**Committee for the**

**Childhood Lead Poisoning Prevention Program**

**Bureau of Environmental Health**

**Childhood Lead Poisoning Prevention Program**

**June 6, 2016**

**Agenda – June 6, 2016**

* Selection and Responsibilities of a GAC Meeting Chair
* Conflict of Interest Law
* Open Meeting Law
* Lead Regulation Promulgation Process and Schedule
* MA Childhood Lead Poisoning Prevention Program – Lead Law, Prevention, Enforcement, and Surveillance
* Proposed Changes to Regulations:
	+ Lead Poisoning and Blood Lead Level of Concern
	+ Screening and Confirmation Testing
	+ Inspection and Deleading Requirements

**Logistical Items**

* This meeting is being audio recorded by DPH
* Minutes of the meeting will be taken by DPH and made available to the public after completion.


# Selection and Responsibilities of a GAC Meeting Chair

**Selection and Responsibilities of GAC Meeting Chair**

* The Chair shall be selected by majority vote of a quorum of members present.
* The Chair is in charge of running the meeting in an orderly fashion, on topic, and recognizing GAC members who wish to speak.
* The Chair must acknowledge anyone who wishes to audio/video record the meeting and notify members of such recording.
* The Chair must ensure that meeting minutes are taken.
* Members may nominate themselves or other members.
* Nominations and Vote for a Meeting Chair


# Conflict of Interest Law

**Conflict of Interest Law**

* + Anyone performing services for a state agency, whether paid or unpaid, must comply with the requirements of the Conflict of Interest Law (MGL c. 268A).
	+ Conflict of interest online training course must be completed within 30 days of appointment.
	+ Ask the DPH Office of the General Counsel if you have any questions regarding compliance with the Conflict of Interest Law.


# Open Meeting Law

**Open Meeting Law**

* The Governor’s Advisory Committee for the Lead Poisoning Prevention Program is subject to the Open Meeting law.
* There are 14 GAC members; at least 8 members must be present to constitute a quorum to hold a meeting.
* Members must be present to participate. Remote participation is not currently approved for this Committee.
* No confidential personally identifying information should be discussed or presented at the meeting.


# Lead Regulation Promulgation Process and Planned Schedule

**Planned Schedule for Lead Regulation Amendments**

* + Review and comment by the Governor’s Advisory Committee. Up to two meetings expected. (June)
	+ Final preparation of proposed amendments by Lead Program staff. (June/July)
	+ Presentation of proposed amendments to the Public Health Council for briefing (no vote). (Summer)
	+ Public comment period and hearings. We expect to hold two public hearings. (Summer)
	+ Review of public comments and changes to draft regulations, if warranted. (Summer/Fall)

**Planned Schedule for Lead Regulation Amendments**

* + - Review and comment by the Governor’s Advisory Committee. (Fall)
		- Preparation of final proposed amendments by Lead Program staff. (Fall)
		- Presentation to the Public Health Council for final promulgation (vote). (Fall/Winter)
		- File with Secretary of State’s Office for publication in the Massachusetts Register. Regulations become effective upon publication. (Winter)


# MA Childhood Lead Poisoning Prevention Program

**Why Do We Care About Lead Poisoning?**

* + Childhood lead exposure is a serious public health issue with significant implications.
	+ Exposing a child to even small amounts of lead can cause severe – and irreversible – damage to mental and physical development.
	+ Lead is a poison that affects virtually every system in the human body.
	+ There is no safe level of lead.

**Why Do We Care About Lead Poisoning?**

* Lead is particularly harmful to the developing brain and nervous system of fetuses and young children.
* Very high levels in children can cause severe neurologic problems such as coma, convulsion, and even death (rare in the US).
* Lower levels cause adverse effects on the central nervous system, kidneys, and can damage the formation of blood cells.

**Why Do We Care About Lead Poisoning?**

* + Lead exposure is associated with decreased intelligence and impaired neurobehavioral development.
	+ Numerous studies have documented correlations between childhood lead poisoning and future school performance, unemployment, crime, violence, and incarceration.
	+ Young children have a higher risk for exposure because they have frequent hand-to-mouth activity and absorb lead more easily.

**Why Do We Care About Lead Poisoning?**

* + Research suggests that the largest portion of intellectual impairment in a child occurs at low levels of lead exposure.
	+ Lead affects children in all MA communities; however, data show that gateway and lower income communities with higher minority populations are disproportionally impacted, making lead exposure a critical health equity issue.

**How are most children exposed to lead?**

* The most common source of lead exposure for children is deteriorated lead paint from older housing.
	+ 2,043,518 dwelling units in MA ( approximately 76% of housing stock) were about built before 1978
* The primary route of exposure for children is by ingesting dust or soil contaminated by leaded paint (windows, loose paint, unsafe renovations).

