

LEGISLATIVE REPORT
CHILDHOOD LEAD POISONING PREVENTION PROGRAM (CLPPP)
RESPONSE TO SECTION 5474(2) OF PUBLIC ACT 219 OF 1998
REPORT PERIOD: OCTOBER 1, 2003 – SEPTEMBER 30, 2004

This legislative report is provided in response to Section 5474 (2) of Public Act 219 of 1998 which requires the Michigan Department of Community Health (MDCH) to annually report to the Legislature:

The number of children through age 6 who were screened (blood tested) for lead poisoning during the preceding fiscal year and who were confirmed to have blood lead levels at or above 10 micrograms per deciliter ($\mu\text{g}/\text{dL}$).

The report shall compare these rates with those of previous fiscal years and the Department shall recommend methods for improving compliance with guidelines issued by the federal Centers for Disease Control and Prevention (CDC), including any necessary legislation or appropriations.

Attachment A. Michigan Children Confirmed as Lead Poisoned, reflects lead testing results for FY03/04. It is important to note that the percentage of Michigan children found to be lead-burdened has decreased from 9.9 percent in FY97/98 to 2.8 percent in FY03/04. (The national average, as reported in the Morbidity and Mortality Weekly Report [MMWR], using the National Health and Nutrition Examination Survey [NHANES] data, is 2.2 percent.) In FY03/04, 3,388 children under six years-of-age were identified with elevated blood lead levels:

- 2,179 children were found to have a blood lead level of 10-14 $\mu\text{g}/\text{dL}$,
- 634 children were found to have a blood lead level of 15-19 $\mu\text{g}/\text{dL}$, and
- 575 children were found to have a blood lead level ≥ 20 $\mu\text{g}/\text{dL}$.

The total number of children tested was 123,837 or 12.9 percent of the total children under seven years of age (2000 census data: 958,657 children in this age group). For FY03/04, 998 children were identified as having an elevated capillary blood lead level; results have yet to be confirmed. Confirmation is made by a follow-up venous blood specimen test (see Attachment A).

The Childhood Lead Poisoning Prevention Program (CLPPP) of the Michigan Department of Community Health continues its efforts to make education and information readily available to health care providers, parents, and allied health and education workers (Head Start/Early Head Start, Early On, Vision and Hearing specialists, WIC consultants, etc.), alerting them to the persistence of lead hazards in Michigan, and to the testing requirements for children under six years of age.

Because many Medicaid-enrolled children receive their health care in the qualified health plans, the plans and their participating providers represent a major focus of our education, outreach and quality assurance efforts. The Medical Services Administration (MSA) is working to assure lead testing of Medicaid-enrolled children at the appropriate ages by including this EPSDT component as an outcome for evaluation in their External Quality Review. MSA also provides individualized reports to the health plans, quantifying their testing performance for that time

period. A current Medicaid bulletin allows children enrolled in the health plans and fee-for-service to receive blood lead tests wherever they present for health care and will allow local public health agencies to bill Medicaid for specimen collection if the 0-5 year-old has not been tested previously. A monthly Medicaid report detailing percentages of children tested, by age and provider, can be found at: www.mdch.gov/leadsafe

CLPPP staff continue to remind pediatric providers at every available opportunity (professional meetings, poster sessions, student rounds, etc.) of the requirement for testing of the Medicaid population and the appropriate testing periodicity. Note: In excess of 80 percent of the children (nationally) identified as lead-burdened are children whose source of insurance is Medicaid, a potent reminder of the significance of the blood lead testing of this population.

The major project for the CLPPP during the months of April through the end of this fiscal year (September 30, 2004) was the development of background documents, identification of the stakeholders, provision of staff support for the Governor's Task Force to Eliminate Childhood Lead Poisoning and the creation of the *Final Report of the Task Force to Eliminate Childhood Lead Poisoning* which was released in November 2004. More than 170 individuals served on the Task Force and/or one of the Task Force's six subcommittees which included: Compliance and Enforcement, Education and Outreach, Funding, Health, Housing, and Legislation and Policy. In excess of 100 recommendations and strategies are contained in this report representing four focus areas. These four focus areas are: Preventing Lead Exposure, Identifying Those At Risk, Assuring Appropriate Treatment and Support, and Providing Ongoing Support for Lead Poisoning Prevention Activities.

As an outcome of the work of the Task Force, seven priority recommendations will serve as essential "first steps" in eliminating childhood lead poisoning and include: (1) Coalition-building and grant development assistance for the eleven high-risk communities identified within the report and listed later in this Legislative Report; (2) case management of children with elevated blood lead levels ≥ 20 $\mu\text{g}/\text{dL}$; (3) establishment of a Public Health Trust to provide a stable funding stream; (4) development of a lead-status housing registry; (5) implementation of a major public awareness campaign; (6) establish a commission to evaluate and coordinate lead resources and activities statewide; and (7) expansion of remediation and control of lead hazards in residential environments. It was estimated that these first steps would require funding of \$3.78M.

