CENTERS FOR DISEASE CONTROL AND PREVENTION

LEAD EXPOSURE AND PREVENTION ADVISORY COMMITTEE

(LEPAC)

MEETING HELD VIA MICROSOFT TEAMS VIDEO CONFERENCING

DECEMBER 11, 2024, 11 A.M.

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WELCOME, INTRODUCTIONS, AND ANNOUNCEMENTS

DR. ALLWOOD: Good morning, everyone, or good afternoon. I think it's morning for everybody. It's time for us to start the Lead Exposure and Prevention Advisory Committee meeting. And it's my pleasure to welcome all of you to the -- to this meeting.

My name is Paul Allwood and I am the chief of the Lead Poisoning Prevention and Surveillance Branch here at CDC. And I'm also the designated federal official for the LEPAC.

Just a few important reminders before we get started. First and foremost I'd like to just remind everyone that we're going to keep all of our audience on mute during the meeting. We will have a full transcript of -- of the meeting, you know, and -- and as well as a summary of the meeting that will be posted on our website in the very near future.

We will have a full agenda today, so we're going to be sticking very, very -- very closely to the times that are laid out on the agenda. So I'm going to be asking all presenters to please make note of the time that you're allotted for your presentation and please do your very best to

stay on time. And, you know, if we need to, we will, you know, give you a little bit of a reminder -- and maybe with -- with a minute left or so -- so that you can do a quick -- quick wrap-up.

With that and without any further ado, let me welcome Dr. Ari Bernstein who is the director of the National Center for Environmental Health for his remarks.

Dr. Bernstein.

DR. BERNSTEIN: Thanks so much, Paul. And welcome, everyone, to the eighth meeting, annual meeting, of the LEPAC. I want to extend a warm welcome to all of you for being here. And your being here today is a great sign of your commitment to the issue of preventing lead exposure among our nation's children and -- and in our communities around the country.

This group, as you all, I hope, can appreciate better than anyone, brings together a unique set of expertise and perspectives. And that affords an important opportunity because as we continue to make progress on eliminating the threat of lead, it is going to require each -- each of us to bring our talents and commitments

to bear.

I'm excited about this meeting for that reason. It gives us the chance for those -- for all of us to -- to bring forward our talents to what is -- what remains an incredibly important health objective: eliminating lead exposure.

In the recent past, there have been several things here at CDC -- and I give immense credit to the work of our lead team within the National Center for Environmental Health to these achievements. We worked with FDA to truncate what could've been an enormous outbreak of lead poisoning in children from cinnamon that had been adulterated with lead and introduced into applesauce pouches. That, I think, is a huge public health win.

The Lead Detect Prize was launched and the winners were announced. And I think we all appreciate how important it is to make sure that we have accurate point-of-care testing available for our nation's children and the providers that care for them to make sure that we are able to, you know, protect the children most at risk from exposures to lead.

I see the Lead Detect Prize as a huge

incentive and awareness-raising tool. Beyond that, the importance of filling what is a really important need in our nation's public health work to prevent lead exposure.

We launched the National Lead -- or we have, excuse me, the National Lead Poisoning Prevention Week again. That's another opportunity to raise awareness to this issue. As I don't need to tell anyone here, there are times in the not-so-distant past where folks were saying lead is behind us. And actually in that period of time was when Flint happened and I would say it was a major reason to LEPAC as it is -- as we are meeting today, relaunching.

And then we did launch the Lead-Free Communities Initiative and Toolkit that I think is an important tool to empower communities across the country to take steps that will prevent exposure and really is formulated in a way that is -- is working to empower the communities that are most at risk to do what we can to protect particularly children from lead exposure.

Each of these you will hear more about during the session today. As I said, I'm very

excited that you all are here and the perspectives that you will bring the table.

Thank you again for taking the time and sharing the knowledge that you bring to the table. And with that I will turn it back to Paul.

DR. ALLWOOD: Thank you, Dr. Bernstein. Thanks for your remarks.

And now I will ask our chairperson, Mr. Matt Ammon, to please introduce himself.

MR. AMMON: Thank you, Paul. Thank you, Dr. Bernstein.

I am Matt Ammon. I'm the chair of the LEPAC group. My -- I guess my day job is the director of HUD's Office of Lead Hazard Control and Healthy Homes. And I've had the pleasure of working with all of you all. And, of course, it was a team for several years now. And I appreciate all of their efforts in putting these meetings together.

But, you know, as Dr. Bernstein was mentioning, this year we've had a lot of successes. There's a lot of activity. There is a lot of inertia in what we have all done collectively, both at the -- all levels: federal,

state, local, nonprofit, universities. I mean, we have a lot of public-private partnership work that -- that continues and that has been very successful not only to -- to address issues around lead poisoning, but, of course, core housing issues, which is really at the center of this work, as well as extending to other sources.

We've had a lot of work obviously -- EPA with infrastructure and water -- so, you know, lead is still front and center in all of our minds and -- and we have a great agenda. I always learn a lot from these meetings. A lot. I think it is not only very engaging, but it really is a source of not only rich information but really is a perspective of any clarity in a lot of work that goes on around the country in this board.

So, you know, today we'll hear about the blood lead testing from a local perspective, and that's always key to -- to -- and central to our work is that -- and I've -- I've -- you've heard me say this many times, is that everything we do is local and we've been focusing on ensuring that the work that we do, both with programs and initiatives, help local programs succeed in their

goals.

So, again, we'll hear about blood lead testing from a local perspective. We'll get updates from our members, which I think will be very enlightening, about how much work and how many successes happened this year. There were -- there were great outcomes that we all really should celebrate and highlight.

And then, of course, we'll hear from the lead -- Preventing Lead Exposure in Adults workgroup. And then we'll hear about some of the challenges in terms of blood lead testing and opportunities post-COVID, which, you know, I feel like we're really turning the tide in terms of -- of getting back to a lot of the capacity and basics that have been shifted because of COVID. And we saw a lot of that in our programs at HUD and so we're very excited to hear that.

And then we'll talk about next steps and wrap-up.

But, again, I appreciate everybody being here. And, again, I always look forward to these meetings. It's a lot of information. It's very exciting to be part of all of this work that we have going on. And it is, of course, not just

one focused on one agency or one entity or one community. This is really a nationwide effort in its focus.

And so, again, I -- I thank everyone for being here.

So with that I will turn it over to Perri.

DR. RUCKART: Okay. Thank you.

Good morning. I'm Perri Ruckart, and I work with Paul at CDC, and I serve as the Deputy DFO of this committee.

So I am going to call on all the members. And when I call on your name, would you please introduce yourself and come on camera if you are able to.

And I also want to say that several of these members are new. This is the first meeting. So an extra welcome to them.

So I will start with Tammy Barnhill-Proctor. Are you there? Yes.

MS. BARNHILL-PROCTOR: I am. Good morning, everyone. I'm Tammy Barnhill-Proctor with the U.S. Department of Education. And I am on the committee for -- I think this is my second term.

DR. RUCKART: Great, thank you.

Gary Edwards.

MR. EDWARDS: Hello. I'm Gary Edwards. I'm new to this committee. First time I'm on.

I'm familiar with Paul. Years ago I worked with Paul at Environmental Health, Minnesota Department of Health. He was an epidemiologist at that time. And lo and behold he eventually became an assistant commissioner of health in Minnesota. A really great guy and I really enjoyed working with him over the years.

So I have a background in environmental health of my last six years with Minnesota Department of Agriculture, supervising pesticide licensing. Happy to be here.

DR. RUCKART: Great, thank you.

Dr. Brenna Flannery.

DR. FLANNERY: Good morning, everyone. My name is Brenna Flannery. I am a toxicologist with the Human Foods Program at FDA, and I specialize in chemical contaminants. This is my first year attending the meeting and being part of LEPAC, so I'm very excited. Thank you.

DR. RUCKART: Great, thanks.

Dr. Rebecca Fry. Rebecca, are you here?

DR. FRY: Sorry. Hi, everyone. Rebecca Fry. I'm at the University of North Carolina at

the School of Public Health in the Department of Environmental Sciences and Engineering and really pleased to be part of this panel. Thanks so much.

DR. RUCKART: Thanks.

Mary Beth Hance.

MS. HANCE: Good morning. I'm Mary Beth Hance. I'm the Deputy Director of Division of Quality and Health Outcomes at (inaudible) --

DR. RUCKART: Mary Beth, you're cutting out.

MS. HANCE: (indiscernible)

DR. RUCKART: Mary Beth, you're cutting out. I don't know if that's just for me.

Is she cutting out for others?

DR. ALLWOOD: Yeah, I think -- Mary Beth, you sounded a lot better when your camera was off. Maybe it's a little bit of a bandwidth. Some maybe if you went off camera, we could ...

DR. RUCKART: Yeah. If you wouldn't mind reintroducing yourself because I don't -- I don't think that everyone necessarily heard what you said.

MS. HANCE: Sorry about that. This is Mary Beth Hance. I'm from the Centers for Medicare and Medicaid Services. Can you hear me now?

DR. RUCKART: Yes. That's -- that's very clear. Thank you.

MS. HANCE: Okay, great. Sorry. Sorry. It looked like the delay at my end was after I had spoken before. So apologies.

I'm the Deputy Director of the Division of Quality and Health Outcomes and have the privilege of having been -- attended this -- or participated in this meeting last year as well and am happy to be here again.

DR. RUCKART: Thank you.

Dr. Christina Hatlelid.

DR. HATLELID: Hello. I'm Kristina Hatlelid. I'm a toxicologist by training. Now I am the Director of the Division of Toxicology and Risk Assessment at the Consumer Product Safety Commission. I have been serving as a member of the LEPAC for a couple of years now.

DR. RUCKART: Great, thank you.

Dr. Gredia Huerta-Montañez. Gredia, are you on?

Okay, we'll keep going and I'll call her at the end. Dr. Aaron Lopata.

DR. LOPATA: Hi. Yes. My name is Aaron Lopata. I am the senior medical officer at the

Maternal & Child Health Bureau, Division of Perinatal Services. And I am also a pediatrician. And I -- I'm sorry, and I should say I'm at MCHB, Maternal & Child Health Bureau at HRSA. And I've been -- started with this -- with LEPAC last -- early last year. And I'm just really happy to be here. Thank you so much.

DR. RUCKART: Great, thank you.

Dr. Mikki Meadows-Oliver. Mikki, are you on?

Okay, I'll keep going. I will circle back at the end.

Grace Robiou.

MS. ROBIOU-RAMÍREZ: I'm the director of the EPA Office of Children's Health Protection in Washington D.C. I'm happy to be with you today.

DR. RUCKART: Thank you.

Mikki, is that your hand who's up? I just see MM; is that you, Mikki?

DR. MEADOWS-OLIVER: I think maybe I figured out -- I'm new to Teams. I'm so sorry about that. I was trying to get off mute and camera.

Again, I'm Mikki Meadows-Oliver, and I'm a pediatric nurse practitioner. I was with the Yale Lead Poisoning Prevention Program in New

Haven, Connecticut. And I am new to this committee and new to Teams, but I'm happy to be here today. So thank you.

DR. RUCKART: Great, thank you.

Jeff Sanchez.

MR. SANCHEZ: Good morning. Hello. Jeff Sanchez. I'm the Deputy Director of Impact Assessment. We're an organization that's been working with local and state -- and our state health department here in California. We're based in Berkeley here.

And I've been working on lead poisoning initiatives since the early '90s, supporting the -- our electronic blood lead reporting law and our surveillance and case management systems. Proud that CDC picked it up as a -- the beginning -- start of their health system. So excited to see where it is. Took them several data and security initiatives here in California. And I'm currently working on several initiatives for Los Angeles County on primary prevention work.

So happy to be here. And this is my first year, so thank you.

DR. RUCKART: Great, thank you.

Dr. Megan Sparks.

DR. SPARKS: Good morning. I'm Megan Sparks. I'm the lead epidemiologist for the Johnson County Department of Health and Environment. I also serve as a technical advisor to the state of Kansas Childhood Lead Poisoning Prevention Program, and I run our county level Childhood Lead Poisoning Prevention Program. This is my first year and I'm really excited to work with you guys.

DR. RUCKART: Great, thank you.

And Brian Weaver.

MR. WEAVER: Yeah, good morning, everyone. Brian Weaver. I serve as the lead policy advisor for the Wisconsin Department of Health Services. I joined LEPAC in June of 2024. And I have been serving as the chair for the Prevention of Lead Exposure in Adults workgroup. So thank you.

DR. RUCKART: And Dr. Gredia Huerta-Montañez. If you would just, now, introduce yourself --

DR. HUERTA-MONTAÑEZ: **Hi --**

DR. RUCKART: -- to the group.

DR. HUERTA-MONTAÑEZ: -- sorry. I couldn't -- I couldn't unmute. You didn't allow

me to unmute before.

Hi. My name is Gredia Huerta. I'm a pediatrician with Training and Pediatric Environmental Health. And I am a pediatrician with the Pediatric Environmental Specialty Unit, Region 2, the PESU, and also a member of the AAP Council on Environmental Health and Climate Change, and I'm based in Puerto Rico.

My first term with the committee. Thank you.

DR. RUCKART: Great, thank you.

And now I will introduce our liaison members.

Ruth Ann Norton, are you on?

MS. NORTON: I certainly am and good morning. From Baltimore, Maryland, this is Ruth Ann Norton. I am the president and CEO of the Green and Healthy Homes Initiative. I've been working to eradicate lead for the last 32 years. So let's keep going. And good morning.