**Non-paint Sources**

* Lead can be found elsewhere in a child’s environment, for example:
	+ Air
	+ Soil
	+ Water
	+ Plumbing
	+ Toys and Jewelry
	+ Traditional folk remedies; and
	+ Imported foods/cooking items


# MA Lead Law

**MA Lead Law**

* The Massachusetts Lead Law or “Lead Law” (see MGL

c. 111, §§ 189A-199B) is one of the nation’s most comprehensive state laws for lead poisoning prevention.

* Enacted in 1971, the Lead Law requires any dwelling unit where a child under six years of age resides to be deleaded, regardless of a child’s blood lead level or whether the property is owner occupied.

**Evolution of the MA Lead Law**

* The 1971 statute established the Childhood Lead Poisoning Prevention Program (CLPPP) and authorized regulations.
* The Lead Law has been amended several times to both protect the public and to encourage compliance. For example
	+ Require inspector and deleader licensing
	+ Require occupant relocation during deleading; full abatement of windows; dust clearance.
	+ Allow Low and Moderate-Risk Deleading by homeowners, encapsulation, Interim Control, etc.
	+ Set penalties for housing discrimination

**CLPPP Regulation**

* CLPPP Regulations were created under the Lead Law’s authority, and set:
	+ Definitions
	+ Mandatory screening and reporting requirements
	+ Requirements to abate lead hazards
	+ Training and licensing requirements for inspectors, deleaders, and those doing abatement work
	+ Inspection and enforcement procedures


# Enforcement

**Enforcement**

* Code enforcement activities are initiated when:
	+ A child is identified with lead poisoning or an elevated blood lead level;
	+ A parent requests a lead inspection from CLPPP or a Board of Health; or
	+ Lead is identified during a housing code inspection conducted by local health


# Prevention Activities

**Private Inspections and Compliance**

* Prevention strategies include educating property owners who have private lead inspections and deleading completed to comply with the law and protect children.
* CLPPP licenses and works with private lead inspectors

• From 1995-2015

* + 237,799 dwelling units inspected by private inspectors
	+ 143,397 Letters of Initial Compliance or Full Deleading Compliance were issued
* CLPPP educational materials must be distributed with all inspection and compliance documents.

**Local Public Health**

* CLPPP works closely with local public health and inspectional services on primary prevention efforts.
* CLPPP trains and licenses LBOH staff to perform code enforcement lead determinations (spot checks) for families, regardless of a child’s blood lead level.
* The State Sanitary Code for Housing includes a provision for testing for lead paint, if the residence is built before 1978 and a child resides there.

**Education and Outreach**

* + CLPPP works with the medical community to educate providers and families about reducing lead exposure and blood lead screening.
	+ CLPPP works with other local and state government agencies to coordinate activities, to educate families, and to incorporate lead poisoning prevention activities into policies.
	+ CLPPP educational material is distributed in multiple languages and by community health workers and on our website.

**Education and Outreach**

* + CLPPP contracts with 7 agencies to provide statewide community health worker services to families with children and to conduct community-based public information sessions.
	+ CLPPP staffs a public information line to provide technical assistance and education about the dangers of lead and the Lead Law.
	+ Lead Safe Homes is a website that provides information about properties that were inspected and/or deleaded. This website received over 200,000 visits in 2015.


# Blood Lead Level Surveillance

**Screening Regulations**

* + - MA regulations require blood lead testing for every child at 9-12 months, 2yrs, and 3yrs
			* Additional testing at 4yrs within high risk communities
		- Results are reported to DPH/BEH:
			* Within 7 days of blood test
			* Within 3 days if the result is >25 µg/dL
		- ~250,000 childhood blood lead tests per year

**Childhood Blood Lead Surveillance and Epidemiology**

* Annual Surveillance:
	+ Screening rates by community
	+ Prevalence of Blood Lead Levels: 5+, 10+, 25+
* Identifying High Risk and Vulnerable Populations
	+ High Risk Algorithm: poverty, housing stock, elevated incidence over 5 years
	+ Mapping and predictive modeling using census data

**Screening Rate Time Trend**

80.0

**Screening rate in MA Calendar Year 2001 to 2015**

78.0

76.0

**76%**

74.0

**Percentage**

72.0

70.0

68.0

66.0

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016

**Calendar Year**

1.20%

1,919

1.00%

1,658

1,510

0.80%

1,242

0.60%

1,000

816

809

0.40%

634

629

592

662

591

0.20%

0.00%

2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015

**Calendar Year**

**Prevalence of Confirmed Elevations**

Statewide Prevalence and Number of Children with Blood Lead Levels ≥10 µg/dL (9-48 months)

**High Risk Communities for Lead Poisoning**

* Based on the previous 5 years of incident elevated blood lead levels (≥10 µg/dL).
	+ Minimum case count of 15 cases over 5 years
* Incorporates age of housing and low to moderate income status.
* Determines a high risk score that must be higher than the state’s score.
* High risk report for CY 2011-2015 has 22 high risk communities.
* 41% of confirmed elevated cases were **not** from high risk communities (2011-15)

