Workers
    - Training programs (tiered) for abatement work
    - Landlord representation with good understanding of the law and the ability to enforce it
    - Partner with LCI/Healthy
    - Homes to ensure subsidized housing is
    - Standardized form that inspectors complete, families keep a copy that goes over where the lead is located, next best steps, how to clean and keep children safe

Lead Level Reported out on the school form

- Challenge
    - Does this get looked at and incorporated into a child's educational plan?
    - Do teachers understand the impact of lead on learning and development?
- Possible Solution
    - For all children requiring a PPT/IEP/504/Extra Help, Lead toxicity history must be included in their report
    - Teacher Trainings

Pregnant Women

- Challenges
    - Screening is not happening at all or consistently
    - Follow-through once Mother gives birth for the dyad
- Possible Solution
    - Start Screening State-wide with ACOG questions
    - Community Health Program to FU once infant is born

Old Housing Stock

- Challenges
    - Landlord vs home-owner vs subsidized housing
    - Lead on the inside, the outside, and the soil
    - Cost of Abatement
    - Grant work comes with string attached
    - High turnover of rental property ownership
    - Renting to new families without repercussion
- Possible Solutions

    - Mandatory and routine dust wipes

Chelation

- Challenges
    - Where does a family live during and after chelation?
    - Medication and adherence
    - Inspection needs to happen within days with close follow-up
    - Close developmental follow (B to 3)
- Possible Solutions
    - Lead Safe house
    - Ronald McDonald House
    - VNA and Town Partnership/communication with them
    - Pediatrician follow-up (imperative)

CGS Section 19a-111

- Establishes thresholds for requiring the LHD to conduct an epidemiological investigation for the purposes of identifying the Lead source causing a person's elevated BLL and ordering remediation. The epidemiological investigation is required following two venous blood lead levels taken at least 3 months apart. The thresholds are:
    - Year 2023 -- BLL ≥ 15 mcg/dL
    - Year 2024 --BLL > 10 mcg/dL
    - Year 2025 + -- BLL ≥ 5 mcg/dL
- If the case of a residential unit where the source of the lead hazard cannot be removed within a reasonable time, the local health department shall use community resources to enable the relocation of the family occupying the residential unit.
- The local health department is given the discretion to allow the family to remain in the residential unit during the abatement process if, in the judgment of the local health department the occupancy will not threaten the health and well-being of the occupants.
- The statute also establishes a reporting requirement in which the local health department must report to DPH within 30 days following the conclusion of the local health departments epidemiological investigation, the result of the investigation and the action(s) taken to prevent further lead poisoning from the identified source.
- The report is required to identify the location and source of the lead hazard, and such other information as the DPH Commissioner may require

Transcript

Heather Aaron 0:00

I have gotten some comments that from some of you on the on these statutes, it's been very helpful. So, we look forward to great discussion today. Thank you so very much. Back to you, Lori.

Lori Mathieu 0:15

Thank you, Deputy Commissioner Aaron. And yes, we'll get right into the presentation here with Dr. Erin Nozetz and she has a number of slides. Dr. Noztez I guess everybody, maybe turn your cameras off. While we hear from Dr. Noztez. Thank you

Dr. Erin Nozetz 0:38

all right. Thank you so much for allowing me to chat again. Yeah, what I was just really hoping to get out of sharing my thoughts was to hear yours because we are such a group of varying expertise and skill sets and perspectives. So, this is just one perspective and I'm really interested to hear your thoughts about you know what I'm presenting today. Next slide. Okay, so the way I had kind of divided it up, if you remember the last time was, you know, what challenges and what possible solutions we're facing when it comes to lead prevention, lead screening, and lead response. So, first of all, start with the screening. And I had, you know, briefly went over this the last time that the challenges we have are kind of twofold. One is the test is being ordered, but not necessarily followed up on and to the test is not being ordered at all. So, if the test is being ordered, we ran it we're running into trouble with point of care testing, which in and of itself, you know, not everybody has access to mainly because of cost of the kit, cost of the expertise required to use the kits and then the kids themselves have been recalled multiple times because of falsely low results. So, we have a lot of trouble with point of care testing in general, but I think most people would agree that if you have the ability to use an accurate point of care test, that it's really the best first step because it's right there in the office. And it gives us a clue as to what's going on in terms of the child's lead exposure. So, if that level comes back as elevated, then we ask the family to bring the child to the lab for a venous test, which as we know is can be quite uncomfortable, especially for chubby arms and little veins. And the lab is not always on site. So, you know, we have to ask the parent to leave an office and then drive somewhere

separate to get blood work. And if there's not complete buy in into this process because their child looks fine or it wasn't, you know, completely explained to them about the importance of needing this, then that is something that might be skipped, and it's not necessarily something that's trapped. Right. So, you know, the physician prints the order in that we expect the family to go. They come back in, you know, six months later and it hasn't been done and it's possible that child has been languishing with an elevated lead level for that the entirety of that six months. So that's if the test is being ordered, which in and of itself or comp is complicated enough, but if the test is not being ordered, that's also an issue and we know that the second screening rates in Connecticut are very low compared to the first screening rates when we're talking about screening twice, right, but we know that the new legislatures were actually screening when we asking providers to screen more than that, but even as of right now, the second screening is only at 56%. And I think that a lot of that has to do with pediatrician misinformation. I mean providers in general. I really should say and incorrect practices. And then also, you know, families not necessarily realizing the importance of getting that second screen and advocating for their child to be screened at least twice. So that's the challenges with screening as I see it. And then possible solutions would be you know, with the money that we are

talking about using towards improving all of the lead related issues that we have, we consider point of care testing for all offices so that everybody has access to it. I will also say just as a side note, that kids who have developmental delays or severe needle phobias point of care testing is a godsend. And we have kids, so this is a little tangential, but kids who have autism haven't usually increased hand to mouth behaviors. And we know that lead poisoning can be a cause of autism so we end up in this chicken or the egg scenario of is this child autistic. Because they were led poisoned, or they lead poisoned to because they're autistic and have increased hand to mouth behaviors. And usually, as those kids get bigger, we're talking, you know, a kid that I'm thinking about specifically is 10. He's not going to it takes three or four people to hold him to get a lot of venous tests which isn't always available. So, point of care testing for everybody would be ideal.

You know, parent empowerment both in the office and in the community. So, the local health level and also at the provider level. With conversation with informational sheets that are language appropriate. With a video we had been talking about preparing with expert and family testimony as to why lead screening is so important. A P initiatives parent and Representative parent representative and leadership roles in the community which kind of ties into Howard's you know this the importance of stories and how families see other families who are like them and can relate to them. And then I put in their epic talks to pediatric practices, which is ongoing right now. So, this is run through CCMC and Jen Hale and I are giving them we just gave one to southwest the other day. So those we had been doing pre COVID and have started up again, to talk to pediatric practices about the importance of screening and we have been talking to them about the new house bill as well. Next slide.

So, then we end up with so we've done the screening. We've managed to you know, get through all of the challenges on the previous slide and we've screened and the venous level is at a 3.5 microgram per deciliter higher. So, what are the challenges with that, you know, in the new legislature, the language talks about the lab and the provider office and local health and state health kind of overseeing and tracking lead levels that are elevated. And I think that, you know, there, it's great that we have all of these folks, right because it kind of helps with the Swiss cheese model where you know, if one of one of the reporting

bodies fall through, hopefully we have someone else who catches it. There's also I think the potential for challenges with everybody working together and accountability. Do we use a carrot versus the stick? You know, if you're not if the lab is not reporting as they should, what happens, the provider office etc.