As these first step recommendations are successfully addressed, the Task Force report will continue to guide the work of the department in eliminating lead hazards and poisoning among young children. The recommendations from this report will also serve as the basis for the development of the Elimination Plan for the state of Michigan that is required by the CDC funding.

The Michigan CLPPP is committed to **increasing our blood lead testing rates**, assuring **case management** for children with confirmed blood lead levels of ≥ 20 $\mu\text{g}/\text{dL}$ and supporting and encouraging **primary prevention** activities, especially in the eleven highest-risk urban areas that were identified in the Task Force Report (plus Detroit and Grand Rapids who have secured funding specific to their communities). Primary prevention activities identify and control lead hazards before children are poisoned.

These eleven highest-risk areas/communities include:

Battle Creek, Benton Harbor, Flint, Hamtramck, Highland Park, Jackson, Kalamazoo, Lansing, Muskegon, Pontiac, and Saginaw. **Note:** Detroit and Grand Rapids have secured funding specific to their communities.

Public Act 55 of 2004 requires that 80 percent of children enrolled in Medicaid MUST receive blood lead testing at appropriate intervals by the year 2007. This mandate is supported, for example, by contractual requirements of Medicaid providers; continuing affirmation of testing requirements and recommendations employing a variety of methods; alerting providers of needed testing by utilizing the Michigan Childhood Immunization Registry (MCIR); and monthly reporting of Medicaid statistics.

Activities for the 2003-2004 grant year included:

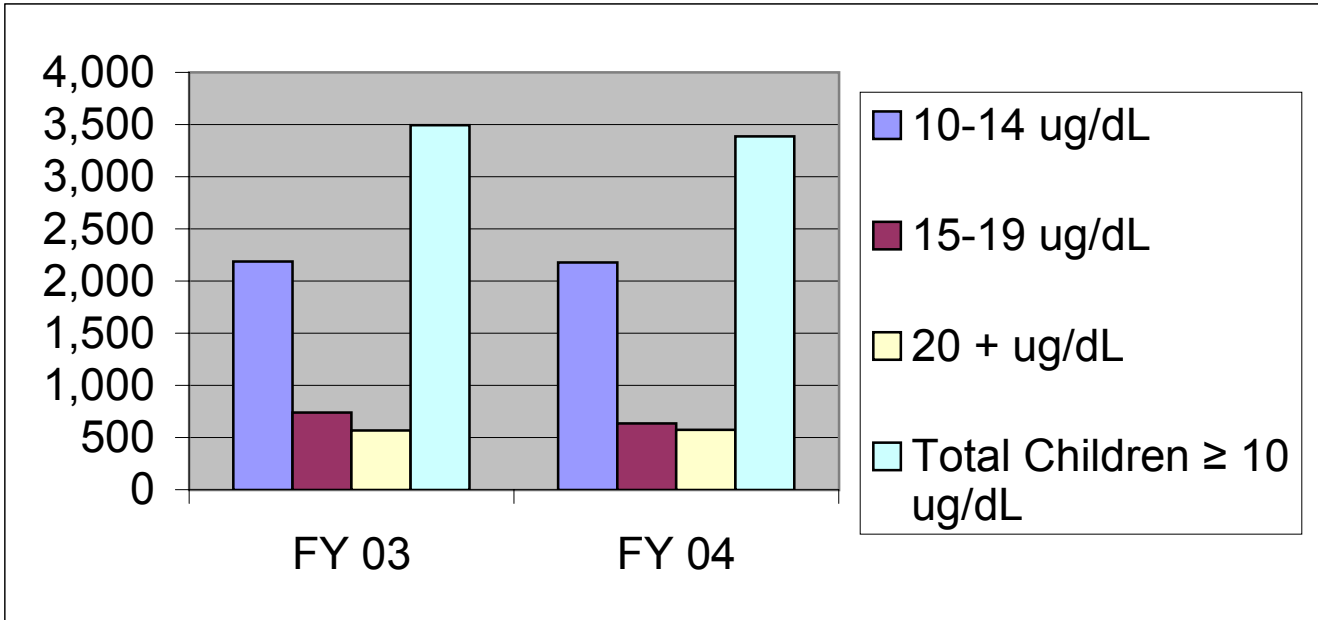
1. Continued to solicit opportunities to interact with pediatric providers (and have our contracted physician consultants do the same) to assure their awareness of the requirement for young children to be tested at prescribed intervals, as well as their awareness of specialized pediatric consultation resources available in their respective regions. In addition, pre-service health care providers (students in medicine, nursing, social work, education, etc.) will have childhood lead poisoning content included in their preparation course work.
2. Continued work with quality improvement managers from the health plans to achieve testing compliance from their providers. MDCH staff strategizes with them and provided supportive professional materials enabling them to work internally to increase their testing rates.
3. Continued work with Medicaid and MDCH Laboratory Services Bureau to encourage labs to report the blood lead testing results electronically. We provided direct, onsite consultation to laboratory directors with special emphasis on improving accuracy, completeness and timeliness of test result reporting.
4. Distributed, through the Family Independence Agency (FIA), consumer information fliers. These fliers were developed by CLPPP staff to assure that families choosing to rent or purchase subsidized housing are aware of lead hazards and how to identify and minimize the hazards prior to occupancy.
5. Aggressively seek opportunities to provide formal presentations, poster sessions, exhibits, etc., to medical and allied health workers, environmental professionals and education department programs that are focused on the health care of children. Identified and developed partners in the housing industry, community development projects, and rental property owner associations to provide presentations, exhibits, and participation at their meetings to reinforce the shared role and goal of health and housing in preventing and treating childhood lead poisoning.
6. Continued collaboration with Medicaid to monitor health care providers' compliance with the Statewide Testing/Screening Plan and reviewed and offered consultation to the health plans for blood lead testing rates improvement.