DR. RUCKART: Great, thank you.

Dr. Patrick Parsons. Patrick, are you on?

DR. PARSONS: Hi, can you hear me?

DR. RUCKART: Yes. Yes. Yes.

DR. PARSONS: I'll say good morning. My

name is Patrick Parsons. I'm the director of the Division of Environmental Health Sciences at the Wadsworth Center in New York State Department of Health. I've been responsible for the lead poisoning lab here for 38 years. I serve as the liaison member for the Association of Public Health Laboratories. Thank you.

DR. RUCKART: Great, thank you.

Amanda Reddy. Amanda, are you with us this morning? Okay, I'll circle back to you.

Dr. Stephanie Yendell.

DR. YENDELL: Hi, I'm Dr. Stephanie Yendell. I work with the Minnesota Department of Health and I am the PI for both our CDC Childhood Lead Poisoning Prevention Program grant as well as a HUD Lead Hazard Reduction grant, and I am serving as the liaison for the Council of State and Territorial Epidemiologists or CSTE.

DR. RUCKART: Great, thank you.

And Dr. Lauren Zajac.

DR. ZAJAC: Hi, good morning. I'm Lauren Zajac. I am the liaison from the American Academy of Pediatrics. In my day job I'm a pediatrician and clinical director of Environmental Pediatrics at Mount Sinai in New

York City.

DR. RUCKART: Great, thank you.

And we do have another liaison member who isn't with us right now but will join be joining us later this afternoon and that's Abe Kulungara from the Association of State and Territorial Health Officials or ASTHO.

Amanda Reddy, are you are on with us?

Okay, well, we do have another member, a liaison member, Amanda Reddy, National Center for Health and -- for Healthy Housing.

And I do want to introduce some CDC staff who are instrumental in helping keeping this committee functioning. We have Alexis Allen.

MS. ALLEN: Morning, everybody.

DR. RUCKART: Alexis is our Committee Management Specialist.

And Nick Hatch.

MR. HATCH: Good morning. My name is Nick Hatch. I am the deputy Committee Management Specialist. Good to be here and good to see everyone.

DR. RUCKART: Great, so thanks to everyone and welcome to the new members as well as the returning members.

And I will turn it back to you, Paul.

DR. ALLWOOD: Thank you, Dr. Ruckart, and thank you for your introductions.

And now I'll just do a quick recap of our last meeting of this committee which happened, excuse me -- happened in October of 2023. And that was the seventh time that the committee was meeting, back October 16th and 17th, 2023. And that was a -- was a hybrid meeting. We had, you know, a large number of people attending in person on the CDC campus in Atlanta and then an even larger number of people attending virtually. Totally there were 361 people that attended that meeting for both days.

And some of the topics that were discussed at that meeting included the sharing from LEPAC members' federal activities that -- to prevent, reduce, and eliminate childhood lead exposure and -- and using both primary and secondary prevention strategies.

There was also, you know, presentations and discussion of lead in drinking water and efforts, you know, across the federal government and community partners to address that issue.

There were discussions about lead service

line replacements. We had a presentation on data and surveillance from CDC and other partners.

And we also discussed adult and occupational exposure challenges and opportunities. Additional details from that -- from that meeting can be found on the CDC's LEPAC website. And that will be if you go to the website, you'll find, you know, details of the presentations that were -- were given at that meeting. And also a transcript of the meeting is available online.

Today we're going to be hearing -- you know, in addition to what chairman Matt mentioned, there will be public comment from Mr. Tom Neltner from Unleaded Kids and that's going to be coming up later on in the agenda.

And so now I will turn the meeting over to the -- to our chairman, Matt, to discuss the charge, to disclose any -- any conflicts and to -- to conduct a vote on the annual report of the committee.

Matt.

VOTE ON THE 2023 LEPAC ANNUAL REPORT

MR. AMMON: Thanks, Paul.

So as a first order of business, you all were sent the annual report back on

November 18th. And just, you know, as a reminder of -- of what we are doing here and what our responsibilities are, so the LEPAC is responsible for providing advice and recommendations to the Secretary of HHS and its companion agency as well by reviewing research and federal programs and services related to lead poisoning and identifying effective services and best practices for addressing and prevention of lead exposure in communities.

Again, this is part of our charter. This is how we've operated for -- for years under this authority. And so as part of this whole process, we need to vote on the annual report.

And so with that, first let me ask if there are any conflicts related to anything in the report or anything on today's meeting just in terms of that we need to discuss or someone may have to recuse?

Okay, seeing none, I am going to make a motion in terms of moving forward the annual report for a vote. So it may be easier if everybody is on camera for this. So I'm going to ask everybody for all in favor to have yourself on camera and raise your hand in the affirmative.

All right, thank you for that.

And any opposed? I'll just wait till the tally finishes.

All right. With that, the report is approved and submitted for the record. Thank you very, very much.

And with that, let's move to our first topic. So our first topic --

DR. RUCKART: Oh, excuse me. Excuse me, Matt. Would you be able to go over the charge just for the new members?

MR. AMMON: Actually, I don't have that in front of me. You could start and I'll add to it.

DR. RUCKART: Okay. Just momentarily. Just bear with me. Okay. The charge -- just -- just want to briefly remind existing members and just new members as well about the charge and purpose of the LEPAC.

So the committee was established by the Water Infrastructure Improvements for the Nation Act, the WIIN Act of 2016, and the purpose of the LEPAC is to review research in federal programs and services related to lead poisoning and to identify effective services and best practices for addressing and preventing lead exposure

among communities.

And the LEPAC is charged with five items: One, reviewing federal programs and services available to individuals and communities exposed to lead; two, reviewing current research on lead exposure to identify additional research needs; three, reviewing and identifying best practices or the need for best practices regarding lead screening and the prevention of lead poisoning; four, identifying effective services, including services related to healthcare, education, and nutrition for individuals and communities affected by lead exposure and lead poisoning; and, five, undertaking any other review or activities that the HHS Secretary determines to be appropriate.

And annually we submit -- the LEPAC submits reports to the HHS secretary; the committees on finance, health, education, labor and pensions, and agriculture, nutrition, and forestry of the Senate; and the committees on education and workforce, energy and commerce and agriculture of the House. And this includes an evaluation of the effectiveness of the federal programs and services available to individuals in communities

exposed to lead, an evaluation of additional lead research exposure needs, an assessment of any effective screening methods or best practices used or developed to prevent or screen for lead poisoning, input and recommendations for improved access to effective services relating to healthcare, education, or nutrition for individuals and communities impacted by lead exposure and any other recommendations for communities affected by lead exposure as appropriate.

So you can see that that aligns nicely with the charge. And are there any questions?

All right, seeing none, I will turn it back to you, Matt.

MR. AMMON: Thanks, Perri. Sorry, I printed out the wrong information.

So with that, I know we are a little early and hopefully everybody is okay if we move a little quicker. Maybe it allows for a longer break. But with -- with the first order of business being done, we are hopefully ready to start our first presentation.

If we're not, let me know. But the first presentation is around improving blood lead

testing from a local perspective.

So with that, hopefully Gail, Nicole, and Ruth are available to present on this topic. I believe we're going to start --

MS. GETTENS: Yeah.

MR. AMMON: -- with Gail.

MS. GETTENS: Yes, good morning. I am here. And I believe Nicole Lang is also here. So thank you.

IMPROVING BLOOD LEAD TESTING FROM A LOCAL PERSPECTIVE

MS. GETTENS: I'm Gail Gettens. I'm a child development specialist by training, and I'm a health communications coordinator for New Hampshire's Healthy Homes and Lead Poisoning Prevention Program. We're within New Hampshire's division of public health under the umbrella of New Hampshire Department of Health and Human Services.

And I'm here with Nicole Lang. She is a nurse practitioner, and she's one of the nurse case managers with our program.

Next slide, please. So as a way of just introduction, Nicole and I are sitting in New Hampshire. We are a very tiny state, total population at 1.4 million. We're tucked in the

northeast corner of the United States. Our northern border is shared with Canada. Our southern border is shared with Massachusetts. And much of our southern kind of southeast corner of our state really is more pop -- more populated, more diverse, are small cities and really are bedroom communities, commuter communities to Boston and Massachusetts's kind of tech and biotech industries.

The rest of our state, as you can see from the map on the left, is very, very rural. As you see, there are no cities, no major roads in much of our state. So we -- we are a small state and a rural state. Next slide, please.

And next slide, please.

We are a small state, but we unfortunately have a very significant, very large childhood lead exposure problem. In 2023, around just last year, we identified 1,207 children in our state with a blood lead level greater -- equal to or greater than 3.5. And over the last five years, even with those years during the pandemic when there was such low testing, we've identified 4,575 children with a blood lead level of 3.5 or greater. Next slide, please.

New Hampshire has been on the right trajectory. Between 2015 and 2019, we had this really encouraging trend in our testing rates. We had a small legislative initiative law change in 2015, and we also did a tremendous amount of work from our department to introduce, educate our pediatricians on point-of-care testing, and really work to transition our pediatricians away from venous draws and onto point-of-care testing.

And then in 2018, April of 2018, New Hampshire by state statute changed laws and we are now a universal testing state, requiring testing at age one and again at age two.

So by the end of 2019, we were at 70 percent testing range for our one-year-olds and 58 percent for our two-year-olds. So certainly great progress but nowhere near where we wanted to be, especially for our two-year-olds. Next slide, please.

Then we all know what happened in 2020. And New Hampshire, like most other states, experienced a really dramatic drop in testing rates. In New Hampshire we saw a 25 percent testing -- drop in our testing rates from just 2019 to the end of 2021. And it equated to 5,360

fewer children tested in just two years in our very, very small state. Next slide, please.

At our New Hampshire's statewide clinical ed advisory committee meeting -- this committee meets three times a year: our pediatricians, pediatric healthcare leadership, health systems. And we were meeting in August of 2022, looking at this data trend, very concerned, and discussing how we might reverse it and quickly and then begin to build upon what our rates have been prior to the pandemic.

And Dr. Walsh, Alan Walsh, is a member of our committee in New Hampshire. He's the medical director of Region 1's Pediatric Environmental Health Specialty Unit at Boston Children's. And he wisely said to us: New Hampshire, perhaps you should consider looking into doing a lead testing quality improvement project and couple it with continuing medical education training using the ECHO model.

So upon his advice, he suggested we reach out to other states that had run similar programs. So we connected with Liz Harris, Dr. Harris, a pediatrician at Intermountain Health in Utah. Liz kindly got up very early

Utah time to join our 8:00 meeting in December of 2022 which was our next meeting.

Once we heard Dr. Harris's presentation on some positive outcomes of their quality improvement project in Utah and then heard from her work as a faculty member and others, we knew this was something we really wanted to pursue.

So I spent much of 2023 learning more, working with and meeting with other states, including Wisconsin and New Jersey's chapter of AAP, to learn about their quality improvement projects, also on a national level with AAP and with partners within New Hampshire so we could figure out how we could establish this, find the funding, set this up. Next slide, please.

I'm going to pause here for just a moment. For those of you attending that aren't familiar with what a project ECHO or an ECHO is, I just wanted to take a moment to explain it.

So the acronym stands for Extension of Community Healthcare Outcomes, and it's really a training model platform that was developed by the University of New Mexico. And it truly revolutionized continuing medical education. The model exponentially increases workforce capacity

to provide best practice specialty care but also to reduce health disparities.

In order to run an ECHO, you have to have an ECHO hub which is getting a group trained in managing and running ECHO programs, and you need the trained facilitators. Next slide, please.

By late 2023 we had establish our partners and were able to be ready to stand up our quality improvement project. New Hampshire chapter of the American Academy of Pediatrics is a partner we work with frequently and immediately came on board.

And in addition to that, AmeriHealth Caritas -- well, AmeriHealth Caritas is one of New Hampshire's three contracted Medicaid MCOs and AmeriHealth Caritas really was essential to us being able to stand this up. They are an ECHO hub and they share their ECHO hub and their ECHO team with us to stand up this project.

We also were able to connect with Ruth Gubernick, quality improvement consultant extraordinaire when she was highly recommended to us by other state chapters of AAP and national AAP. And she came on board as well. Next slide, please.

We started our onboarding of practices just about a year ago, in November of 2023. The flyer you see on the right is what we used to advertise, promote, and recruit practices to register. It involved six monthly sessions. So we had one meeting each month, June -- January to June of 2024, and it required seven data submissions: a baseline data submission and then six additional submissions, the last of which just came in by the end of this past July. Next slide, please.

A unique part of this particular model is that the practices, the pediatric practice, did just that, joined as practices. So we had acquired a minimum of one physician and one additional clinical team member. It may have been a -- a nurse, a nurse practitioner, it may have been another physician, may have been a medical assistant.

We had hoped to get at least six for our inaugural run -- our maximum was ten that we could involve -- and we had eight practice teams join. We were pretty pleased with that. Many others had expressed interest, but it wasn't the right time either because of workforce shortages

or changing EMRs, that they hope to join us if we stand up another cohort. Altogether we have 15 pediatricians and 38 clinical participants. Next slide, please.

We were also really pleased that we had very diverse practice types from across our tiny little state. We had independent rural health centers in our north country. We had a federally qualified healthcare center in our rural area. The remaining practices were all hospital-affiliated practices, but even great diversity in amongst those.

We had our largest health system -- it spans multiple states -- and our largest employer participating. We also had practices from our tiny hospital, which you can see on the screen, that had 25 beds. So very diverse practice types. Next slide, please.