If a family cannot be reached, we've run into this and the contact tracing and who was responsible for that can get a little bit tricky. Then there's the educational materials inspection and the abatement and how all of that moves through in a timely manner.

You know, so, do we leave the educational materials at the door which language do we use? Do we if the family doesn't come to the door to know if they actually live there? How long does it take to get the house inspected? If once it's inspected, how do we move forward with abatement? These are all really sticky, challenging points, and something that hopefully we can at least initiate discussions on how to work through. I think this was brought up in the visit this meeting at an earlier time about landlords and I think it was Bridgeport specifically, but this is the case for all towns where landlords might be out of out of state. And also, even if they're not, you know, how to how to work with them in an effective way realizing that abatement is incredibly expensive and, you know, generally these are people who are trying to maintain buildings and not deliberately poisoned people. But also realizing that you know, they could turn over an apartment and then rent it to another family if somebody moves out right now without necessarily any oversight on that. Training contractors they set you know, as everybody knows, there's a shortage of skilled folks. How do we kind of sort of kind of move past that and have people who really know how to do the abatement work without making the lead levels worse, we certainly see that with people who are doing their abatement work or construction or repainting on their own. They're like great, we'll do it and they scrape down the walls and then the dust is everywhere and the kids let bubbles actually go. Closer. I had mentioned that we have had several cameos and webcomic who are poisoned in Section Eight housing, mostly on the outside in the soil. But how do we collaborate with our colleagues on preventing that from happening? So, some solutions on this? You know, it's basically creating a team of experts, right? of inspectors, led outreach workers and training programs to increase the number of contractors who know how to do the abatement work appropriately. I think landlords need to feel like they have a voice with representation and a good understanding of the law and then we have to have

the ability to enforce that law. And then partnering with LCI and healthy homes. The subsidized housing pieces are really a real sticking point. And so, I think that for me, personally, I just feel very strongly that we really, for this is housing that we're overseeing that we need to make sure kids are safe. And then this was actually an idea that came through from Martin Kawasaki who is the backbone of our LEAD program, that there's a standardized form for inspectors to complete which we could make statewide that families keep a copy of and it specifically goes over where the lead in the homeless located and how the family in the interim can protect their children from the lead that is there because as we know abatement takes time. But we also know that when we share with families, you know, if you move this piece of furniture over here, or cover this window, so with painters tape so that the child can't fight the sale, or put their toys in the window, sell in a wash hands, use a Swiffer, instead of a vacuum, these very small, seemingly simple interventions work extremely well for getting that child's lead level to come down. So, we need to make sure that we have this kind of ability to communicate with families that they have a physical form on which this is written and gone over with them so that when they interact with their providers or when they interact with us, as a lead treatment center, we're not getting our most kind of, you know, this line that we're just like we create the cringe worthy line of lead is everywhere, which is not actually true. It might be in a lot of places, but there's there are many things that we can do in the interim to keep families safe. Next slide. And then anyone who needs to time check me please feel free. So that I think this was addressed in the new legislature lead level reported out on the school forum it is there. It's already there. The question is, is anyone looking at it?

So, I think we might need to think of some education initiatives in the schools about empowering teachers and school nurses to look at the lead. Look at the school forum and what the it's the lead level is on it because it's not only asking you what the child's last lead level was, it's asking you have they ever been lead poisoned before it's actually quite a good, you know, a robust representation of their history. And so once that empowerment takes place, and people are aware that a child has been led poisoned, that that needs to be taken into account if they're struggling to learn, if they're happy, they have a PPT an IEP if I before they're getting extra help, so that we're able to support them the best ways that we can because as we know love levels, even in the single digits can cause impact on learning, and behavior moving forward, even if it's in the remote past we're talking about a kitten or a kindergartener who has been poisoned as a toddler is hasn't been, you know, exposed to lead in years but is still struggling with language and reading and that is certainly a thing the new legislature also talks about pregnant women as we know lead crosses the placenta screening is not happening at all or consistently, certainly not in New Haven with you know, after conversations with OBGYN is here, and then follow through once moms give birth for the dyad pregnant women are poisoned differently than children generally speaking, it's makeup, imported spices, teas, pots, prayer powders, things like that, that the mothers are using that then cross the placenta. So, the babies are possibly be, you know, poisoned when they come out and we might not even know and then moving forward, how do we support that family to prevent the child from getting poisoned in the first place or re poisoned? So, what we have come up with in New Haven, but hasn't actually been initiated yet is

to start with the ACOG American college of gynecology screening questions. When not, you know, people come in initially, if they're pregnant to the OB, and if they screen positive then going ahead and adding on a lead level. So, these are set questions that a call comes up with about practice general practices. And then we had set up again we have this you know, talked about in theory, but not in place yet through local health, a community program to follow up once the infant is born. So, we have all the resources, you know, on a small scale, but how do we make this statewide? Next slide.

Of course, now you know, talking about prevention in our old housing stock over 70% of the New England homes are built before 1968 Which is when lead was removed from paint. And so, the challenge is with that is, is it a landlord owned property a homeowner or section eight house and each of those come with their own troubles right so the landlord may be out of state less responsive, have financial difficulties. If it's a homeowner, they may be completely overburdened by the costs of abatement and then subsidized housing. As I had mentioned before, and then of course, there's lead on the inside, there's lead on the outside of the house and then there's lead in the drip zone of the house, which is kind of where, you know, right underneath the eaves within 10 feet or so. And the soil that's those are kind of the most common areas and by outside we also mean steps and porches which are really high culprits. And so, these are places that families spend time that kids play abatement is hugely expensive as you know, historical homes, it's like $2,000 a window to replace which is just insane. If you think about how many windows there might be in a particular home. grants come through so New Haven has many but there are strings attached that come with those. And it can be prohibitive. high turnover or rental property ownership, which I think we also did talk about as a group. And then like I mentioned earlier, renting to new family, so family as a child who's leaded, they move out and then the house gets turned over to another young child. I don't have great possible solutions for this one. But I think other states are doing things that we might be able to kind of borrow and share like mandatory and routine dust wipes on properties.

At least rental properties. And then the challenges with chelation, which I think I had shared a little bit about its incredibly, incredibly stressful time where we call a family, their child does not lead poisoning. They have to drop everything. Spend at least one or two nights in the hospital with their child whether administering medication, that they are themselves gagging as they administer because it smells and tastes so bad. And then we tell them that they can't go home because there's lead in that environment and the child is now a lead magnet because they're on medication that binds lead. So, it's just it really rocks families, in addition to the fact that they can't go home, they have to continue to work to support their family. What about child care, and then the child has to continue to take that medication three times a day down to two times a day, and then follow up with us with multiple level drawers. So, this is unit six again. So, we have trouble with adherence. We're trying to support the family the best we can. The town's need to respond in a really timely manner because once that child is admitted their home needs to be inspected to find out where the lead is and whether they might be able to go home. That child

needs very close developmental follow up so you buy in from the providers or it's an automatic verse two, three referrals. So, solutions for this aside from really close collaboration between the town the lead treatment center and the pediatrician and the family. Haven used to have a lead safe house. We've talked about this a lot in the New Haven lead Taskforce. But

it was really difficult to maintain it was hard to get people to leave and who oversees that becomes a challenge in and of itself. So, it's a solution and a challenge both. We have Ronald McDonald House which we do utilize but with COVID has been tricky. They've been really useful. Haven has talked about collaboration between visiting nursing who might go out to support the family on medication administration, or at least do a medication count to make sure the family is giving the medicine and then the pediatrician follow up that I mentioned which we do in part to the pediatricians every time we give these group talks.