7. Encouraged our contracted physician consultants to contact health care provider offices, managed care organizations, and professional organizations in their catchment area to offer at least one Grand Rounds presentation on the topic of childhood lead poisoning each quarter.
8. Continued to encourage non-Medicaid providers and local public health agencies to identify, treat, follow-up, and educate the families of children at-risk for lead poisoning or who have been tested and found to have elevated blood lead levels.
9. Pursued public education venues to raise community awareness of potential lead hazards, the effects of childhood lead poisoning, and strategies to minimize the dangers of lead exposure.
10. Provided regional consultation to non-funded local public health agencies to develop and/or enhance their respective agency's lead activities. Worked with local public health to assist with the development of childhood lead poisoning "action coalitions." Encouraged and supported primary prevention activities in the target high-risk geographic areas.
11. Worked with the Women, Infant and Children Agency (WIC) to identify and overcome barriers to provide blood lead testing in WIC clinics for one- and two-year-old children.
12. Continued to work with Medicaid to increase Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits to include a lead test with children enrolled in the health plans. These visits, that include a lead test, should occur with children one- and two-years of age.
13. Assured case management of all Michigan children with elevated blood lead levels ≥ 20 $\mu\text{g}/\text{dL}$.

General Fund appropriations to the Childhood Lead Poisoning Prevention Program have been flat since 1996. The Governor's Task Force on Eliminating Childhood Lead Poisoning has established priorities for spending, and has identified estimated costs of the highest priority items. One million dollars from the Healthy Michigan Fund has been allocated to Lead Poisoning Prevention for the Fiscal Year 2005/06.

Attachment A: Michigan Children Confirmed as Lead Poisoned (1 page)

Attachment A. MICHIGAN CHILDREN CONFIRMED AS LEAD POISONED



	FY 03	FY 04
Breakdown: 10-14 ug/dL	2,187	2,179
15-19 ug/dL	740	634
20+ ug/dL	568	575
Total Children ≥ 10 ug/dL	3,495	3,388
Number of Children aged 0 through 6 tested	101,977	123,837

Michigan Department of Community Health, Childhood Lead Poisoning Prevention Program
12/10/04

A lead level of 10 micrograms/deciliter (*u g/dL*) is considered to be diagnostic of lead poisoning. Recommended actions include the following:

- * 10 - 19 *u g/dL* - referrals are made to the local health departments for follow-up. A nurse makes a home visit to recommend a diet high in iron, calcium and Vitamin C to decrease the potential for absorption of lead from the environment. There is a review of environmental factors that can place the child at risk for lead poisoning.
- * 20 *u g/dL* and over - Medical management is needed. Referrals are made to the local health departments for home visits by both a nurse and an environmental health sanitarian. The environmental health sanitarian inspects the home to determine the source of the lead poisoning and recommends actions for lead hazard control. When blood lead levels reach 45 *u g/dL* and over, hospitalization is required for special treatments to remove the lead from the bloodstream. The danger to the child increases with the blood lead levels. Levels of 70 *u g/dL* or more are considered medical emergencies requiring immediate hospitalization. Children who have been hospitalized for treatments cannot return to their homes until the environmental lead has been removed.