It was a very significant commitment. You're required to attend all six sessions with your camera on and to be actively participating. This wasn't a "eat your lunch, check your e-mail with your camera off" kind of thing. You were in and discussing and participating.

There were seven monthly data submissions

that we're going to be talking about. And each practice team in addition to attending the six sessions, they also had to meet at least once with the quality improvement coach separately to look at their data on their practice -- individual practice level. Everyone involved was required to sign an MOU, both as an individual and as a practice team, so everyone understood the commitment. All practices were required to prepare and submit one case study and be prepared to present it if -- if selected.

And a piece I do want to mention and you're going to hear me mention it again is that because this was a quality improvement project, we were able to offer to physicians participating 25 MOC part 4 points in addition to what you would think of the typical or usual expected continuing medical education credits and continuing nursing education credits.

So what is MOC part 4? MOC stands for maintenance of certification. And every five years, when a physician renews her or his license, they're required to have accrued 50 MOC part 4 points, which you accrue them by participating in quality improvement projects.

It's a pretty big lift and it's a pretty big lift if you're from a smaller practice, independent practice, smaller health system.

So the fact that by participating we were offering half of what was needed, 25 MOC part 4 points was a very significant incentive and carrot and, well, the third one because of the commitment. Next slide, please.

What you're seeing here is kind of the back side of our quality improvement study. So because New Hampshire Chapter of the American Academy of Pediatrics was one of our partners, we were able to access through a national level with American Academy of Pediatrics the Quality Improvement Data Aggregator, which otherwise known as QIDA, where we're assigned a QIDA consultant. There is a fee for this.

So this is us figuring out what we wanted to measure; how many measures we could afford; what questions, what data questions do we need to ask to get the data we needed; and the actual formulas, the math behind what we were going to be measuring. Next slide, please.

This is what the practices would see. The QIDA team creates an interface for each study.

So this is the data entry portal. So our practices would log in and this is where they would enter their data each month. Next slide, please.

And, again, they submitted baseline data which was the month of November's data of last year was submitted by the end of January of this year and then each of the six months going forward -- next slide, please -- with the last of the data just coming in at the end of July.

Those of you that are familiar with an ECHO will know it (indiscernible) kind of two-thirds of this pie chart in front of you. So during ECHO session, there is a didactic presentation. We were really fortunate that we were able to tap local, regional, and national experts to provide that educational portion of the case study discussion where practice teams presented their case study. Everyone asked questions, discussed it, and provided recommendations.

But the piece that really makes this particular model different is that the session, each monthly session, was kicked off by our quality improvement consultant who reviewed the data. Next slide, please.

Before each session, Ruth would prepare a run chart, which is what you're looking at on the screen, for each one of our measures. And she would present it -- this was the aggregate data -- and ask questions and share thoughts and we'd look for where we were improving, where changes still needed to be made, where there might be missed opportunities.

And, again, in addition to looking at the aggregate data each month, the teams also met at least once, so to speak, offline, individually with Ruth to look at their practice level data. Next slide, please.

So now that you have an appreciation of, you know, the why we did this and the how we stood it up, I'm going to turn it over to Nicole to share with you about the measurable outcome improvements that we saw.

MS. LANG: Thanks, Gail.

So I will be sharing with all of you how this framework translated into meaningful quality improvement because when we're considering where to invest our time, our efforts, and probably most importantly our limited funding, we want to choose an activity that we feel confident will

pan out.

You're looking at some of the areas in which we saw measurable improvement and we'll go through them one by one, starting with lead exposure risk assessments which are a series of questions to ask families about possible lead exposure. So with that defined, let's look at the next slide, please.

So this is a chart of all of the preventative action steps that the American Academy of Pediatrics asks healthcare providers like myself to take at well-child visits, from newborn all the way through 21 years of age. And lead exposure risk assessment is on this chart.

The AAP and all of us on this call, to be honest, consider the impact of lead exposure on a young child so detrimental to their potential that we should be asking about lead exposure seven to nine times by the time the child turns six years of age. So that means asking these questions at the six-month visit; the nine-month visit; again at the 12-month visit, if you're not doing a test, the parent declines the test; again at 18 months; and then 24 months. If no test is done, three-year-old, four-year-old,

five-year-old, six years old.

Now, as a clinician, I see this lead exposure risk assessment as a "two for one, more bang for your buck" tool. And the reason is that, one, you're assessing a child for possible lead exposure realtime. You're not waiting for a state-mandated test tool around in three to twelve months. The other reason I love this is that it's primary prevention in that parents are hearing or seeing these questions seven to nine times, all about lead exposure, by the time their child is six years of age. They may be able to stop an exposure before it ever happens. So how are our practices doing with performing lead exposure risk assessments? We can move to the next slide.

So initially, at baseline, less than one in four children was being assessed. And you can see -- again, we met for the first time in January. So just the increase in the number of these assessments being done in one month's time by the time people were putting in their February data, that is impressive growth. But you can see as the months progressed and our clinicians got familiar with lead exposure and its impact on a

child and more familiar with their own data, their quality, their own EMR, this rate of assessment increased more than -- more than doubled. So we can move to the next slide.

Anticipatory guidance. This is another measure we looked at. It's the process of counseling families on possible dangers to their child's health and safety. It should be both age and developmentally appropriate. It includes things like lock up your weapons and put sunblock on your child and rear-face that car seat. But it should also include, hey, lead -- lead hazards may exist in your child's environment. Let me tell you all about them.

Anticipatory guidance is also a required component of a well-child visit for meeting certain conformance measures but also for being reimbursed for your well-child visit. So it needs to be included.

In the board book that you're looking at in these photos -- is provided by our program at no cost to New Hampshire providers -- and it's -- it contains critical messaging regarding all things lead on each page directed towards parents. It was developed with clinical guidance from New

Hampshire chapter of AAP and also from the region 1 PESU. It was funded by grants through the CDC and the EPA. It's now used across the nation by pediatricians, by public health entities, and it's well received by parents and children alike.

So when that clinical team puts this book into the families' hands, that allows the provider to click the box that says age-appropriate anticipatory guidance was provided at this visit. So we wanted to find out how many of our practices were providing this no-cost-to-them board book at well-child visits between six to twenty-four months. So we can move to the next slide.

At baseline, not very many. Not very many children were receiving this book. But again impressive growth as the ECHO progressed through the months and our clinicians became more familiar with lead exposure. They changed their workflow to make sure this book got into families' hands and, you know, we're looking at a -- a nine-fold increase or a little bit more in the percentage of children and, quite honestly, you know, the whole family that was receiving

this guidance through the form of this board book.

So now we can look at the actual testing data because that was our original reason for starting on this journey to begin with. So let's move to the next slide.

So what you're looking at is aggregate data for all eight practices at baseline. I'm not sure what's going on with the slide, though, but I'm sure it'll be fine. But at baseline our practices came in at a rate of, you know, slightly above our pre-pandemic testing rates. With time we saw growth of the testing rates of our 12-month-old children. Nearly 90 percent of children were being tested at the project's end.

But how about those two-year-olds? The ones we really must test because we know that lead exposure peaks between 18 to 24 months of age, but the ones who are hardest to test because they're two years old. So we can move to the next slide.

So our aggregate data demonstrated the baseline that really wasn't too shabby was higher than our pre-pandemic baseline testing. And we still saw growth, impressive growth, with the

number of our two-year-olds who were tested as our clinical teams changed practice. Although the rates dipped in the summer months, they did not decrease below the baseline testing rate.

Remember that Gail mentioned an estimate of 5,360 children -- I think that's the number -- that were calculated as having missed a test during the pandemic years. We wanted our eight practices to look for those children. We can move to the next slide.

So we asked them to assess kids coming in for a 30-month well-child visit, a three-year-old visit, four-year-old visit, a five-year-old visit to find out how many of those children had no blood lead tests on file. And we found a number of them and Gail did the math for me. So we can move to the next slide.

This is eight practices, fifteen pediatricians, and seven months of data. And we found 361 children, ages thirty months through five years of age, who had no blood lead level test on record. This was a phenomenal find. All of our providers, every single practice said, Oh, my EMR has no way of notifying me of this, which brings me to our next slide.

There were some things that we couldn't afford to measure or just things that occurred that we thought were really positive and notable and we wanted to make sure we included them. One of those things was overcoming knowledge gaps whether it's about your EMR, the fact that medical schools didn't cover childhood lead exposure to any great extent. You know, within that first session we had a provider saying, I don't know how to follow up on a child with an elevated blood lead level, or I really did not understand the impact of lead on a person's potential across the lifespan.

So acknowledging those gaps led to significant changes in workflow. And the EMR is one of them. We saw our pediatricians leveraging their internal IT department and even each other if they shared the same system to modify that and make sure it was notifying them about missing lead exposure risk assessments, missing anticipatory guidance, missing blood lead tests or follow-up tests being due. We also saw them change their testing processes to include that lead exposure risk assessment as well as the workflow practice to capture a blood lead

specimen at the time of the visit rather than afterward. We also started hearing from our participating practices here in my department, as a nurse case manager, directly asking to collaborate on existing and new cases and special -- special types of cases which just historically have not been the trend.

And it's this last bullet point that I'm really excited to share some data with you on where we look at point-of-care testing versus venous testing after (inaudible). Move to the next slide.

So here you're seeing in the blue that aggregate data for 12-month-old testing rates that we already looked at. And then what we're looking at in the yellow, at the top of this chart, are a couple of our practices that came into this at baseline, committed to the process of collecting a blood lead specimen at the time of the visit.

And then in red, at the bottom of this graph, is one of our practices that's currently unable to offer point-of-care testing for a couple reasons. They were relying on a venous test after the appointment ended at a lab. And

the lab was not off-campus, it wasn't in a different building on campus, it was just down the hallway from the practice itself. And this group -- very motivated, engaged group, their baseline data was close to 68 percent of one-year-olds having a test. And they actually never got back to that level, dropped the entire project.

How about our two-year-olds, the ones who are hardest to pin down for a test? I know that sounds terrible, but that's the way it goes with two-year-olds. We can move to the next slide.

Again, we're looking in blue at the aggregate data that we saw on the previous slide. Our point-of-care testing groups, they have the same exact workflow for the two-year-old well-child visit. Hundred percent of those kids got a test. And then our "venous-only, after the appointment, down the hall" group came in expectedly low with their testing rates.

And then they built this incredible momentum. I told you they're very engaged and motivated. They changed their messaging to parents to say, We missed this at your child's one-year-old visit, we really need to get this

today. And the improvement here is just so impressive. But once those summer months rolled around, that "venous-only, after the appointment, down the hall," those obstacles, they just -- they were insurmountable for this group and they fell back nearly to baseline.

So after seeing the aggregate data broken out like this for 12- and 24-month-old children, the catch-up testing shouldn't be that surprising. Let's move to the next slide.

Again, we asked our practices, you know, some of them, like our red -- red-line venous-only group had to change their EMR really to look for and prompt them to find these children who had never had a blood lead test. And once they did that, it's not too surprising to see that they found proportionately more one -- more thirty-month-olds, three-year-olds, four-year-olds, and five-year-old children who had no blood lead test result on file.

So why is this meaningful for a rural state like ours? It -- you know, this is a very small sample. I recognize that. I would love to run multiple iterations of this ECHO, but I think I would see the same trend for our practices that

rely on venous testing only. We've long suspected they're probably struggling to get one- and two-year-olds tested. We lack a mechanism in New Hampshire to quantify that, but what we're looking at here certainly supports the idea that if you are relying on that venous test, if you are a child in that process, you are less likely, far less likely in some cases, to be tested appropriately, which in our state is at ages one and two.

So, Gail, I'll hand it back to you to wrap things up.

MS. GETTENS: Next slide, please.

So what did we learn? We learned that a project such as this requires a fair amount of time to stand it up. It certainly requires a large amount of funding. And the way we did it in New Hampshire with other partners, they require some logistical efforts and collaboration.

But it was absolutely worth it and it was worth it because it worked. I mean, you can see the increase in testing rates. You can see that we were engaging and educating our physicians and we were also providing really important

anticipatory guidance direct to the families through the use of *Happy Healthy Lead-Free Me* and the risk assessment questionnaires. It worked. It was worth it because it worked.

We certainly learned the incentive of MOC part 4 points. We certainly have heard from other states and other locations that it's hard to engage pediatricians on this topic. Providing MOC part 4 points with a quality improvement project brought physicians into this project. Without a doubt, combining a quality improvement project with the continuing medical education training and using the ECHO model, which is a really trusted and respected model, putting those together was highly effective. So not only were our physicians and their teams learning, but they were immediately applying that knowledge within their practice to make quality improvement changes.

There was a high level of engagement by having practice in the roles. So everyone at a practice heard the same information. In essence you had people to continue to discuss what you were learning or what you wanted, to changes you wanted to make in your practice. And as a

result, as Nicole shared, we saw multiple -- multilevel changes from front-end registration or perhaps risk assessment questionnaires were passed out, or to the board book being passed out, to many changes within the EMRs.

But the piece that -- that we saw so significantly in -- in this project, and we are a small state, but it became very clear, blatantly clear, that if you're not using point-of-care testing, your testing rates are going to be considerably lower.

In New Hampshire we are huge proponents of, actively support, at times have incentivized point-of-care testing. And we really encourage others to do the same. And not just encouraging it but really looking at what barriers you might have in your state or in your region to a practice transitioning to point-of-care testing.