I think that that's it. So that's kind of the my bird's eye view over the years of things that I've seen and I hope that we can maybe start to tackle some of these together.

Lori Mathieu 20:46

Thank you Dr. Nozetz knows it's at this point, so don't go away. First of all, thank you. That was incredible. A lot of excellent input and an identification of the challenge and the possible solution. So, I'm going to ask everybody I'm going to go a little bit off script here. I'm going to ask everybody is Dan goes to the chart. If we could go to the chart, possibly. Yep, there we go.

So, I ask everyone to turn their cameras on as well. Please, this will be a time to really step back and think about what we just heard from Dr. notates, and all of the great input and thoughts that maybe are floating through your minds and our minds as well here when we consider possible change or additional change to the statute. So, I heard a number of things and I want people to like raise their hands or say hey, I would like to speak up on these ideas. Something second notice that you said you know first and foremost screening machines. It doesn't start unless you have the first, we always say in our business here, you know, you don't know until you test and it is so true. If you don't have the machines there. You don't have them available. It is difficult always to get in the car, go somewhere else with your child. Absolutely. So. on screening machines alone, I'm going to ask the group, you know what, any further input, anything that you all your experiences that you want to add to that point. Chris?

Chris Corcoran 22:23

Yeah, just quickly, I know years ago, there was issues that were developing where there were some insurance providers that were covering this so having the machines great, but it was a mess

and I know a number of practices. This is probably 70 years ago, we're starting to stop using machines because the inconsistency being reimbursed, I don't know if that's something that still exists because I'm not in that world but definitely something to think about.

Lori Mathieu 22:48

Excellent point, Chris, that any other input on that point. Have you had an experience with these machines and having

Aisling McGuckin 22:59

Yeah, I think we brought it up. earlier. We are moving ahead to implement the screening machines and our Community Health Center. I think Amanda has mentioned this as well. There is no opportunity to build for them the accuracy setting and it's an expensive cartridge. I think it's 1750 per test. And that just is something I think that we're I'd be aware of and think about whether there's any help since community health centers, you're likely to see a large number of these children. And the second piece, I think does go to the training and I think we heard about this maybe in the last meeting about concerns about people maybe not understanding they have to wash their hands first. They obviously have to be done. Precisely and, you know, not to give our DPH inspectors more work when they come out and visit but I do think ensuring that people are getting the training and the competencies to do those tasks. Precisely and accurately and with the right techniques would be helpful.

Lori Mathieu 24:03

Excellent. Thank you, Margaret. Excellent input. Amanda.

Amanda Decew 24:07

I'll add to that. Just wanted to say strong agreement for everything the doctor knows it's presented so well, and agree as well with what with Margaret Flinter, said Dr. Margaret winter. I think it's important to keep in mind we're talking about point of care testing and the cost that in the community house in our world and the FQHC most of our children from the 36 months to 72 months are going to screen positive on that risk assessment. And so effectively, we're not only going to be testing one and two are those intervals but for most of our patients, then we will start to screen them and test them at those ages. And so that's a quite, that's a big jump in cost. If we're using point of care testing. That's not reimbursed as Margaret mentioned.

Lori Mathieu 24:59

Thank you, Amanda. Other input on that point. Other experiences you want to share? I see Dr. Haile. Hi, Dr. Haile. How are you?

Dr. Jennifer Haile 25:15

I'm good. Thank you. I'm in the middle of clinic again. So, I'll be in and out.

Lori Mathieu 25:18

Sorry. Thank you for being on. I see representative Jonathan Steinberg. The morning representative. How are you?

Jonathan Steinberg 25:27

Good morning. How are you? This has been extremely helpful and help somebody who's not on the frontlines like me dimensionalize the challenges that we face, but what really is important to me are any legislative changes, or clarifications we need to come up with so we're on the right track. I'd love to make this as quick as possible.

Lori Mathieu 25:52

Thank you, Representative Steinberg, appreciate that input. And what you see in front two fibers points. What you see in front of you is the gathering of what we did the last time the walkthrough of 19 a 110. And identifying certain points within that we provided all summary because you know reading the statute is pretty boring. Well, we wanted to provide you a summary and then all that we gathered all of your comments that came in in Dan, I don't know if you want to speak a little bit about just a little bit about this spreadsheet and you see the doctor knows its name is there quite a bit quite a bit with a different color. But why don't you just give it like 30 seconds because we're trying to get more input into this. This spreadsheet model that you have Dan.

Dan Aubin 26:39

Thanks Lori. As anyone as you all remember the homework assignment was to kind of look at the statues and provide us some feedback. And what I did was I compiled the feedback back into one chart, and many provided general comments so you'll see the more general before which means we should take that comment and apply it to the whole piece. And then we also had some technical analysis. And I promise I didn't call it code. This was pretty I did it because I wanted to show the sequential view of that technical analysis. So that's the 32nd overview. Thanks Lori.

Lori Mathieu 27:11

Thank you, Dan. And great work so what we would like you know, thank you Laura. And oh, and Dr. Nozetz for your input. Anyone else who has had the time. I know time is precious these days. But this is really important back to Representative Steinberg's point. We want to have this specific input as possible because what we heard from Dr. knows it's on I think over 40 different topics. There's very good specific input there, which can help us lead toward what we might wish to possibly modify, you know, maybe soon or maybe over time. So are there anything else so I have I have a lot of other topics. I see it is after 10 and I see Sue. Sue.

Sue Dubb 28:00

So, one of the points that doctor knows that's made about you know what the point of care testing, if it's elevated the child obviously needs to go for doing this follow up and for whatever reason, the parent doesn't understand the importance of the follow up or uses for paperwork or whatever. But sometimes it's just that the parents do not want to take their child for a venous follow up and I had an excellent example yesterday. Of a parent that, you know, got to Chaplin on screenings wanting to and was told by the provider that that the second sample was contaminated and that they were good to go and I said no, they're not. We have to Linus levels. And because both capillary levels were elevated. So, I think, again, as Dr. Mills put out there educating or reeducating the providers about what is actually required. By the statute. But then I think the other piece is who ultimately is responsible for ensuring that the parents are compliant with the laboratory orders and what is our alternative if the parents don't comply? Because I can tell you right now that, you know, sending the letters for template letters that are generated through a system that say, first reminder, second reminder, third reminder slash DCF I can send that out certified mail, and people still ignore it. And yet, when I have referred on a very rare occasion, and that would be four times in eight and a half years. The response I got from VCF was, well what do you want me to do with it? I don't know. It's written on the template letter. I'm assuming you're supposed to make them go and get the lab work done. But I don't think we have anybody representing here from DCF. And I think we asked for that early on. Because there needs to be some repercussion for parents. And I will say it's rare most parents can explain to them what the importance is they do understand and they do follow through but for those that just don't want to get it we're kind of stuck.

Lori Mathieu 30:29

Thank you, Sue. appreciate that. You know, the real world you know, reality of what you work with, and what you see. Is there any other input now I thought it was time a couple of things other than screening? I like the idea about the education in the video, and I see Howard there and I know that we've talked about this prior but I think your point is well taken about having some consistent education and communication tools that we don't have today. So, is there anyone else

that wants to elaborate on any of that? I know how are you spoke very well of having, you know, people come out and talk about the reality of what is out there.