**High Risk Community Report**

### Boston

* + Brockton
	+ Chelsea
	+ Chicopee
	+ Everett
	+ Fall River
	+ Fitchburg
	+ Haverhill
	+ Holyoke
	+ Lawrence
	+ Lowell
* Lynn
* Malden
* Milford
* New Bedford
* North Adams
* Palmer
* Pittsfield
* Somerville
* Southbridge
* Springfield
* Worcester

0.9

0.8

High Risk

Remainder of State

0.7

0.6

0.5

0.4

0.3

0.2

0.1

0

2009

2010

2011

2012

2013

2014

2015

**Prevalence (%) of Blood Lead**

**≥10 µg/dL**

**Prevalence of BLL ≥10 µg/dL High Risk vs. Remainder of State**


# Break

Proposed Regulatory Changes

**Why Propose Regulatory Changes?**

* Executive Order 562 – Regulatory Review required all state agencies to review regulations to establish that:
	+ There is a need for governmental intervention;
	+ Costs do not exceed the benefits;
	+ The regulation does not exceed federal or duplicate local requirements;
	+ Less restrictive alternatives have been considered
* Medical Review Panel Recommendations
* Federal Standards - CDC and HUD

**Medical Review Panel**

* CLPPP convened a Medical Review Panel to advise the program on possible changes to policies, regulations, and ways to enhance screening rates.
* The Panel’s White Paper issued in August 2015 provided support for proposed amendments, including the regulatory definition of lead poisoning and requiring venous confirmatory testing.


# CDC and MA Requirements and Blood Lead Levels

**CDC Lead Poisoned and Reference Values**

* CDC has committed to a Healthy People 2020 goal of eliminating blood lead levels of 10 µg/dL or above (CDC definition of lead poisoned) in children under six.
* Additionally, CDC uses a “reference value” of 5 µg/dL, that identifies children who have been exposed to lead and need education about medical care and about preventing additional exposure.
* CDC does not mandate a code enforcement response or identify legal liability.

**Current MA Definition of Lead Poisoning and Legal Requirements**

* The current definition of lead poisoning in MA is a venous blood lead test result of 25 µg/dL or greater.
* In MA, when a child is identified as poisoned there is
	+ Mandatory code enforcement of the law (inspections/deleading);
	+ Clinical case management services for the family and child
	+ Property owner liability for damages if the property was not in compliance

**CLPPP Case Management for Lower Blood Lead Levels**

* CLPPP currently enrolls all children with a BLL of 10

µg/dL or greater into case management.

* Case Managers ensure the child is re-screened to confirm levels.
* Environmental investigation/code enforcement and family advocacy services are offered.
	+ These can be declined by the family at this level
	+ When families decline, CLPPP recommends that they meet with community health workers and have a private lead inspection.

**Proposed Change to Blood Lead Level Definitions**

* Current Regulation:
	+ Defines Lead Poisoning at 25 µg/dL or greater venous blood lead in a child
	+ Defines a “Lead Level in Excess of a Level Considered Dangerous to a Child’s Immediate Health” between 15-24 µg/dL
* Proposed:
	+ Define Lead Poisoning at 10 µg/dL or greater venous test result
	+ Establish a “Blood Lead Level of Concern” at 5-9

µg/dL 47

**Capillary Test Reliability**

## Evaluation analyses of 2011-2012 capillary tests

≥10 µg/dL

* Capillary tests found to have a positive predictive value (PV+) of 27%
* Only about ¼ of initially elevated capillary tests were truly elevated based on follow-up testing

**Test Positive**

**Truly Positive**

**Proposed Change to Blood Lead Screening Requirements**

* CDC recommends that initial capillary test values of 5

µg/dL or greater be confirmed by venous testing.

* MA enforcement activity requires a venous confirmation
	+ Children without this confirmation may continue to live in homes with dangerous lead hazards.
* Current Regulation:
	+ Recommends, but does not require, venous screening or confirmation.
* Proposed:
	+ Require venous confirmation for capillary test values of 5 µg/dL or greater.

**Lead Poisoning Prevention and Control Regulations**

* HUD abatement standards are, in essence, an intact paint standard with the exceptions of window components and friction surfaces.
	+ HUD evaluation done by Battelle and National Center for Healthy Housing in the 1990s.
* Proposed changes make MA more consistent with federal standards that evaluated a standard of care, which included making accessible surfaces intact.
* Proposed changes would reduce cost by approximately one-third as incentive for preventative deleading.

**Lead Poisoning Prevention and Control Regulations**

* Current Regulations:
	+ Define as Accessible, Mouthable Surface as a surface 5ft. or less from the floor or ground that forms a protruding corner or similar edge or protrudes 1/2 inch or more from a flat wall surface.
* Proposed
	+ Definition of Accessible, Mouthable Surfaces would remove outside corners of walls, window casings, door casings, chair rails, balusters, or latticework from the deleading requirements and apply an intact paint standard, consistent with HUD requirements.

**Other Proposals**

* Delete regulations related to the encapsulant material and use approval process and refer to ASTM standards.
* Move language regarding the abatement and containment methods as well as the procedures for initial inspection and reinspections and code enforcement to policies, procedures, and training materials.