In some states they -- or some areas they charge practices -- our WIC clinics, our public health departments clinical laboratory -- registration fees. This might be a one-time fee. It might be an annual fee. And this test unfortunately is -- is sort of a breakeven in its reimbursement rate, maybe just slightly above

break -- a breakeven level. So if a practice is looking at that they might have to pay a clinical laboratory registration fee, that might be a barrier. And certainly if it's an annual fee, it might be a very large barrier. So it's just something to think about, that it's -- it's very clear that if you're not supporting and promoting and actively working to get point-of-care testing into your state, into your pediatric practices, your testing rates are going to be lower.

As I said, we've been real big supporters in New Hampshire since 2016 of getting our practices to transition away from venous draws to point-of-care testing. And this study, amongst other things, just really made us want to amplify our efforts for our kind of one or two outliers that aren't using point-of-care testing to help support them make that transition. Next slide, please.

So this is our contact information. Nicole and I are happy to share. I mean, obviously, now, during question and answer, but at any time going forward if your program or agency or state is interested in learning more. And we can also connect you with the many others who helped

mentor us as we were standing up our project. Thank you.

MR. AMMON: Thank you very much, Gail and Nicole, for a great presentation. You know, any -- all these presentation I'm always amazed because my head goes a million miles a minute about thinking about -- but this seems so easy. You guys make it look so easy, and it's not. I mean, it's -- it's a huge amount of work, you know, for me and all the programs that we have at HUD, you know, how we -- seeing how we can make this scalable and directly into the areas we are, like for public housing residents, you know, and things of that nature and setting up point-of-care testing to really get on top of what's going on at the houses and things of that nature.

One -- one main question that I have -- and now that we are open for questions and I invite others to ask and I'll open -- so for me, obviously, the connection between testing and remediation is key, right? And those referrals make a difference in both -- in terms of linking clinical management into doing the actual intervention work in the homes.

So if you could -- could -- if you could talk about -- a little bit about your work to then take this work and then make the right referrals to a lot of the agencies that do the actual home intervention so that -- that it's not just, you know, static data that we have, but it actually is -- is used to focus on homes not only those -- those homes which may already have poisoned kids but also on the preventative side by doing large, you know, structures and things of that nature. So again the connection between this work and programs that actually do the housing intervention.

MS. LANG: Do you want to begin, Gail, or should I?

MS. GETTENS: I was going to have you start --

MS. LANG: Okay.

MS. GETTENS: -- by talking about the linkages we put in place.

MS. LANG: Sure. So in the state of New Hampshire, our legislative action value -- not health-based, it's just what the representatives agreed upon -- is 5.0 micrograms per deciliter. So when a child has venous draw at that level, a

nurse case manager like myself is able to contact a family and offer referral not only to nutrition services like WIC and child development services like early intervention, but also to having their home assessed for lead hazards.

In New Hampshire by law if a child resides in rental housing, then our internal environmental team will visit that property, do some XRF testing. If lead -- lead hazards are found, the property goes under legal order and the landlord or property owner will need to abate -- it's a pretty thorough abatement process that these properties go through. I don't work on that side but it's required by law.

If a child resides in owner-occupied housing, there is no law to compel the owner of that home to make changes. We pay for an assessment, a limited assessment of the home, with a very trusted vendor. They do a very good job. And they also help families apply for federal monies, like HUD money, to abate at -- at their property.

Gail, jump in any time because I know you know a little bit more about that side than I do.

MS. GETTENS: In New Hampshire we have

three -- we're really fortunate to have three lead hazard reduction grants. Our small city of Nashua; our small city of Manchester; our county, Sullivan County; and a fourth one is at New Hampshire Housing and Finance Authority that covers the rest of the state minus the areas I just mentioned.

And when our team members, our lead inspectors, go out to do an assessment, a lead inspection, to determine where the lead hazards are in the home after we've had a child who has a blood level test documented at five or greater, if they are finding the lead hazards in that rental unit, we work with our lead inspectors to work with connecting the landlords of those properties to these lead hazard reduction grant programs so that they can access the funding that comes through HUD into our state to remediate the lead in those rental units.

So there is -- you know, when we're increasing our testing rates as we did in this QI study, it means Nicole and her nurse case managers and that are lead inspectors are all the busier because they're visiting these families and inspecting their homes. And when they're

rental units, we are actively working to connect those landlords with our HUD-funded lead hazard reduction programs.

MR. AMMON: That's music to my ears, of course. I mean, I think that we structurally -- yeah, I mean, the -- I guess the one thing that we're facing too is that you guys have a lot of structural components in New Hampshire, right? You've done a lot of the foundation work, both in terms of screening, testing. You have the lead house control programs which have been operating for -- for decades, you know (indiscernible) --

MS. GETTENS: They're excellent, yes.

MR. AMMON: And also -- yeah. And also the legislature has been very, very helpful too in -- in -- again, in helping build out at capacity and things of that nature. You know, one of the things that -- that we're finding that I'd like to hear from you is that -- that taking -- taking this model and -- and bring it to scale, both in terms of communities that already have a lot of the capacity -- but we're finding a lot of communities -- in fact, you know, we just had our national new grant orientation last week and it was -- it was amazing how many brand-new grantees

are there.

And so I'm just -- I would like to hear from you in terms of, wow, you guys have a lot of structural components already built in that help this process. Could you see it being used, too, as somebody who's very new to this process, who is trying to build capacity? Because there's a lot that can be learned here across the country since there's a lot of, you know, uneven not only application but also just a level of capacity. And -- and it would be great if you feel that this could definitely be -- be used by, you know, brand-new folks who are just trying to get up to speed and trying to build out the capacity and really start their programs that you (indiscernible) fund.

MS. GETTENS: I would -- if you're referring to this quality improvement project, I would say absolutely. I mean, we -- no joke, if tiny little New Hampshire can pull this off, anyone can. But we -- we really relied on learning from Utah and Wisconsin and New Jersey's chapter of the American Academy of Pediatrics. And I would encourage any state, any new grantee, to connect with their local chapter of AAP. Many of them

are ECHO hubs. New Hampshire's isn't so -- but many state chapters are ECHO hubs, so you may be able to partner with them to stand up a similar quality improvement continuing medical education training project so that you would be identifying more children.

And I would just add one of the didactic presentations that we had in our series was a discussion. It was actually presented by Nicole in one of the best well-received on all of the supports -- that once a child is identified as having an elevated blood lead level, all the supports that our nurse case management team can provide to the family -- but to the clinic -- to the physician in terms of managing this child's health.

And it also explained that we have lead inspectors that go out. And we explained the whole process so our physicians could understand all that -- all that is triggered with an elevated blood lead level and then what additional resources are available for families, predominately our HUD funding for lead hazard reduction so that the lead hazards in this child's environment can be addressed and reduced

if not removed completely.

So it -- we're happy to share how we stood it up with funding we used. But I would say that if we stood it up, I'm confident that other states can as well. And, again, recommending reaching out to your state chapter of AAP. But in addition to that, we -- our huge partner that really made this possible was AmeriHealth Caritas. AmeriHealth Caritas is a contracted MCO in, I believe, 41 states. So that would be another partner to tap as well.

MS. LANG: And -- and, Gail -- she kind of touched on this and I alluded to it a little bit when I said that our providers really didn't -- they expressed, I don't know how to follow-up on this problem. He -- the -- the big assumption and rightfully so amongst our participating providers was, Oh, I thought when a child had, you know, a lead level of five or higher that the state comes in and fixes the housing. I mean that was just -- flat out that was the understanding of how this process works. And it is, you know, disheartening to have to explain that, you know, if the child lives in owner-occupied housing, the family is not under

any obligation to do anything at all regarding the structure. And that -- that's just how our legal framework is at this time and also that we had families who wanted to abate who sat on the waiting list for a very long time, trying to get funding to do that work.

So my job as a nurse case manager, and my colleagues as well, is to really help the families understand how to live with lead hazards. Like, now you know about this terrible problem, how are you going to shelter in place until either your child's a bit older and has different behaviors or until some funding is available and you're property owner can work to make this housing safe moving forward?

So that piece of education was critical for providers because they're like, Oh, now I understand these blood lead levels. You know, I -- I couldn't understand why they were static or even went up a little bit and then finally started coming down because they had no background information on the housing part of this.

MR. AMMON: Yeah, no, I can imagine. And I think the continuing education, you know, is a

huge part of not only educating families but also practitioners and things of that nature, you know, as we try to universally increase the number of children which are screened.

Okay. So I see we have a question. I'm trying to see who it is.

DR. RUCKART: And it looks like Brian Weaver.

MR. AMMON: Oh, there we go. Brian. Sorry, I had to expand my view.

MR. WEAVER: Yeah, yeah. Thank you.

MR. AMMON: Brian, I'll turn it over to you for a question. Sorry about that.

MR. WEAVER: Yeah. No. Well, first, thank you, Gail and Nicole. I have been a big fan of New Hampshire's work. You guys are always, like, willing to share the lessons learned. I think you guys are the models in that as far as sharing the resources, information out to other programs. So thank you for that.

So as I mentioned earlier, I -- I work in Wisconsin with the Department of Health Services. So, yeah, I would be a proponent of the ECHO project. I didn't actively participate in our ECHO, but I know we had very similar results that

New Hampshire did as well. So appreciate you highlighting that.

I guess I want to make one comment, and I did have a question for you. But one comment: I really appreciate your emphasis on point-of-care testing. I have found it sometimes a contentious issue depending on the audience and kind of like the outcomes you're looking for. I would -- I'm a big proponent of it.

We have heard from our 13 Medicaid HMOs in Wisconsin that they also, too, are trying to create the point-of-care testing in their clinics because they know that they're being measured in Wisconsin on the proponents of blood lead testing in children enrolled in Medicaid under six. So they're very interested to increasing their performance on that measure. So they, too, are talking about and trying to increase point-of-care testing.

And so I found -- this is now -- this is a couple of years old, the caveat is I've done a little bit of research into this issue versus venous testing that I would think this would be a great area for CDC to explore more, support research and point-of-care testing, and really --

and I know they've done -- they're doing the -- the innovation project that they were funding, but to come up with some really clear guidance used in point-of-care testing and what the research is saying in the utilization of that. So that's my comment.

My question for you -- which I'm not sure you're prepared to answer this, but it's related to your universal blood lead testing law. And I'm just curious -- so I'm really curious on kind of policy and the systemic impact statewide, what -- if you're able to -- if you're monitoring that, if you're seeing any outcomes of that universal testing law and just kind of lessons learned from that, anything you want to lift up related to that.

MS. GETTENS: It certainly -- Brian, it certainly drove our testing rates, increased our testing rates, and continues to. And I would suspect, it -- it helped us recover quickly, more quickly than we might have post-pandemic if we hadn't had the universal testing law in place.

It also helped us move beyond the HEDIS measure, the Medicaid HEDIS measure of one test by two. So there was a lot of misinformation or

misguided physicians prior to our universal testing law change that we're really focused on a HEDIS measure which is one test by two.

So it -- it not only moved our testing rates but also really helped almost a paradigm shift with many of our health providers -- and I'm going back to 2018 -- to understand that two tests were needed at age one and again at age two.

So it's had a huge positive impact. We also by this point, 2018, so almost six years -- granted we had a pandemic in the middle of it, but, you know, there was kind of no tradition, oral history, kind of you -- you know, your first child was never tested, so you never thought of having your second child or your neighbors' children or your cousins, you know, were never tested, so you never thought to have your own child tested or to ask for a test.

So now that we're at six-plus years into this, you know, we're beginning to see that -- that momentum, that understanding, that -- that this is just part -- should be part of your child's routine well-child check-up visits.

Yeah, it's with a huge legislative success

and a real gamechanger in a -- in a small state such as ours.

Which Wisconsin has also just moved to universal testing as well; correct?

MR. WEAVER: It's not in law. It's a recommendation.

MS. GETTENS: Oh, okay.

MR. WEAVER: And -- yep, yep.

MS. GETTENS: Okay.

MR. WEAVER: So we do struggle with the HEDIS measure being used as the measure for performance for our Medicaid --

MS. GETTENS: Yes.

MR. WEAVER: -- programs in Wisconsin and -- but public health recommendation, we follow the -- the test, you know, one and two. So it looks like it's been widely accepted at least in this first year. We're seeing significant jump in our numbers as well, too. So maybe it doesn't need necessarily to have, like, the rule of law behind it, but that ultimately, I think, is our outcome to what we're looking for at some point in time. Thank you.

MS. GETTENS: Two -- the one other thought that I would point out is that -- well, two

thoughts. One was that our change to universal testing, a piece of the legislation that did not make it through was requiring it for school entry. And we -- we've had some legislative attempts to bring that requirement on. Actually 2022, I believe it passed our House, passed our Senate and then was vetoed.

So that's the only piece that we wish we had captured, that knowing school nurses are looking at health forms for all the immunizations or whatever other requirement a state might have that they'd also be looking at those health forms in childcare entry and public-school entry to determine if the child's been tested. And if not, require that testing over -- in a certain period of time.

We have one school district in New Hampshire that as a -- as a small little school district in New Hampshire has passed that policy for their school district, that they do require it. And our one school district in New Hampshire requires that testing for school entry.

The other piece I just might mention is that New Hampshire, too, has been really frustrated by the HEDIS measure being one test by two. And

just in our new Medicaid contracts that just started this past November, we actually changed our metrics and requirements in our state level contracts because we knew little New Hampshire wasn't going to be able to change the HEDIS measure. So in our Medicaid contracts that just started September 1st, our Medicaid contractors are now required to test at one and report on it, test at age two and report on it, and also report on how many of their members have had a blood test at both age one and at age two.