Dr. Howard Smith 31:15

Yeah, I still think that multi prong approach, you know, as we mentioned before, that you know, giving people the facts sometimes I think it's good, because facts will tell you something but the stories is what's going to really sell people and in the last 30 years, I know one of the things that I've done in community health centers is to create community based programs like our community family night program, which was a basically a community empowerment project that touched on issues that was vital to the community. So, lead was taking you know lead poisoning, an ounce of prevention is worth more than the cure. Those are some of the topics we covered. And we were able to really captivate the attention of people. So, I think it has to be consistent whatever that messaging is, and having parents who might have had a child who suffered from the consequences of elevated continuous lead, shared their stories sometime I think it's what's going to move the dial a little bit, you know, more so than all of our scientific information that we're throwing in people. Sometimes it's having that layperson say, you know, my kid had that poisoning as a child and this is what I'm dealing with those stories, I think sometimes is what will move people.

Lori Mathieu 32:27

Thank you, Howard. That's an absolutely, absolutely. So, I see Chris with his hand up.

Chris Corcoran 32:33

I'm sure he knows and I'm thinking about globally about a lot of the issues and documents. That's really amazing presentation, I took a lot of notes and kudos, the care coordination. You know, this happens in my role a lot when we're trying to do work across different disciplines. So, I'm trying to work with the putting on airs program and with the utility program to make a home that is safe for the occupant because of asthma gins, weatherized, and then also, let's say unhealthy, it's very difficult because I can only do a certain amount and they can only do so. But if we have a care coordination team and here at the hospital that tracks kids who are coming through the system and they have multiple needs throughout the system, because it's overwhelming for parents, so I don't know where it would sit and I don't know how it would be funded. But to have a care coordinator in charge of making sure that parents understand the importance and try and track them down and establishing a personal relationship with them. So, it's not just me calling one of my people call Hey, you got to get that lead test done. Is Samaras, Julie. Oh, hey, how are you? Okay, give me a ride. Okay, let me see if I could find resources for a ride, you know, those types of things that the care coordination model I think would be really effective and if we're

going to really tackle this and we're going to if we have these resources available, I love that concept.

Sue Dubb 33:49

Can I just add on to that the information on the text for baby, I thought was genius. And I think that having a platform similar to that would be helpful in sending text reminders to parents. When your child is approaching age one, have you made your appointment for your physical by the way they shouldn't? It should include a screening for lead and just messaging about are you looking for a new home? Are you looking to move? Here are some things you should ask the landlord about that I think that messaging could be incorporated very easily into the already present text for baby platform. But I think a similar platform for when the child transitions out of that program, I think at age one, so covering ages one to six, that could be kind of the 2.0 of the textbooks maybe and it would have other health messages in there too. But I think if we started with read messaging, that would be a good start because honestly, I can't Well this is my stack from yesterday for lead that I'm still following up on so there's a whole file cabinet phone right next to me, for me to make individual calls to parents to providers to track their address if they've moved once or twice in the interim. It's just a lot of legwork that I'm only one person. And I think if we had a platform that we could program in the dates of when the child's first lead test similar to the template letters that are generated in the system, text messaging, people don't necessarily change their phone numbers as frequently as their address. Maybe that would be a way to sort of catch the people that fall into that transient population. That moves and we can't find them

Aisling McGuckin 36:00

yet so I had proposed text for baby because we used it in Texas but I reached out to my contacted the organization at zero to three it was they took over the campaigns and the campaign ended a couple years ago and has since transitioned over to Virgin pulse so you can actually you know, pre populate your own you can develop your own text messaging campaign for parents and you know, kind of replicating the same thing that text for baby did but text for baby itself as a free social media platform is no longer alive, unfortunately, but it is great that the technology is there and it can be purchased, you know contracted for and to me that makes sense at a state level. So, I can send that information to Lori

Lori Mathieu 36:57

please do.

Dr. Howard Smith 37:00

Just say Can I say one thing Lori? was so doped in the mentioned earlier about the involvement of DCF I think that's a critical and important piece if we could get them involved as part of this group as well because we can talk until, we're blue in the face. If there's no one on the side to help support and enforce, you know, compliance for testing then we immunize a mute point. So, I think that's a very important piece. This as well.

Dr. Erin Nozetz 37:30

Okay. I know that we probably have to move on. But I think as I'm listening to everybody talk and I was I was thinking, you know, I was talking about the Swiss cheese model before. I think if we have a series of hard stops, we create this system where we can have, you know, the text for babies, and then we have a system where we have the central reporting that the legislature is talking about, and then the school has a hard stop or the daycare, and then we have DCF involved and we have to somehow incentivize providers or and or hold them accountable. And I think that that, you know, really creating these hard stops that are solid, knowing that not all of them are going to work all of the time, but that we will catch kids at least once or twice along the way. is probably the most effective, I think.

Lori Mathieu 38:23

I think I agree. There are multiple catchments that you know, overlapping so that children don't slip through, as you mentioned, the Swiss cheese which the statutes are filled with that need some help, right and that's where your comments are really great. So, anybody else? I see a lot of people thinking though, right? Look at everyone's face, everybody has some thoughts and some input and I look at clothing, and as you know, the State Department of Education, and they serve such an important role. In the young person's life coming into school and this initial screening of events another big effort, I think of a way that we can capture kids in that process and maybe, you know, we want to capture kids when they're, you know, in the mom's womb, but also, you know, when you're heading into school, so Chloe Ann I don't know if you have any thoughts

Chloe-Anne Bobrowski 39:23

you know, I returned my suggestion for mandating that history for elevated blood level be completed on that health assessment form because right now it's not a mandate. So then is one easy, I think an easy fix. Also, I really appreciate that they're known as is a recommendation that with its children are do have an IEP or 504, or IBA, or any kind of extra support that they do include it, whether it's on a checklist to make sure that they investigate a history for an elevated blood lead level. So, again, I think those are pretty, you know, pretty easy ways. And I also agree that this with the Swiss cheese model, it's just the building, you know, trying to build and move forward. And these are easier catchments, I believe in the school system. Where they don't occur

right now. I mean, in early childhood forms, we have them but not when they enter kindergarten, so it would be a really targeted time.

Lori Mathieu 40:35

Excellent. Thank you. Margaret, you had your hand up on

Aisling McGuckin 40:39

Yes, I want to build on that. I think my comments are probably further down the document is on the screen, but I agree that if no evidence or flood screening or testing has been done at the point of arriving at school, that I would hope it could be done at the school and investing in the machines at the school and empowering nurses under the standing order of the medical adviser. To the school nurses to do the testing is the most pragmatic way to catch this and I'm particularly concerned actually was following the children who certainly are experienced that this past year with people coming from all corners of the world, in environments that I have no idea where the lead screening was done in Afghanistan on a regular basis that I'm thinking not, and people come from all corners of the world, but that was certainly a large group we cared for. I think we have to have that that catch point and school entry seems to me the place to do it and I would hope that could actually be done at the school instead of looping the parents back into a cycle of having to get back in someplace else. Thanks.

Lori Mathieu 41:48

Thank you, Margaret. Ebony

Ebony Jackson-Shaheed 41:52

I just had a comment. I wanted to echo on what a few people were saying. And also Mr. Howard show. Great question. Before I make the comments, have we thought about or have we already made collaborative sort of collaborative agreements with other state agencies so that they can build in what we're talking about into their programming so like our International Office of Early Childhood Education, something like, you know, this going into part of their assessments, right. And then the other thing is, is you know, for those organizations that don't have a lot of money for marketing. One of the things that we have done here is really try to partner with those organizations that may have more funding, and then make it a part of their program. And so, for instance, I know that Bridgeport recently, we're having like the shoe home visiting program, right, where mothers you know, get like this home visitor and basically, it's done by CHW's. And so, it just so happened that the person who's in charge of the CHWs for that very important program, actually was a contractor for us. So, we were trying to work with her so that we can actually make you know what education a part of the CHW program, once they, you know, get to

the mothers because that program is like women who are in their late stages of pregnancy, and then they're eligible for this home visiting program. And so now with this education is that you know, they're going to be getting from that home visitor that comes out. You know, that whole visitor can also say, Well listen, we need to make sure that around if needed in this area. So that actually helped me and our children need a population that otherwise we may not have been able to get through especially our growing immigrant community, because we're always trying to find ways to get to that population as Mr. Howard has spoken about. But that's that was just some, you know, ideas that have been floating around and some things that we've been trying to do here.

Lori Mathieu 44:01

Thank you. Thank you. Any anything you could share with us? via email, links to your program? Any details? Please share that with Dan or Ben and myself. It'd be excellent to see. Thank you. Thank you. Appreciate that. Are there other I have a couple other things for Dr. Gnosis just to bring forward. You mentioned a team of inspectors. Could you elaborate a little bit more on that? what your thoughts were their doctor Nozetz

Dr. Erin Nozetz 44:31

It's you know, just looking at the New Haven model and what they've been able to build over time. I think they have for New Haven keep in mind has a heavy load burden, as does Bridgeport and Hartford, the larger cities but they have six lead inspectors for the town so that they can respond to right now levels of five and up for all kids six and under and so when we have a lead level that elevated, we take, you know, can breathe a little bit easier when the child resides in New Haven, because we know that inspection is going to happen within 30 days. They have the data tracking system. And you know, that it took time to build up but these inspectors are experienced, they're trained, and they partner with at least one if not to lead outreach workers who I think similar to what was being mentioned. About care coordination kind of take maybe fills that role a little bit so that the family you know, is able to understand what the inspector is saying, able to figure out what they can do in that moment to protect their child get the information that they need. In the language that they speak in support. So, it is a team approach as I think we're all kind of coming to the conclusion of and I think the ability to be able to you know, Marta again quoting her again,

inspection does not mean resolution. But it is a really good first step as it right we screen we inspect and then we evade and resolve and you know, I think doing that in as timely a manner as possible is key. But again, we need inspectors you know, I realized I sometimes don't even have one lead inspector. So, we need probably a shared inspector model. And we need people who not only know how to inspect but also people who know how to talk to families. And also, you know, show, talk to them and also show them right so this happens a lot it happens more than

you would think. Not because families are deliberately trying to evade our questions or not understanding our questions, but more than just a shift in perspective. This your child put their toys in the windowsill? Nope. They never play in the window, literally beyond telehealth, watching the child and without fail. They walk over to the windowsill and they put their toys in it happens literally once a month, at least once a lead clinic and so we need an inspector who's into you know, to ask the child is home and who's in tune with family dynamics and kids in general. So, it's not just an inspector, and it's an inspector with specific skill set. And I said I meant teen because I think it's going to need to be a shared resource.

Lori Mathieu 47:42

doctor Nozetz it's I agree green. Because what we what we want is just the parents to know and have the knowledge base so that they understand how important the screening is and to make sure that it happens and then to understand how a child could be poisoned as well. And to get that information from multiple places whether you know when you're an expecting mom, when you have the child when you're in the hospital and you go home and you have, we need for blankets, information and then once I look at Laura from a OEC and think about you know the connection there early childcare and all that our colleagues at OCC license and so I just thinking Laura, if you have any input here because I know your work is so important to all of us.

Laura Fournier 48:33

Yeah, I agree. I mean, I think you know, we work so closely with EPA flag unit. I think there's more we can do. You know, we do require the full comprehensive lead inspections for centers, not for family. But we do look for peeling paint, you know, paint just samples you know, as I went over all that a couple of meetings ago, but there's definitely more and I think there's definitely more room for education for the programs and parents. Thank you, Laura.

Sue Dubb 49:05

Lori, Patrick had mentioned to me as well when we were going on unfortunately, he couldn't be on the meeting this morning. But the pooling of resources, maybe looking at a regional approach for cost benefit. And just because right now, everybody seems to be short on lead inspectors or you know, think really need to get out and do X number of cases. And that's going o just increase once the new legislation hits. So, if there was some way to kind of support a regional approach at least in the beginning so that there's equal resources available across the state, especially for some of the more rural communities that may or may not see a lot of lead cases. But for them, it's important to have that level of expertise. of someone that does work with it very regularly.

Lori Mathieu 50:07

Thank you. So, I appreciate that point. It's a really great point to think about and consider. Chris, you had your hand up at all moment, if you still have

Chris Corcoran 50:17

Of course, I have my hand up. This is my world. You know, thinking through a couple of things one is the private firms that do the lens spectrum assessment work. All of our work that we do across the state is done from private firms. So, we wanted I would want include them with that work too. But I think that idea of bringing these factors together I mean, they're struggling right now they're struggling to get people come sure the same way at the local and local health department level or city level, they get inspectors and then keep them and I can keep a couple of firms that have been very involved in not only just inspecting but also that broader look at how does this work? What can we do to improve and then also the contractors. We haven't touched on that but there's one firm in particular that has shifted from not just doing construction work, but also training. So, I think that that's another place where we would want to have at the table like maybe some of the big lead abatement contractors that can also provide some real time like, this is what I need. This will make it go faster. And then finally, just as I was talking about the care coordination model, I'm wondering if it's the kidney health worker model, because I'm hearing what Aaron was saying about people coming to talk to people that I know the community health worker model we're going to be implementing up in the north end on our HUD grant is to find local people local to that community that get that trainee, get that credential gives them an opportunity for upward mobility and also they're going to have an easier time getting to the people in the areas where we want so I'm not sure how the community health worker might be an alternate or part of a care coordination model.

Lori Mathieu 51:58

Chris, thank you for that input. And appreciate that to coordinate. You know, the term inspector and the word inspector and enforcement are scary words to many people, right? So, I think it's a maybe it's a different terminology that we use because we do all care so much that we probably want to step away from those harsh terms of inspectors and enforcement, but people who are care coordinators I really liked I really liked that terminology. Chris, very much, Ebony you have your hand up.

Ebony Jackson-Shaheed 52:30

Yes. So, I have a quick question. And then the comment, a question about the in terms of workforce development for the lead inspectors. I know that for those who do have lead inspectors, if it's coming through a particular grant, inspectors are usually locked into a particular you know, salary and that salary, there is no increase for it. So, I know that that's probably, you know, for a lot of people who are going into the environmental field, they don't really want to do

lead, because lead it's basically locked into a salary of about $50,000 and there are no increases. So, I have highlighted inspectors who have worked for my department for more than 10 years, and who have never gotten an increase in pay. Even though there has been an increase in you know, standard of living. So, I think that we need to figure out a way to try to see if we can amend that because that can be a real deterrent for debt to debt anymore when inspectors and the other thing is is that I know the requirements for a housing inspector is technically less than an LED inspector but they get paid more. So, what we have done here to try to increase our lead inspectors is we've crossed training, we basically created a new job description. And that job description basically includes the housing inspectors, someone who you know is trained in lead inspections, and also can be employed, because that person, it doesn't make sense for them to be at the same address and then have to call in someone else to do another job that they could do while they're there. So, I mean, I'm doing things like that we were able to get around it and basically increase on salary, but if, if we didn't do that for maybe a smaller district, or a smaller local health department, they would just be stuck with the lead inspector salary as is and I don't really know if they would get many people who are qualified. So, I don't know if we want to take a look at that.