And we still collect the HEDIS data but it's fourth on the list and that has driven tremendous change already in our Medicaid testing numbers. In addition to changing the requirements, there are specific metrics for each year of the contract, that they're required to increase testing for one- and for two-year-olds by a certain percentage each year of the five-year contract or there are fines and penalties.

We also put it into the incentive program. So in addition to you being fined if you're not meeting these metrics each -- each year of the contract, the increase in your testing rates for both age groups over the five-year contract,

you're also able to -- if you move beyond and move at a higher rate, there are huge financial incentives and also incentive of being assigned more members, auto-enrollment assignments.

So -- so we've really worked. It was a long game, but we successfully changed our contracts as of September 1st to really move around the HEDIS measure which was really a barrier to getting our two-year-olds tested.

DR. RUCKART: I see we've got other questions, Matt.

MR. AMMON: I do see.

Paul, you -- you were there first.

DR. ALLWOOD: Well, yeah. I'll -- I'll just make a quick comment and I'll turn it back over to Stephanie.

So I just wanted to kind of express my -- my gratitude to Gail and Nicole for a really awesome presentation. Like Brian said, you know, we really, you know, appreciate the work that you're doing up in New Hampshire. Really loved the presentation, really loved how you describe the state and how it's, you know -- how the -- the population is distributed and, you know -- and the work you do with ECHO.

But specifically I wanted to mention that the board book -- I was visiting one of our community-based organizations that we recently began funding on the east side of Chicago. And they have an after-school program for kids who are not quite meeting their academic milestones and they're living in a kind of heavy lead-exposure risk community. And they bring them in after school to the library and they make the kids and the parents go through the board book.

So I -- you know, I just think this is just an awesome, you know, intervention, something that's actually, you know, kind of delivering more than its -- than its weight in gold, you know, and it's, you know, very widely distributed. So just wanted to acknowledge that and if you have any statistics on how broadly distributed that -- that resource is now, I'd like to know that. But you can tell me offline. So thank you.

DR. RUCKART: Thank you, Paul.

MR. AMMON: Thanks, Paul. And our last question from Stephanie. We have a hard stop at 12:30.

DR. YENDELL: Okay. So this should hopefully be quick. I was just wondering, when you're talking about the testing in New Hampshire, it sounds like providers either do capillary with the point-of-care testing or they do venous that's sent out to a lab. And I was just wondering if you could clarify that's the case. Because in -- in Minnesota our experience is that a lot of providers have success with collecting capillary samples in Microtainer tubes and sending those off to the lab rather using the point-of-care devices. And during the -- the recalls, we saw an exact, like, one-for-one exchange in capillary testing on point-of-care with capillary testing sent out to labs and we didn't see any drop in testing during -- during the recall during -- during the recall periods. So I was just wondering is that something that providers in your area do or are there barriers to them sending out capillary samples to laboratories?

MS. GETTENS: It's an excellent question. And we are heavily point-of-care testing. And that's something we've really driven in terms of educating and incentivizing it. Especially as I

said in 2016 and 2017, we were really working -- we were a state at that time that was almost solely relying on venous and it wasn't working. And we worked really hard to educate our physicians and our health systems on point-of-care testing, and most made the transition.

We certainly have practices that collect a capillary sample in the office and then send it out. It's certainly fewer in number. The pieces we hear often is just, you know, it's a much larger sample that you'll have to collect from a tiny finger to send out. And then if it is elevated, you're not getting that result back for usually, you know, depending upon what lab you use, 24, 48 hours. And it does -- sometimes longer. And it does require, then, the practice following up with the family and getting a family to come back in for a venous draw.

And those are the -- those are the reasons or the drawbacks that we hear from our physicians. Because with a point-of-care device when you have that result immediately while the child's still in the office, talking to the physician, if you explain that your child may

have an elevated blood lead level at that time, then you can escort the family to the lab and the family's usually really motivated to go get that follow-up confirmation test.

So that's just some background on our state. We certainly do have a few practices that use Microtainers to collect capillary specimens that go out, but there -- there are some -- it's certainly way better than a venous draw which isn't just -- which isn't going to happen. But there are certainly some drawbacks with a Microtainer that -- that I just mentioned.

But that certainly is an option that's out there to collect -- at least to collect a sample at the time of the child's well-child checkup. But, again, in New Hampshire we are -- I can't quite say exclusively, but a very, very high percentage of our practices use point-of-care testing. And that's really where it's driven -- drove those really positive trajectories that you saw in our testing rates from 2015 to 2019 and continue to. Thank you.

MR. AMMON: Thank you for the question. And thank you very much to Nicole and Gail. It was great presentation. Thank you very much for

fielding questions.

And now we're going to turn it over as part of the agenda for public comment. We have one public commenter, Tom Neltner, who Paul mentioned is the national director of Unleaded Kids. And you probably know his previous work on the Environmental Defense Fund and others. So I will turn it over to Tom.

Welcome, Tom.

PUBLIC COMMENT

MR. NELTNER: Thanks, Matt. You guys going to turn my camera on too? Or -- okay.

So I've got ten minutes, and I'm going to go quickly through it. I really appreciate this opportunity. I want to thank Gail and Nicole for their outstanding program and their presentation in raising these issues. Also want to thank CDC for the million-dollar challenge that's helping to meet the need for point-of-care testing.

Big picture: I wanted to raise the need for more frequent meetings. I know Congress said annual. That doesn't mean only annual. I think there's need for more meetings. And the agenda here is a good example of why LEPAC needs to be meeting more often.

I had a number of issues. First up is the mapping lead exposure risks. This was -- it was a -- LEPAC had a meeting in 2022 that -- where CDC presented the Lead Exposure Risk Index. It showed promise but we haven't seen anything since that. And it's important because more than a thousand drinking water utilities are posting maps of service line materials, of where the lead pipes are. And it lacks all context with other exposure sources, specifically paint but also aviation sources, cleanups, and the like. And that lack of context is -- means it's misleading for the public.

If CDC were to be able to come up with the Lead Exposure Risk Index and move that forward after two years of waiting, it would be -- I think the utilities would grab it up, but they need something authoritative.

I know EPA, CDC have worked on lead exposure hotspots. That's really important, but it doesn't cover the country to point out the hotspots.

Switching topics, next is action levels. We're going to have food action levels from (indescernable),hopefully this month. We got them

from EPA on dust in October. We've long had them on water in workplaces. We're going to have them on soil and paint from the EPA.

Back in 2016, CDC's board of scientific counselors considered whether the blood lead reference value should be really framed as an action level, and I would encourage that it should be, especially now that "action level" is a more common term. The reason the BSC didn't do it was "action level" seemed like an unfamiliar term. I think that's going to change.

Shifting over to the Preventing Lead Exposure in Adults recommendations, one of the things that I liked a lot was the recommendation for Cal/OSHA as a model. That Cal/OSHA rule is a role model at preventing the lead exposure and preventing lead take home from -- to families. So it's not just protecting the people that work in that area, but also protecting their families and that's critical.

One of the things that quote -- that caught me on that PLEA report was when it said that, quote: The magnitude of lead related risk is -- for lead from exposure to adults, is on par with

that of other prominent cardiovascular risk factors such as elevated cholesterol, smoking, and hypertension. That had been the focus of extensive public health concern. We need to be thinking about adult exposure in the context of cholesterol, smoking, hypertension.

So I agree with the recommendation on emphasizing Cal/OSHA. They provided a path forward. It's well-documented in that report. Thank you for that.

As I review the ACOG and CDC guidelines on testing during pregnancy, I think the recommendation should also call for review of the ACOG, CDC risk factors. Those risk factors, while they made -- made general common sense, are not validated. They also, frankly, as somebody who's worked for a quarter century in this area, would be very tough to apply. In practice I don't know how a fam -- a patient or the doctor is going to come up with them. In essence they -- they serve as a barrier. They've been crafted to exclude rather than include.

So put reviewing those factors on how to make them more validated, more useful would be important.

Also we need to focus on screening houses not just people because houses are the biggest source of most of lead exposure. We also need to consider the unintended consequences of blood lead testing. How do we not just advise the family but given all the attention on the fetus, how do we make sure that that's being handled properly?

And I think as you heard from Gail and Brian that we need to evaluate universal blood lead testing for children and pregnant (indiscernible). Pediatrics -- the *Journal of Pediatrics*, published by the American Academy of Pediatrics, just recommended that we do universal blood lead testing for pregnant (indiscernible).

Wanted to highlight a couple of other points on the PLEA recommendations. It is great to see the group work -- that report putting recommendations and calling out specifically the low compliance rate for the renovation, repair, and painting work. If we improve that, it would protect workers, it would protect children, it would protect the families living in the home.

I did want to highlight the recommendation, Roman number VI, Roman number six, for the first

one says that CDC should collaborate with CPSC, FDA, and EPA but it fails to mention HUD. And I think CDC should also be collaborating with HUD on this one. I think that's an oversight.

And, finally, I'm concerned that earlier this year, CDC, HUD, and EPA signed an MOU on data sharing, which I was excited about. But when I read it, CDC basically says, We're not going to share data unless it's already publicly available. I think we need to recognize that EPA and HUD are public health agencies. One of their purposes is to protect public health by providing -- reducing environmental health hazards, by providing safe housing, and then as public health agencies, they know how to protect this data. Rather than discouraging data sharing like CDC did in this agreement, they should be encouraging it. We need more of that.

Thank you very much.

MR. AMMON: Thank you very much, Tom, for your comments.

And that actually puts us right on schedule for our lunch break. And we will reconvene at 1:15 to go over some lead-related updates from the LEPAC members.

So, again, we will pause and we will reconvene at 1:15. So I will see you then.

DR. RUCKART: Thank you.

(Recess)

LEAD-RELATED UPDATES FROM LEPAC MEMBERS

MR. AMMON: All right. It is 1:15. I hope everybody is ready to launch back into the agenda. Everybody had a quick lunch.

So for this part of the agenda, we're going to go through and have the LEPAC give updates. And so I'm going to actually run through the list of folks and if you have an update, great. But we -- we'd like to hear from everybody. I mean, there's -- again, as I mentioned early on, it's been a lot of work that -- that transpired this year. And it's good to hear back from everybody.

And so with that, hopefully everybody is ready. And we'll start with -- I'll just give you the first three just to make it easier, but I'll have everybody commit. First, we'll start with FDA and then EPA and then CDC.

So with that, let me turn it over to Dr. Brenna Flannery from FDA to give her updates.

DR. FLANNERY: Yes. Hello. Good afternoon. I do have some updates for you all with regards

to Human Food Program updates for lead.

So FDA collaborated with federal, state, local, and international partners to respond to lead contamination of apple cinnamon pouches and identified the potential source of the issue. FDA's compliance activities included but were not limited to issuing public health alerts, warning letters to industry and distributors, and pursuing voluntary recalls by the industry.

FDA continues to sample through its Toxic Elements monitoring program targeted assignments and testing by states. Testing of a variety of foods includes colored spices offered for sale in the U.S., imported foods with levels of toxic elements that may be unsafe can be placed at import alert and detained.

FDA is engaged with international partners through Codex Alimentarius, specifically the Codex Committee on Contaminants and Foods to work toward development of recommended maximum levels for lead in herbs and spices including cinnamon.

FDA shared its lead-in-cinnamon data with Codex in Spring 2024.

FDA intends to finalize the Guidance for Industry on Action Levels for Lead in Processed

Food Intended for Babies and Young Children by the end of 2024.

FDA continues to maintain import alert 99-45 for imported pressure cookers from a specific manufacturer found to contain high levels of lead that can leach into food during cooking and to monitor retailer sites to ensure this product is not sold in the United States. These products have previously been connected to high blood lead levels in children in African and refugee populations in Washington state.

In the fall 2024, FDA contacted third-party Internet retail sites, requesting the removal from retail websites of the products covered by the import alert. In response these retailers committed to remove and prohibit product listings for all related pressure cookers from their website.

FDA is engaged in the International Lead Exposure Working Group (unintelligible) under the lead subcommittee of the President's Task Force on Environmental Health Risks and Safety Risks to Children. The International Lead Exposure Working Group is committed to reducing lead exposures in lower and middle income

countries.

And then the final update I have for everyone is that in October 2024, FDA scientists published dietary lead exposure estimates for infants, zero to 11 months of age, and young children, one to six years of age. Dietary lead exposure estimates were determined using lead concentration data from the 2018 to 2020 FDA total diet study and food consumption data from the NHANES survey: What We Eat in America, 2015 to 2018.

In infants not consuming human milk, 81 percent of total dietary lead exposure was from the processed baby food and infant formula food group. This exposure appeared to be driven mainly by food consumption levels. In children the grains and baking food group contributed 25 percent of total dietary lead exposure.

And that is all of the updates that I have for you all from the Human Foods Program.

MR. AMMON: Thank you very much for that update.

Now I'll turn it over to EPA.

MS. ROBIOU-RAMÍREZ: Hello, everyone. Grace here from the U.S. Environmental Protection

Agency.

So I prepared a -- I think a five-page handout that summarizes EPA activities between the last LEPAC meeting and now. I made it available to the LEPAC organizers. I'm hoping that they can distribute it to the membership and the affiliates somehow. I don't know, by e-mail or by attaching it to the -- to the meeting conversation.

I -- I organized the activities in that handout based on media because that's the way that EPA is organized. But what I'd like to do today with my five or five, six minutes is highlight a subset of the activities that we've carried out during this time.

EPA has -- as you may be aware, has been very busy at work putting out proposed and final regulations, loaning out money in the form of loans and grants, conducting research, training, and communicating about our work.

In the regulatory sphere, we have done a -- a ton of things. Briefly, without dwelling too much on each one of them, we, about a year ago, put out the endangerment finding lead emissions of lead from aircraft that operate on leaded fuel

cause or contribute to air pollution and that may be anticipated to endanger public health and welfare. I think we -- I think that was actually put out the day after the last LEPAC meeting.

We've also put out regulations on secondary lead smelters, on large municipal waste combustors, on -- on the iron and steel manufacturing industry, on the national standards that were put out on air pollution for passenger cars, light truck -- light-duty trucks and medium-duty vehicles. And all of those have economic benefit consequences for lead specifically.

In the drinking water world, we, of course, put out the Lead and Copper Rule Improvements which requires that drinking water utilities replace lead pipes or -- yeah, lead pipes within ten years. It requires rigorous testing and lowering the threshold for taking action by water utilities.

In the dust -- in the lead paint dust space, we put out, of course, a regulation. That was the most recent, perhaps, for pre-1978 housing and childcare facilities.

And in the soil space we put out guidance on

reducing screening levels for lead in residential soils. And that actually was coupled with about a billion dollars of investment funds for cleanup projects at about a hundred Superfund sites.

All of the work that we've done has not been exclusively regulatory. There's been a lot that has been left to the partnerships. And I want to highlight that for the lead service line work, we've -- since we last met, EPA has put out about $3 billion for states and territories to identify and replace lead piping, about $26 million for lead in schools and childcare facilities.

And there's also a partnership that has been launched called let the -- Get the Lead Out which is with about 200 communities, underserved communities specifically, to provide them with both funding and medical assistance.

There's been a number of actions being done in the enforcement space, which I won't get into at this time, and good training space, and the outreach space. I do provide in the handout a list of select 2024 publications by EPA scientists that relate to lead. There's about a page worth of those, a page and a half.

And lastly I do want to feature the -- in

the international space -- and I think that was just mentioned by our FDA colleague -- the work that's been happening to further -- to really, you know, tackle lead poisoning in lower- and middle-income countries to do something called the Partnership for a Lead-Free Future.

To cap it all off, I do want to acknowledge the work that has happened under the President's Task Force on Environmental Health Risks and Safety Risks to Children, which I have the privilege to cochair with HHS. We have, of course, the lead subcommittee there that's been very, very active. This year we published a report.

There was actually a very nice three-way press release by EPA, HUD, and HHS to release the progress report on the Federal Lead Action Plan which is a comprehensive update on the government's progress since 2018 towards reducing childhood lead exposure. So if you haven't had a moment to take a look at that, I think it's a -- kind of a nice capstone collection of ac -- of actions.

So with that, I just want to leave you with kind of our thoughts moving forward. I want to

second the mention -- the comment made by Tom Neltner that this group in my opinion should meet -- meet more frequently. That would allow it to be more active and for the partnerships and the relationships to be sustained in a more kind of collaborative way, more active way.

I also -- I also want to acknowledge that EPA has a lot of things that are -- we'd like to do in the space and, you know, moving forward, both in the regulation space and other areas. And we're kind of waiting to see what the direction of the new administration is going to be.

But one common thread or common denominator through all of that is made for federal, state, and community collaboration. So one area that I think we should all think about, all members of the LEPAC and all the agencies involved, and this is how we can sustain and further the collaborative nature of our work to make sure that we are taking action, leveraging resources, both authorities and the -- you know, the strength that each of our agencies might have in order to -- to move the needle on this issue.

So thank you for the time. I'm available

for any questions. There's a lot in the handout that I shared, and I'm happy to have any side conversations with any of you. Thank you.

MR. AMMON: Thank you very much, Grace.

And now we will hear from Dr. Allwood for our CDC.

DR. ALLWOOD: Thank you very much, Matt.

And good afternoon, everybody.

You know, it's my pleasure to give a -- give a few updates from the branch since our last meeting. You know, we've been -- we've been quite busy and -- as I'm sure all of you have been. And, you know, we -- we're -- we're happy to share some -- some important updates about, you know, some special projects.

So starting off with something that I think most of you might have heard something about, I hope -- certainly hope that many of you, that all of you have heard something about the Lead Detect Prize. And, you know, on the tenth of -- I'm sorry, on the 24th of October this year, we announced three winners of phase 2 of the -- the Lead Detect Prize and this was done at an event at George Washington University at the Milken Institute of Public Health, at that institution.

The Lead Detect Prize was launched with a -- with a clear mission to enhance and improve testing for lead in children. And we did this through a one-million-dollar prize competition. The focus was accelerating the development of more advanced point-of-care blood lead testing technology. And this is part of CDC's broader commitment to addressing childhood lead exposure.

The first-place winner of the competition was Meridian Bioscience and they're using electrical -- electrochemical sensors to detect lead in blood and measuring the electrical current in a blood sample. And -- and for their entry Meridian was awarded a $500 prize for first place.

Second place winner is OndaVia. And this company is applying optical technology to detect the presence of lead using a distinctive fingerprint signature. And for their entry, OndaVia was awarded a prize of $250,000.

Our third-place winner was GlucoSentient. And they -- they are adopting a blood glucose meter platform and using a DNAzyme sensor to detect lead in a sample -- in a blood sample. And for their entry, they were awarded a prize of

a hundred thousand dollars.

One of the major successes of this prize is how it accelerated innovation across the entire field. Through both phases, one and two, we distributed a million dollars in prize across multiple teams and each of these teams brought unique approaches to the challenge. The prize motivated both established players to accelerate their innovation and -- and, you know, current technology and timelines, but it also brought in new entrants to tackle this critical public health deed. This included companies that have never done any testing for lead in blood.

The prize motivated both -- I'm sorry, thanks to the prize -- thanks to the prize, we have several promising technologies that are advancing towards development from new optical approaches to innovative biosensor designs. This diversity of solutions and the competitors will ultimately give healthcare providers more options for protecting children's health.

The Lead Detect Prize demonstrates how innovation, open innovation and public-private partnerships can stimulate the development of new tools and new technologies to protect children

from lead through better testing.

To help one or more of these teams, these new solutions get to the market, CDC may consider continued support including developing a comprehensive resource kit that helps teams identify and pursue additional support mechanisms or by launching additional phases of the Lead Detect Prize to continue to support these promising solutions.

The next update I'd like to give is on our supplement to the *Journal of Pediatrics* which is published in October of this year. In partnership with -- with pediatrics, we were able to put out a supplement titled, *The Impact of Lead Exposure on Children and Adolescents: Current Updates*. And this work is vital to driving targeted research to fill gaps in certain areas of lead poisoning prevention.

A link to the supplement can be found on the CDC's website, that is CDC's lead program website. And I would encourage all of you if you have not had a chance to see the supplement to, you know, take the opportunity to do so. There are a number of research articles as well as, you know, very, very important commentaries that are

provided in the supplement. And it speaks quite impressively to some of the -- the major opportunities and challenges that we still face as far as childhood lead exposure is concerned.

Just about -- just about a month ago, we hosted the -- CDC hosted the 2024 Annual Recipients Meeting in Atlanta. The theme for -- for this year's meeting was "Taking the Next Steps: Collaborating Across All Sectors Towards a Lead-Free Future." And there were almost 400 people attending this meeting from all of our 62 CDC-funded programs at the state and local level.

We also had representatives attending from the Flint Registry and we had representatives from 11 community-based partner organizations which CDC began funding in 2023. The attendees were -- you know, were either virtual or in person, although most of the attendees were in person this year, which was really great.

This was the largest attendance since the COVID pandemic. Presentations were organized in four major tracks, namely partnerships, community outreach, communication, and surveillance and data.

Next I'd like to share that CDC is beginning

a new effort to evaluate the need to update its current guidance for blood lead testing at the community level. And this is guidance that has been in place since 1997. So it's probably the right time to take a look at that guidance. The current guidance recommends following CMS requirements for universal testing of children that are enrolled in Medicaid at ages 12 and 24 months or between 24 and 72 months if there's no record of a previous test.

For children not covered by Medicaid, the current recommendation is targeted testing of population of high risk based on age of housing and sociodemographic risk factors. In the absence of such plans, CDC recommends universal blood lead testing. So that's our current guidance.

Our evaluation will include the following main efforts. First we'd like to do a systematic review of a literature pertaining to community-based childhood lead testing approaches. We would like to conduct partner engagement at -- you know, at the appropriate time to get input and support and, you know, to explore the various policy -- potential policy

options that there may be.

And we're also planning ultimately to develop a report and list our recommendations that will be presented to -- for -- for consideration by leadership at higher levels within the CDC.

We will -- as this process moves forward, we will plan to have opportunities for partners to provide feedback and, you know, to get your -- get insights and, you know, whatever guidance that we -- we can possibly gather from -- from our various partners.

Finally I would like to give the update that this year the CDC launched the Lead-Free Communities Initiative and a toolkit to empower communities to take proactive steps towards creating environments free from lead exposure.

The Lead-Free Communities Initiative offers a unique, comprehensive, and multisectoral approach for encouraging and supporting communities to collaboratively develop and implement customized plans to become lead-free. The Lead-Free Communities Network launched in July of 2024 and this is a national learning and support network for communities interested in

reducing and eliminating lead exposure hazards.

Additionally the Lead-Free Communities Initiative includes a curated library of resources and information about lead as elimination strategies and practices. And the access to the toolkit can be achieved by going to the CDC's lead poisoning prevention programs website.

Those are my updates. Thank you very much. I'll turn it back over to you, Mr. Chairman.

MR. AMMON: Thank you, sir, for those updates.

Now, I'm going to turn it over, if she's ready, to Tammy Barnhill-Proctor from education.

Tammy, are you out there and available?

DR. RUCKART: I think she may have needed to step out for a meeting. We can circle back with her right before you go. Thank you.

MR. AMMON: Yep, not a problem. So let's move to Gary Edwards.

MR. EDWARDS: Hello. Okay. Am I on? Are you there? I am? Okay.

Gee, I didn't know I was going to be giving an update exactly, but I guess what I can tell you is this -- and, you know, this is my first

year on this committee. I'm retired. I've been retired for about five years now. I was asked to serve on the Preventing Lead Exposure in Adults workgroup. That was wonderful because it really gave me a good step -- step stone into this -- into this committee. Gave me a good background and information of what's going on and some current research and so forth. It was really great. So I appreciate that.

And really the presentations and speakers I've seen today, I'm very, very impressed with and learned a lot.

So I guess that's my update. So I'm really getting into this information and I've enjoyed the process so far.

MR. AMMON: All right, thank you very much.

Dr. Rebecca Fry from University of North Carolina at Chapel Hill.

DR. FRY: All right, hopefully you can hear me. Several updates from -- from us. You may remember that last year around this time lead was discovered on UNC's campus. And so I served as the -- with the scientific liaison for helping to address that. I'm really proud of the university for the way that it managed that. And I was

actually -- we published an article on it. So I'll share that with the group.

At UNC we also have the Water Institute that is run by at Aaron Salzberg. And under his direction and leadership, that team is working to help to promote initiatives for global lead-free environments. So I can also send around some of that work.

And then as part of the UNC NIEHS-funded Superfund program that I run, we focus on private well contamination. And, you know, in North Carolina we have one of the largest, if not the largest, population on private wells in the country. And we have issues of naturally occurring contaminants as well as lead.

Some of our work from the past year has shown that the lead in private drinking well water is associated with preterm birth risk in the state. And that's led to several grant applications where in particular we're concerned about exposure that's unequal across the state and higher for Native American communities who are working some of our public health initiatives on that.

And then we also are trying to make headway

in terms of increasing the understanding of clinicians, whether it's pediatricians or obstetrics, gynecologists on how to ask questions around environmental factors like lead and being able to address that. So I was really impacted by the presentation today.

So those are -- those are my updates.

MR. AMMON: Thank you very much.

Mary Beth Hance from Medicaid -- Medicaid and Medicare.

MS. HANCE: Thank you. And I will try with my camera. Hopefully this will work.

So I have a very brief update today which is that we have included in our Child Core Set of Quality Measures, the NCQA HEDIS blood lead screening measure. So this is a new measure that is new to the Child Core Set as of the 2023 trial. Of course, that which was -- which states reported to us a year ago and reflects care delivered in 2022. We publicly report data that has been reported to CMS by 25 states or more and meets our data quality standards. And this is state level data. Other than that --

DR. RUCKART: Excuse me, Mary Beth.

MS. HANCE: -- blood lead --

DR. RUCKART: Mary Beth?

MS. HANCE: Yep?

DR. RUCKART: You are cutting out just a little bit. I'm thinking, could we try it without the video to see? Thank you.

MS. HANCE: Sure. Yep. Okay, hopefully -- is that better?

DR. RUCKART: I mean, so far, but --

MS. HANCE: Okay.

DR. RUCKART: -- I'll let you know. Thank you.

MS. HANCE: Sorry. Our CMS system really does not like Teams. So I apologize.

So the -- the HEDIS measure is not a precise alignment with the Medicaid blood lead screening test. Of course, it's a blood lead test up to two years where the Medicaid blood lead screening requirements, as Paul mentioned in his update, is at 12 months and 24 months.