Lori Mathieu 54:35

Ebony Yes. Could you send to us that job description that you mentioned, the changes that you may show up? Thank you. That's really great input because that's another piece of this is the workforce and the people that do the work that people have to do the inspections were the care coordinators that we need to develop in the future and to make sure that they have a, we do that a lot here. We want to make sure people have a pathway forward in their careers, right, otherwise, they're going to come and go. And it's so important, especially at this time when we have a hard time bringing people to our jobs. And specifically environmental health and drinking water seems like a struggle these days but I think things hopefully we can if we show people a pathway forward and there's a career ladder there for this work. And but I think making the job duties broader make a lot of sense. And the time that you spend in the field and talking to people to have, you know, not just a narrow job but a much more broad view so that you can bring the education in coordination and information to people along with while you're inspecting or maybe enforcing. So, with that, Do I see any other field lot of people thinking Sue again?

Sue Dubb 55:58

So, I also have to advocate for all my public health nurses out there we have a lot of knowledge and understand the medical piece of things. But we also had a lot of public health nurses that came in during COVID that are now just figuring out that there's other things other than COVID that public health nurses can do. So, we did put together an educational program for the public health nurses it was a one-hour lunch and learn which we partnered with Kim cote at DPH. But having some kind of ongoing educational support for your local public health nurses because that partnership between the environmental health staff and the nursing staff, I think it's a more

holistic approach to the lead issue. When I when we get lead cases, I go out with the inspector and we kind of look at things with two sets of eyes. And inspector can talk about the statutory things and you know, what work needs to be done. I can talk to the parent immediately about health-related concerns because of those efficiencies. And it's a system has worked very well and I would encourage other departments if you haven't tried that to give it a shot. But I would really love to see some kind of formal training for the public health nurses as well and I'd be happy to work with whoever on that.

Lori Mathieu 57:35

So, thank you, because that is, you know, tend to sometimes in our programs, we do one off things, right. And in these days, we're also busy that you know, to your point, that if we're doing it here, we should expand it we should think more broadly and how we could gather more people and do hybrid approach for or record it so we can share it later. There are other things we could do to offer all veterans statewide or in maybe these regional areas for people to come in and learn and get some training. So excellent points. Very well said. Okay with that not seeing any other hands. So, what we're going to do in front of us is we're going to switch gears a little bit here. We're going to go try to a little bit more of the undertaking of the boring statute Ruby, but what we want to share here in front of you and what you see on your screen is what Dan has put together, which provides the summary. We still want. You know, we walked through the statute 19 a 110. Last time two weeks ago, we sent out this spreadsheet to you all and you gave your comments back in we still would like your comments on this here. Right and 110 111 the statutes we're going to walk you through these are so important to everything we've been talking about. You see the way that the statutes are written and you see that there's a number of items that say, you know, within reasonable efforts, a good faith effort. You know, in my world and regulating drinking water, we don't have such words. Because we don't, we don't if you have an E. coli, we're coming after you you're going to deal with it. Right, there is no Well geez, but we really tried hard to do that. But Laurie, it's fine. We don't have the money to do. There are no excuses if you have an E. coli it's cute risk and drinking water. We're going to go after that and make sure the water system does what they need to do to make sure they do the education and notice the outreach, and then they follow up and they they make the change that needs to be made. And then we issue them in order to fix it for the long term. So that's how we deal with acute risk issues. And drinking water and look at this all the same way and think about these words that are in the statute about how it needs to be, you know, sort of tightened up with some of the off ramps that are here in the statute, and that's why it was really important to get your input on this one in particular is the start of it all. You know, it is it is the testing, it's the screening. If you don't test you don't screen you don't know. In this case, it's until it's too late for the child. So, to be more preventative and proactive that's what we're after here. So, all of your input and comments and doctor knows it's got us off to an excellent start on all of us thinking about what needs to change and how we could change for the better. So, Dan, I know that this is the first page do you have the second page because that too. So, we have the as Daniel mentioned before, we have some general comments here from people but we also have, you know, a lot of love from Dr. Nozetz.

It's you'll see that We've color coded, you know, to where the items are, and they're highlighted in the statute itself. So again, we go to 19 A dash 111, which is the investigation, preventive measures, relocation of families reports, it's like a lot of stuff put into one statute which you know, sometimes is too much in one place and it becomes very confusing to follow and in the structure of this is very difficult. And you know, I think about representative Steinberg here, you know, all of these words, you know, I see your thinking about you know how this is set up and this is something that needs to be you know untangled. So that it's much more clear and clear to follow. And that's one of the general comments that that I have about the statutes just in general. And so, is there anything, Dan, that you want to mention here on the input we received in this part?

Dan Aubin 1:01:44

No, I think I think what's great is we'll always take general comments, but the technical analysis is really helpful to for when it comes to their statutory revisions and cleanup. And as you can see here, and Laurie kind of alluded to from us in the drinking water side. This is very clear, regulatory wise that we have to do, and you know, a phrase that I'm looking at right here on the screen I'm sure you all can see is within a reasonable time. What is that? You know, that's the who makes that judgment of a reasonable time. So, any type of technical revisions that you see in it will be a part two homework assignment with other statutes. So, we want to show this today. So, in the next two weeks, when you see the other ones come through that hopefully you'll feel even more motivated to really go through those and and look at that and give us general thoughts or technical revisions.

Lori Mathieu 1:02:33

Correct and more input on in what when doctor knows it's started. I love the phrasing that you use. To go back to my notes, the prevention, the screening and the response. And just thinking about those terms about prevention, how do we how do we be? How can we be as proactive as possible? I think it starts with the screening, and really making that a very comprehensive program so that we're capturing everybody along the spectrum from pregnancy to you know, from initial birth all the way through when we need to end this it just needs to the screening is so very important to help families and children initially. So, we went through 110 and 111 the last time but again, we're still as Dan mentioned, we're still willing to take all of your comments and all of your thoughts on these particular statutes. So last time, we did spend time walking through these and we will probably now spend the next few moments then unless and succeed. Unless there's any members of the public that we see. For public comment.

Dan Aubin 1:03:40

There are no public attendees. Okay.