But we did think it was important to get this measure into the core set and the work -- therefore the workgroup added it.

So the data that we released earlier this year with additional data products coming shortly, showed a state median of 57 percent of

children receiving a blood lead test -- blood lead screening test by their second birthday and that reflects 45 states that are reported.

We also release a different report that also includes blood lead screening data which is for the part of the requirements for recording for the early and periodic screening diagnostic and treatment benefit -- Medicaid benefit. And we -- right now we have data through 2021 on our website and we will hopefully have 2022 and 2023 data released in the near future.

And that is my update.

MR. AMMON: Thank you very much.

Dr. Hatlelid from CPSC. Do we have CPSC on? Is Dr. Kristine on?

DR. RUCKART: We can try her again at the end.

MR. AMMON: Yep. Yep. I'll skip -- I will skip to move on. So let's hear from Dr. Montañez from the Icahn School of Medicine.

DR. HUERTA-MONTAÑEZ: Hi. I'm very grateful for the opportunity of serving this committee and also highlight in this opportunity the importance of PEHSU in supporting local AAP chapters and our department of health in Puerto Rico to develop

the Puerto Rico lead surveillance system. So I can attest how PEHSU support can really enhance the efforts of establishing a surveillance system from scratch and then having the successes that they've had in 32 years.

Also I really appreciate the presentation about the ACOG program on lead prevention. We conducted a similar activity in Puerto Rico through the Puerto Rico AAP chapter and CDC support, and it was very successful. It allowed us, actually, to -- in addition to support the -- the board certification of the -- the maintenance for certification of -- of our clinicians, also helped us identify what we called lead prevention champions.

And these pediatricians, now, in 2024, continue to support our efforts in our AAP chapter, PEHSU Region 2, and then also of the Puerto Rico Department of Health to be the eyes and ears of all of us to know what's really happening on the field, what's really happening in the pediatric practices and the barriers that they encounter every single day.

As -- you may not know that in Puerto Rico we don't have point-of-care testing. It's not

legal to do point-of-care testing in Puerto Rico, so we have no option. So our challenges are huge. So we have a -- a perspective of what it is to not having the -- the incredible resource, what point-of-care testing is.

And also, we're also focusing on -- and it's something that I want to share -- on how we promote increasing the capacity of our trainees, of pediatric residents, because we know in three years they become part of the -- of the clinicians and -- and they -- you know, focusing on their training and the understanding to how they see, they -- how they perceive the -- the importance of lead testing is -- we believe it is very important.

And also, finally, how Dr. Allwood presented how incentivizing innovation gave so incredible results. Also how can we incentivize our clinicians to do that testing given the current barriers in pediatric care.

Again, thank you very much for the opportunity. And I look forward to the following meetings. Thank you.

MR. AMMON: Thank you very much.

Dr. Lopata from the U.S. Health Resources

and Services Administration.

DR. LOPATA: Hi. Thanks.

So -- so first I would say the majority of the direct work done in regards to lead screening is probably done by our Bureau of Primary Health Care through our health centers. Since we -- they provide direct patient care. That is something that they certainly do and they track. I believe in 2021 the health centers had seen almost -- close -- I think 575,000 had screened for lead, about 575,000 children between the ages of 9 months and 72 months. And in 2023 that has increased to over 600,000. So it's good to see that number going up.

I will say that I think there's probably, you know, another way that we support through Maternal & Child Health Bureau at HRSA. Lead screening is through our Title V program, our Maternal Child Block Grant to states. And with those dollars, many of which go to local health departments, those dollars can be used to do not just lead screening but the lead abatement and other type of prevention and treatment. Prevent -- lead prevention testing and treatment again, of course with abatement.

The only other thing I want to say is I think there -- and I -- I know I'm new to the -- to LEPAC, but I -- I think there's a lot of maybe more opportunity for us to do additional work in this area by partnering with the other agencies, you know, and -- and the other people at universities around the country. For one example, one thing we do at Maternal & Child Health Bureau is the Healthy Start program which is a program that works with pregnant women from, you know, their first trimester and then after they give birth and then up to 18 months of age.

And so particularly during that -- and a lot of what they do in terms of -- in addition to making sure women are plugged into prenatal care when they're pregnant, they do a lot of health education for women who are pregnant and also for women and -- and parents and fathers. As parents, a lot of health education. I think a good part of that can be reminding them to ensure that they get their children screened for lead and also making sure that those visits -- especially in early childhood making sure and asking the questions, Did your child get tested for lead at 9 months and -- or, you know, 18

months or 24 months? I think there's a role to be played there that maybe we're not really focused on. But I think there's more work that we can do.

Any -- anyplace that our programs are touching families and communicating directly with them is during this, you know, early childhood period. I think there's an opportunity to do that. And I would love to be able to work with my partners on the committee to -- to do those types of things.

So anyway, that's -- that's all that I have right now, but again, really looking forward to working more with my committee members going forward. Thanks.

MR. AMMON: Great, thank you for the update.

Next we will hear from Dr. Meadows-Oliver from New York University.

DR. MEADOWS-OLIVER: Hello, everyone. My mic and my camera were disabled because I'd logged off at lunchtime.

But -- so as I mentioned before, I'm a pediatric nurse practitioner, and what I've done for this meeting was I sent out a survey to our pediatric nurse practitioners in the state to

kind of see, like, what are the barriers in practices? Because I know that a lot of people that have spoken so far were, it seems like, municipal agencies and I work in a direct practice. So I'm not as tied in with our health department other than the work that we do with the kids that already have lead poisoning.

But what I've found from our members is some of the main barriers to getting our children screened is -- especially in the privately insured is that people don't think that they're at risk. Like, our Medicaid population gets insured because, you know, it's re -- sorry, gets tested because it's required. But our privately insured, maybe they're living in homes that are newer and so they don't necessarily think that they are at risk. So I find that those are some of the biggest barriers.

So it's interesting for me to hear a lot of the updates that people have been giving here. And I'll take some of these back to our members and I appreciate being part of the committee. So thank you.

MR. AMMON: Thank you very much.

Jeff Sanchez, Impact Assessment, LA County

Health Department.

MR. SANCHEZ: Thank you.

So since 2014, Impact has been working with our Los Angeles County's CLPP programs as well as our county's and city's HUD Lead Hazard Reduction grant-funded programs. And so what we've basically done has been working to provide additional services that highlight kind of non-housing sources in these primary prevention programs.

So I'm just going to give you a quick background on the Lead-Free Homes LA program, so it's part of a twenty-year paint litigation resulting in 305 million settling in 2019, specifically for lead hazard abatement or alleviation across ten California jurisdictions. So that established Lead-Free Homes LA, focusing on pre-1950-51 housing, low-income families, and households with any children. And so I wanted to highlight that today. They just reached their thousand remediated home benchmark for such a fairly new program. So excited about that. Both the city and county of LA, as I mentioned, have received HUD lead hazard reduction funding as well.

So, again, as I mentioned, these programs obviously are focused on housing sources. And what we're looking to do here and we've been doing is we're looking at those non-housing sources and how friendly is that to this opportunity to -- while we're already in these homes to start talking about some of these other non-housing sources: So foods, cultural sources, take-home exposure, et cetera.

So (indiscernible) for the first program, we were able to implement since, again, 2014 basically a community health worker intervention program where we're conducting lead housing and non-housing risk surveys and providing tailored education based on those risks that results in tailored education as well as referrals to other services such as education, housing stability, mental health, and nutritional resources. It also refers to additional blood lead testing. So there's a free lead testing program that we offer those families too.

The main thing we've been doing is this program evaluation. So we were able to establish a Lead-Free Homes LA evaluation committee. We're using the CDC's program evaluation framework to

guide that work and the analysis of the data. It's resulting in evaluation reports, stakeholder feedback, ultimately process improvements, and accountability for the program.

I also want to highlight some work that we've done in the past, and we can segue into, I think, kind of a similarly -- kind of like what -- what I'd like to see and potentially work with our LEPAC pack -- LEPAC members on is basically using housing data, specifically housing inspection data, to guide some of the work in doing our outreach focused, you know, to establish our primary prevention programs.

So what we did is that we partnered with the city of LA. They have a proactive code enforcement program. We identified 21 housing code violations that are linked to lead hazards, (indiscernible) active. So that means that they were cited for an active paint hazard -- chipping and peeling, et cetera -- as well as potential hazards. So anything that would -- that would require any kind of disturbing lead-based paint. So moving a structure, that sort of stuff.

And we used that, overlaid it with housing data, property rates. And we used that to guide

our outreach and education work as well as that also included blood lead testing. So to get those kids in for testing that are living in these properties. Also it's an opportunity to inform the families about -- or the property owners to -- about lead safe practices, et cetera. So just, you know, working in the city of LA where they identified about 10,000 high-risk units. And again it -- it led to that prevention campaign -- their prevention campaign was in blood lead testing referral services.

So I just wanted to kind of go through a little bit about kind of this opportunity, I think, to be able to work with our city and local housing departments to -- who are -- are looking to or already have proactive code enforcement programs. I think we have about 25 right now across the country, of proactive rental inspection programs.

And looking to -- to -- you know, this basically covered integrate that data and their work and to guide the work of primary prevention and getting kids tested. A lot of times we're -- we're kind of working with kids that have been historically tested for lead to guide our work.

And I think that this is an opportunity here to work with our housing departments where there are active lead hazards that have been identified. They're just not within the house -- within the health department. So happy to talk more about what that might look like that.

But -- and those are my updates.

MR. AMMON: Thank you, Jeff.

Now let's hear from Dr. Megan Sparks, Johnson County Health Department.

DR. SPARKS: So Johnson County has been working really closely with the state of Kansas Childhood Lead Poisoning Prevention Program to really jump start our point-of-care testing. We've also been working pretty regularly with our municipal water systems who've done the inventory and they're preparing to do the drinking water testing in schools and childcare facilities next year.

They've actually been a huge boon to our communication with families. They were happy to disseminate educational materials to families as they were doing inventory. So we actually saw a huge uptick in calls and people seeking information from our website, like we've never

had before. And we're going to be doing a point-of-care drive-through testing event next summer when they do back-to-school immunizations as they start doing more of the drinking water testing. So we're really excited to get those efforts off the ground.

At the state level, here, they've been working on expanding testing among Medicaid enrolled children. And that's proved to be a challenge, but we have been making some big steps forward in getting some reimbursement processes in place to get in home inspections done and to onboard more lead-focused nurses in local health departments.

So things are starting to happen that have been the topic of conversation for many years. But we're -- we're getting it done.

MR. AMMON: Excellent, good to hear. Thank you for the update.

Now let's hear from Brian Weaver, Wisconsin Health Department.

MR. WEAVER: Thank you. And I'm honored to be able to give this update for Wisconsin. My role as policy advisor, I end up interacting with a lot of lead staff here. So I'll provide an

update on one related to blood lead testing.

So you heard earlier if you were on in this call that Wisconsin did update our blood lead testing recommendations. So we have recommendations now for testing at -- all children at ages one and two. And then if they have not had a previous test, between the ages of three and five to be tested for lead. So that is a public health recommendation.

I would say along with that, kind of connected to that, is our state Medicaid program. They have maintained the pay-for-performance measure related to blood lead testing in children under six enrolled in Medicaid. So an important element for the state to be able to maintain high performance of testing in the Medicaid population.

In addition to that, the CLPP program, the Childhood Lead Poisoning Prevention Program has been working really hard this year to develop a media campaign on our new universal blood lead testing recommendations. Happy to report that that has been finalized and we are going to be rolling out that media campaign in 2025. I think that's noteworthy because there will be resources

available for other of our public health partners out there to perhaps utilize to support their blood lead testing efforts as well.

Another update, kind of noteworthy for this year, I've been leading a multi-agency effort to support the city of Milwaukee where we have our highest number of childhood lead poisonings in the state. In fact, significantly higher than the rest of the state. They have the oldest housing stock, a very large, low-income population as well. So we do see a high rate of lead poisoning.

This multi-agency effort actually was to support the city of Milwaukee in the enforcement of their open lead hazard orders in rental properties. So we were able to convene three state agencies: one that oversees consumer protection, another Department of Justice, Department of Health Services, where I sit, to support the city of Milwaukee in their enforcement of those hazard orders.

We were also able to get a couple of federal partners around the table, representing from the regional offices HUD as well as the U.S. District Attorney's Office. So all going to play a key

role in supporting the city of Milwaukee in their enforcement of their lead hazard orders. So that'll be an interesting partnership to share with everyone on this call.

And in addition to enforcement or support of the elimination of lead paint hazards in older properties, our governor and the Wisconsin legislature passed a pretty significant housing bill last year, in the last fiscal year, that is. And they have invested $50 million in rehabbing of older properties. And a part of that -- key component of that is to address environmental hazards in those older -- and these are owner occupied homes, to be able to address the environmental hazards. So mold, lead paint is included to abate those by certified contractors.

So that was a big win for us. It's $50 million that could be spent. These are up to $50,000 loans -- some of them forgivable loans based on your income -- to the homeowners. So a great investment from our governor and the legislature in that effort.

And then lastly I just want to highlight some really key partnerships, I think, that might interest the people on -- on this call. So we --

we've been working really closely related to Healthy Housing. And lead exposure has been kind of driving this, although it does focus on healthy housing. So asthma triggers, other environmental contaminants you find in a property. Key partnership in foster care. So we're working with our state agency that oversees foster care programs to be able to integrate and support foster parents in maintaining a home that is healthy and safe from environmental hazards as well as the relatives who are -- are housing some of these children in the foster care system.