Lori Mathieu 1:03:43

Thank you for that. Check. Appreciate it. So why don't we move to the slides that we had and you know, start some of the, you know, difficult walkthroughs of heavy labor. We're going to start with 19 a 111, which you see in front of you and Dan has done a great job summarizing and I see Claire, there have Claire, my colleague there from the Office of the Governor wants to assist or point out anything in particular. We shall we should do that. So, 99 Dash 111 establishes throughout and you can read this, but I'm going to highlight a few things so establishes thresholds for requiring the local health director to conduct an epidemiological investigation for the purposes of identifying the lead source causing a person's elevated blood lead levels and ordering remediation. That's a lot there. Right. That's that this statute again, is very thick with information and must dues. And again, the thresholds are and you'll see that what you know the public act changed their overtime over the next three years. So, if in the case of a residential unit where the source of lead hazard cannot be removed within a reasonable time, the local health department shall use community resources to enable the relocation of the family occupying the residential unit. So again, the words of within a reasonable time, and then shall use community resources. Some of these are really sort of wide-open terms. Like what does the term community resources mean? What's a reasonable time as Dan mentioned, and then you know, to enable the relocation of the family as we heard from Dr. Nozetz it's I mean, that is not as simple or easy. Or you know, that is a very different can be very difficult process for the family, right, as Dr. Nozetz had mentioned. And so, you know, there's a lot there in this particular statute. Also, the third bullet down the local health department is given the discretion to allow the family to remain in the residential unit during the abatement process. If, again, in the judgment of the local health department, the occupancy will not threaten the health and well-being of the occupants. So that's another that's another item there again, within the judgment of the local health department and not you know, how do you determine not threaten the health and well-being of the occupants that is, I think that would be very difficult judgment in in the field to make and you know what are the details there that need to be better defined? I think the words, you know, not threaten the health and well-being of the occupants in the judgment. Again, those are words from the statute. The statute, so the fourth bullet down the statute also establishes a reporting requirement. In which the local health department must report to DPH within 30 days following the conclusion of the local health department's epidemiological investigation, so within 30 days following the conclusion of the epidemiological investigation which means it could that could take a long time. I don't know what the timing of the EPA logical, you know, investigation, could that be delayed for certain reasons. But again, we have to at the department, the state level, State Department of Public Health within 30 days would receive a report and the results of the investigation, which the report would include, and the actions taken to prevent further lead poisoning from the identified source. There's a lot there to consider as well. About the reporting requirements, the investigation, the timing, and now if you think about it, if a while this investigation is going on the family is elsewhere and is displaced for that amount of time.

Claire Botnick 1:07:40

So, Lori, if I may to kind of direct the conversation to zero in on a couple areas here. A lot about venous blood tests and the difficulty of that and one one question that I have for the practitioners is whether changing the standard makes any clinical sense in terms of if you could switch it to from, I know there are problems with the point of care testing and Venus is more accurate, but is there a way that we could change the language of the statute that would make it easier to comply and confirm what you need to confirm in order to move forward? That's one thing that would be helpful to weigh in on I'd also love to hear from Chris on local health, about the realities on the ground of relocation. I know what you've heard from Chris in his healthy homes presentation about some of the costs associated with that, and rising costs of rehousing. And then one other area that I am just interested in is that it seems like 30 days following the conclusion is when the state gets elevated information and I wonder if we might take a look at tightening those requirements so that the state is getting more regular reporting, but obviously want to balance that with the realities on the ground have, you know issuing additional reports. So those are some areas of interest for me.

Dr. Erin Nozetz 1:09:05

So, I can tackle the first I wish that we could just use point of care testing as the standard because it would make things so much easier. Although as we know it has its own challenges, but we can get a point of care test of 60 and an undetectable venous level. It's that extreme. So, we definitely need that venous. There's just no other way around it and you know that as we know, it comes with its own challenges. We've had some luck with using you know, specific pediatric oriented lab draw stations, and for providers out there or people who might work with providers. We have used EMLA cream as a numbing agent for people for kids who are really, really struggling and needing multiple sticks. So, we have childlife at our multiple our primary line lab draw site there, you know and these, we have a special machine that can visualize veins. So are really hard sticks. We send kids there. And then how to use the lobby for but we absolutely need us.

Sue Dubb 1:10:23

From the local health perspective, I can tell you that when I get an elevated lead and just yesterday, I got a report of a child with a 17.4 Capillary but a 17 point a venous confirmation. And when that happens, whatever else I'm doing stops and you know it's a phone call to the pediatrician. It's a phone call to the parent and sort of doing a cursory risk assessment over the phone just to allay any concerns that the parent may have initially. If there's any big things that jumped out and turns out this particular one of the parents works in a scrap yard. And so immediately, you know, you think metal lead and this child's only been in this residence for five months. And but he's in that window of when you think crawling around on the floor, a lot of hand to mouth behaviors. So, I think that every health department may handle things a little bit differently, but I know when I get a lead call here at Uncas that's what I do. I call the physician I

call the parent and then I set up a time to go out and meet with them and I talked to one of our environmental health staff to see what works for them and we go out as a team.

Amanda Decew 1:11:59

Lori, I wanted to ask a question to the group. Following up on Claire's question. Why do we need two venous blood lead levels at least three months apart? I agree with Dr. Noses that we need that venous blood lead level. What we've talked about and I have talked about this in the lead advisory committee in New Haven. Sometimes we do a good job of educating the child or the health department does a good job educating the child on how are the parents and have avoided that contamination. But it still exists in the house and so the blood lead level might drop down on that second test that follow up test and then what so I guess that's a question. I don't really understand why do we need to before we implement the epidemiological investigation.

Lori Mathieu 1:12:48

Very good question from Dr. Nozetz or Dr. Haile, is there any input on that particular item? Is it just because we want to make sure that the results are consistent or is thinking that or

Dr. Erin Nozetz 1:13:05

point I mean, that's my guess is you know, I think it was 20 ones, right? Or fit 15, three months apart. And honestly, I think that was probably put in there because anything less than 20 was viewed as, you know, I guess perhaps a little bit less acute and they wanted to be really certain that it was elevated. But I agree. I mean, we should be going out. As soon as there's, I mean, as soon as there's really any elevated blood level. So, it's just, that's more work.

Lori Mathieu 1:13:42

So, the question is like, how do you do confirmation? Right, so are you I think that was like a maybe a confirmation sample of consistency, you know, for consistency. So, you know, hear what other states are doing. doctor knows it's I don't know, you know, on the very first sample, you know,

I don't know if you necessarily need a confirmation. I mean, usually its exposure very rarely. We have a kid who, you know, bid on an heirloom rocking chair in a new house, but most of the time it's a chronic exposure. I think it's worth going out on the first the first test.

Okay, thank you, doctor Haile.

Dr. Jennifer Haile 1:14:26

And I would just say sorry, I'm doing a lot of things but just to jump in, and I agree. I mean, I don't feel like you need a confirmation and what I think is frustrating about this three-month thing is that let's say your first one's 15 And your next one's 12. Right like the source is still there. You've proven that it's fair the first time and then you repeat it and find it went 12 Because naturally, you know if after the 15th they had an appointment with you know, to or myself and we've gone over wet cleaning, but my opinion is they've maybe brought the dust the dust down and went to 12 but then, you know, it's almost prohibitive and so frustrating the three months apart because to me, don't 15 You don't need confirmation they've been exposed and you know, those kids that dropped just a little bit because they've gone through a growth spurt or you know, again, the other levels just estimation of your total body lead level you know, it's just frustrating to me that you get those kids that just slipped by because their second went down a little bit not you want it to go up, but it's yeah, I wouldn't. It's not really a confirmation, but I wish we didn't I wish they could just go out on the first one. Basically, I think Aaron would feel the same way.

Lori Mathieu 1:15:40

I mean, we're always pro moving faster rather than late. I just wanted to make a really quick point. I'm so sorry that we're crunched for time. But the blood lead level like Jen just said is our best guess at what the body burden of the lead is and is, but it's not reflective of the true body burden. And we see this in kids who have lead levels of 100 or above who undergo chelation and it takes them years, sometimes a decade to get rid of the lead in their body completely. Because the lead gets everywhere. This is the problem. So, it gets into the brain. It's in the bones. It's in the soft tissue. So, we're measuring the blood. It's our best measure, but it's certainly not. It's certainly not the most accurate measure. And we just have no other way of measuring it.

Sue Dubb 1:16:35

I think too with the second test, parents are usually very vigilant in the beginning with housekeeping measures, you know, keeping the window wells clean mopping the floors. And things like that. But eventually, competing priorities they get multiple kids in the house are running to this event or that event and housekeeping measures start to drop off. So as Dr. Haile said, the lead sources still there. And they did a great job of keeping things clean for the first couple of months because it was very much on the forefront of their mind. But as the second level comes back and it's slower, I think the message that goes to the parents, in their own mind is that oh, okay, so, you know, I don't need to clean as often because his levels are coming down. So, I think the three-month test is a bit of a boiling point.

Lori Mathieu 1:17:35

Thank you, Sue. Thank you Dr. Nozetz.

Chris Corcoran 1:17:38

I'll just jump into for 13 years and that was the that was the 15 twice and in 20 We have no idea what the legislative process was to get that through it just could have been the compromise you know, back way back when the kinetic realtor association for example, they were vehemently opposed to all kinds of lead legislation. So maybe at the breaking point, like we're going to get this sort of monopoly got a compromise, right, find two tests out who knows what the what the forces that work for that product, because it sounds like the two health professionals that do this for a living don't understand why it would be a requirement. So, it may have nothing to do with that.

Lori Mathieu 1:18:15

Agreed, agreed and it’s what doctor knows it just said it's in the brain. It's in the bones to the soft tissue. This is just a screening. It is not a comprehensive test of the child and the impact to the child. And so, this is a great conversation, Claire, I know you teed up like three major questions. I don't know if you want to, you know, Dr. Haile, as you go ahead.

Dr. Jennifer Haile 1:18:41

I just want to say just one thing about moving forward in you know, we're looking right now at the 2023. But the 2025 You know, it's just you know, going out to the next levels at least three months apart. So, if you look like we, you know, recommendations of People First time, I mean, we're very conservative. And if you have a five you know, we're repeating it in three months, but we actually look at the recommendations that can be three to six months. So, a pediatrician is managing this themselves, not referring to a lead treatment center and they repeated that six-month mark now you have six months and went from a five to you know, a 15. So, within these, it's just frustrating because, you know, as we get out further and it's that five if not everyone's doing it right away, right, right. Is that three-month marketing you're doing? You're getting two fives nine months apart. You know, it's just again delaying the inevitable of the backs the canary in the coal mine. The kids been exposed. We know there's lead. We need to get in there. Which is just frustrating. Something that sticks out as we're all kind of focusing on 2023 Because it's here, but I'm thinking about, you know, 2025 in the future.\

Lori Mathieu 1:19:55

Dr. Hill, thank you. I know we have a time check here. We have six minutes and we want to be my we're going to end at 11 This is we could talk I think for the next six hours. This is a lot of great input, Claire's, or anything else you want to emphasize or ask again, because I know you throw three major concepts so

Claire Botnick 1:20:17

no, I mean, I think relocation is an important issue. I mean, my takeaway, I think was that next but my takeaway from the conversation that we just had about the confirmatory testing, it's possible but that's right, consider adjusting because it might not. It goes to a clinical decision right. In terms of what should be referred to local health. The confirmatory test may not be required. Is that my hearing?

Aisling McGuckin 1:20:46

Okay, excellent. Just in response to your question about relocation. Relocation is a problem, even when there's a fire here in our city, and we're actually working on re envisioning of how we do relocation within the guidelines and other regulatory bodies but just to keep in mind, and designed that many options and the cost of the cost of relocating a family is considerable, but it's also hard to get that family back into their house because they don't want to go back. Like most families, even when there's a fire even there's no burst pipe or sewer. outbreak in the house. They their idea of relocation is that temporary relocation it's like oh, you're gonna find a new place to live. And in a city like Waterbury there isn't any stock to choose from, but also just you know, we need to use that. One of the folks that we work with says when there's a fire, we lose two houses because you lose the house that burned but you also lose that house that would be able to use for somebody else. And putting people in hotels doesn't just speak we have somebody who just moved out. We've been in the hotel for 13 months. So just I guess is a word of caution. I don't have a solution. But it is something to really seriously consider when we're thinking about this as a cost that I don't think is necessarily taken into account.

Lori Mathieu 1:22:33

Thank you. Excellent. Excellent, excellent point. So, we have we have three minutes. So, I think what I'm going to do at this point, it didn't make it through everything but this slide here in front of you a 19, a 111. Really very important items here for your input. So, to Claire's questions to all of your input on the other items through Dr. knows it's and our recent discussion over the last hour or so. It's really important for you all to capture your additional comments or send us what you had said today. Obviously, we're capturing everything you you've said today, right? We have notes, we have the video. We're taking a lot of notes ourselves, all of your input, but it's so meaningful for us to have your input directly. Hopefully you could take a little bit of time. Maybe if you have time. Now while it's fresh in your memory. To provide input Dan will again

send out the spreadsheet and share that with everyone so that you have a chance or a moment in the next few hours. If you're thinking about things give us your thoughts. We really welcome your input. And you heard a lot of great items here today to focus more on prevention. And you know, one thing doctor knows it's we didn't identify it unfair for me to bring this up. But you mentioned many many concepts. You know, you mentioned also section eight and Section Eight housing and maybe next time we can talk a little bit about that and about your concern there. And you know what else can what addition can be done? But at this moment, why don't we go to the last slide we can show when the next meeting is seen we had a lot of other items that we wanted to bring to your attention, but this was excellent discussion. Our next meeting, which is our seventh meeting is Wednesday, November 16. From 930 to 11 o'clock again, we'll continue on this mission of sharing. You're getting your input over the next couple weeks, sharing that again, and then talking through the statutes and we have a couple more statutes to walk through with you. But again, our next meeting is Wednesday, November 16. It really is important maybe over the next I'll give you to the end of the week to give us your input really as at this point, we're at a critical point and heading into you know, starting and you know working toward putting notes together and based upon all of your input right now it's so important. So, I can't stress that enough. So, Dan will be sending out today probably soon or shortly thereafter. This meeting closes out the spreadsheet will share with you the notes we already received. But we also want to make sure that you have an opportunity to give us your input in writing. So, with that, it is 11 o'clock. And I'm going to turn it to Deputy Commissioner Heather Aaron to close this out this year.

Heather Aaron 1:25:35

Okay, thank you, Lori. I have to say this is this is a great group. Dr. Nozetz thank you Dr. Haile and all the practitioners on the fall I think that what we have discussed today, we have a lot of answers here and a lot of things that we can put together to improve this in a major way. And I think this is this can be a historic moment for us. As we tackle this. I will pose a big question to take away and think about we keep talking about the elevated levels. But keeping in mind with what the science has shown us. It doesn't matter what the level it is dangerous to a child's brain and to the impact on that child's life. So think about we talked about cost, what is going to be our cost in the future if that child is not taken care of now, and we can go down that road and see where that leaves where we will spend more if we don't spend now so thank you so very much for what you're doing. Thank you for your responses. This is great. And we will see you next time. Thank you. Thank you Take care