We're also working with that same agency on refugee population. We have started an initiative sort of multi-sector looking at refugee housing and making sure that that housing is maintained and is in good condition, again, to prevent any potential exposure to environmental hazards in those homes.

Another partnership we're having -- this is related to blood lead testing, and that is with our Head Start programs in the state. So we have started an initiative to really connect our local Head Start and Early Head Start programs with our local public health agencies.

So the state agencies overseeing public health, Head Start are working together to kind of bring together these relationships at the local level to increase blood lead testing in that high-need population.

And then lastly, this is an internal partnership. Our adult lead program and our Childhood Lead Poisoning Prevention program are working closely together to develop recommendations for lead exposure screening and blood lead testing of pregnant (indiscernible). So we hope to roll those out in 2025. We're really close to developing those. And so those are some of the key partnerships I did want to highlight.

And that wraps up my update. Thank you.

MR. AMMON: Thanks, Brian.

Let me go back and see if two of our LEPAC members are now available. Is Dr. Hatlelid available from CPSC?

DR. HATLELID: About earlier, I -- technology glitch, very bad timing, knocked me off. I had to --

MR. AMMON: No problem.

DR. HATLELID: -- retry.

MR. AMMON: No problem.

DR. HATLELID: I -- yeah, I heard the -- the very last part of Mary Beth and I was all set to go and I don't know what just happened. It all went blank. Okay.

So CPSC, we continue an emphasis on enforcement of our existing lead-related regulations largely through our import surveillance at our ports where we screen tens of thousands of products for lead and other hazards every year.

Our enforcement efforts may result in consumer product recalls or other announcements concerning safety of consumer products. The -- the latest information on recalls, including for lead hazards, is available at a couple of our websites. We have CPSC.gov, our main website, as well as saferproducts.gov.

And I would encourage everyone to sign up to receive recall notices by e-mail. We have -- already on our main page, the CPSC.gov main page, is an e-mail sign-up link and everybody can get updates on recalls, other announcements, and as well as other information.

And the last update I have related to lead, for this fiscal year, the CPSC staff is preparing

a request for information and comments related to the current regulations for lead content component parts of children's products and lead content of paints. And some are surface coatings, including painted children's products.

So we'll be doing that this year according to the commission-approved operating plan. And you -- we will see that published in the Federal Register in the coming months. That's all.

MR. AMMON: All right. Thank you for -- thank you for the update.

And going back to see if Tammy Barnhill-Proctor from ed -- education, U.S. Education is available.

MS. BARNHILL-PROCTOR: Here. Education -- hi. And here at the department, we do not technically have activities that target lead prevention in that we don't have the authority to push in our school environments. However, we do continue to share guidance and share the information that we get from EPA and from CDC around lead and lead prevention.

And so we have a clearinghouse that we have here at the department that we post information on. And in our Safe and Healthy Students, they

also include information about lead prevention.

MR. AMMON: All right. Thank you very much.

I believe we're through all of the members. I will go last actually, after everybody.

So let's hear from Abraham Kulungara for the Association of State and Territorial Health Officials.

MR. KULUNGARA: Afternoon. Can you hear me? I think I've come online.

MR. AMMON: Yep, I can. Yep, I can hear you.

MR. KULUNGARA: Great, yeah.

Afternoon, folks. My name is Abe Kulungara. I'm a senior director on the Environmental Health Team with the Association of State and Territorial Health Officials. And we represent state and territorial health directors and commissioners.

So the update I have is around an ongoing project with CDC. So with support from CDC's Lead Poisoning Prevention and Surveillance Branch, we continue to collaborate with state and territorial health agencies, including those in Arkansas, North Dakota, Maryland, Guam, Northern Mariana Islands and American Samoa.

We also work with the National Center for Healthy Housing and our activities include offering resources for childhood lead poisoning prevention, providing (indiscernible) support such as staffing, providing (indiscernible) assistance in on lead poisoning prevention.

And finally with the National Center for Healthy Housing, we're working with them, along with community-based organizations, to tackle some of the unique challenges in rural areas.

So that's the update on my end. Thank you.

MR. AMMON: Great, thank you.

And Ruth Ann, Green Healthy Homes Initiative. Maybe we can -- we can come back.

So let's hear from Dr. Patrick Parsons, Association of Public Health Laboratories.

DR. PARSONS: Thanks, Matt. Can you hear me okay?

MR. AMMON: Yes, I can. Thank you.

DR. PARSONS: Okay. I got some brief updates from the laboratory perspective. I'll begin with a publication that appeared in April of this year from the Clinical & Laboratory Standards Institute or CLSI. So CLSI is a consensus organization and they develop clinical

laboratory-based documents to assist in measurements. And this particular document, which is C-40, is a third-edition measurement procedures for the determination of lead in whole blood. And I was privileged to be asked to chair that document committee.

And just so you know how it works, it's a consensus organization. And so there's representation across a broad spectrum. So we have representation on the committee from CDC, from FDA, from MST, from Harvard, Meridian Bioscience is the company that manufactures the point-of-care lead-care device, Wisconsin State Lab of Hygiene, and the American Academy of Pediatrics. And there was also representation from several overseas institutions as well.

So as I said, this is the third edition of a document that's been around for more than 20 years. In fact, I chaired the committee that published the original version. I want to just read a brief update of the changes in this new document.

So they've added detailed procedures for measuring lead in blood, based on inductively coupled plasma mass spectrometry. So that's the

dominant method that's used in what's called high complexity labs these days. And so that, I think, will go some way towards harmonizing measurements from that particular lab community. And there were updates on information on clinical and public health significance of blood lead levels below five. And again this document is -- although it targets the analytical chemistry community, it does provide a lot of background information that I think is important.

There was additional guidance on anodic stripping voltammetry devices that use disposable screen-printed electrotechnology -- so that's the long way of saying lead care -- guidance for laboratories on quality assurance practices at 3.5 micrograms per deciliter which is the -- the reference value, current information on lab certification and proficiency testing programs in the U.S., Canada, Europe and elsewhere.

And then there's a protocol for checking contamination of materials and supplies for lead which is a very important part of the measuring process.

So two things that were deleted from this version, the classic anodic stripping voltammetry

procedure for older bench-top instrumentation. That's no longer manufactured or available. And the procedure for measuring lead in urine was deleted. It's now considered redundant for clinical purposes.

And so that wraps up the CLSI documents. I think that will be very useful to the blood lead lab community, especially given the -- the new reference value.

And that kind of provides a good segue into the next update which is actually about proficiency testing. And CMS has tightened the criteria or quality specifications required of labs that do blood lead testing under a CLIA permit. And so the -- the old criteria of plus or minus 10 percent or plus or minus four have been tightened to plus or minus 10 percent or plus or minus 2 micrograms per decimeter.

So what that means in practice is that when laboratories are challenged with proficiency testing samples at concentrations of blood lead below 20 micrograms per deciliter, they're going to have to be proficient to within plus or minus 2 micrograms of the target value. That still means that 3.5 micrograms per deciliter, they're

going to be allowed to report between 1.5 and 5.5. But that's a very big improvement over the previous specifications which allow plus or minus four or a range of eight.

So those are quality specifications for PT. That does not -- that's not quite the same as uncertainty. So most labs do a lot better than plus or minus two, but that perhaps is something for another time.

The -- the last item for update is actually an APHM update. So at their annual conference this year, there was a whole session devoted to lead poisoning or get lead out, public health laboratory, and medical initiatives to identify and reduce pediatric lead exposure. And I was honored to be included on that panel.

So there were three speakers. The first speaker was Mary Jean Brown, who I think is known to this -- to the LEPAC community. She spoke from an epidemiological and public health perspective on blood lead levels, how low should or can we go? There was a presentation from Dr. Morri Markowitz from Montefiore Medical Center, Einstein College of Medicine, a pediatrician's perspective on blood lead levels

at 3.5 micrograms per deciliter. That was really well received. And then I rounded things out with a presentation on the new reference value at 3.5 and the implications for laboratories.

So that sort of wraps up the update from the lab perspective. Thank you, Matt.

MR. AMMON: Thank you very much for that update.

Is Amanda Reddy on from the National Center? All right, I'll come back.

Dr. Stephanie Yendell from the Council of State and Territorial Epidemiologists.

DR. YENDELL: Hi. Yes, I have several updates from CSTE.

The first is that at the annual conference in June of 2024, several CSTE environmental health and occupational health members did discuss a priority that they were not able to move forward with this year without CDC funding support. That priority was to coordinate and review ABLEs and CLPPP surveillance; to assess opportunities to improve coordination, data sharing; and tracking lead poisoning cases across the lifespan. So something that CSTE is very interested in but not able to move forward with

at this time without funding support.

The second update is that CSTE administered an assessment of jurisdictional policies and practices to identify what blood lead levels in pregnant and lactating women activate public health action. The results of the assessment were presented at the November CLPPP meeting and the assessment identified a need to review and clarify the clinical blood lead reference value and recommendations for public health action as well as funding.

And several responding jurisdictions indicated a variety of practices as well as inconsistent policies and then also had requests for additional guidance.

And the third update is new CSTE project that may be of interest to this group, that CSTE is partnering with NCEH and the Division of Environmental Health Science and Practice on a noninfectious food-borne outbreaks workgroup and assessment. We'll be covering a -- or convening a multidisciplinary group of partners and state and tribal, local and territorial representatives to identify unique needs and opportunities to improve standardized surveillance and processes

for responding to outbreaks such as blood (indiscernible) and also outbreaks such as the (indiscernible). That will be starting in January. Thank you.

MR. AMMON: Excellent. Thank you for that update.

Dr. Lauren Zajac from AAP.

DR. ZAJAC: Yes, hi. Thank you. Great meeting so far. My quick update: So thanks to a grant from CDC, the AAP's healthychildren.org website, which is -- has a lot of traffic every month was able to publish a set of parent videos, short videos, on lead that covered topics about the health impacts of lead, what are some common things that contain lead, what can I do to protect my child? So it's a really great suite of short videos that I hope you all will take a look at and use. And I will try to get the link shared with you all, but if you go to healthychildren.org and just search for lead, it's -- it should pop up pretty easily.

The other big update I have is the academy -- our policy statement and technical report on lead. Dr. Jennifer Sample and I, along with the Council on Environmental Health and

Climate Change have revised the existing documents and they're currently being reviewed by stakeholders at the AAP and then will be published. I don't have a specific timeline on that, but it is in the works.

Concurrently our council is also updating the Pediatric Environmental Health Manual that's currently -- this is the fourth edition has been published. We're working on publishing the fifth edition which will obviously contain a chapter -- updated chapter on lead. So that's in the works as well.

And I just wanted to flag Gail's talk. I'm always impressed with New Hampshire's lead program.

And, Gail and Nicole, your presentation was so interesting and I was wondering if you would be able to share the slides or any reports or publications you have on your work.

That's it. Thank you all for the opportunity.

MS. GETTENS: The answer is yes. And I can share them directly to you or with anyone in this group. And thank you, Lauren.

DR. ZAJAC: Thanks, Gail.

DR. RUCKART: This is Perri. I --

MR. AMMON: All right, thank --

DR. RUCKART: Matt, can I just --

MR. AMMON: Oh, sorry.

DR. RUCKART: This is Perri. I just want to let everybody know that Gail -- well, New Hampshire's presentation will be put up on our website in the near future. So everyone will be able to access it. Over.

MR. AMMON: Thank you.

All right, I'll turn it over to Ruth Ann Norton from Green Healthy Homes Initiative.

DR. ALLWOOD: And, Matt, I -- oh, I'm sorry, I thought maybe somebody had their hand raised, but it is Ruth Ann. Sorry.

MS. NORTON: It was just me, Paul. And I had to hop off for a quick meeting. I'm not sure what the updates have been, but let me tell you a little bit about the work of -- that GHHI is doing on lead and its work here.

First, I would say for all the folks who may be on here from Maryland, I chaired the -- Governor Moore's Task Force on Lead Poisoning Prevention and served on the Green and Healthy Homes Task Force for the governor. And in the

work in Maryland where we have had significant decline, what we are really trying to do is to ensure that we have lead in all policies to re-up our efforts not only on the work that's been done in lead and water and the significant work on spices where we're seeing an impact here in Maryland from immigrant communities, especially where we have lead levels being detected through spices and food products, we're trying to build a greater awareness campaign on that work.

So I was very interested to see the work being done by FDA and others. We want to join across the country on that good work, and then we may have the potential legislation going into the Maryland General Assembly on that.

But we have -- we're increasingly looking at the opportunities in low-income homeowners on a whole-house basis to be looking at lead as a linchpin activity for all of the greenhouse gas reduction dollars going in. For those dollars to be able to be implemented, we will have to address lead. We'll have to address things like mold, mildew, and moisture around asthma. So we are deepening the work on the role that lead elimination plays in both electrification,

decarbonization, a whole-house approach.

We've released this week -- are releasing this week a toolkit on that for all who are advancing those elements because of health. We are in the carbon reduction in homes, grounded in the health work of benzene nitrous oxide and carbon monoxide. But you cannot do this and walk away and not have done the lead work first. So we are trying to advance that work not only in Maryland but New Jersey, Pennsylvania, California, and a number of places.

We're also working with the city of Oakland through their lead settlement to ensure that we build a highly equitable holistic approach to lead poisoning prevention for the city of Oakland and county of Alameda. Working to revamp that, much like work that we're doing with the city of Milwaukee to align programs from weatherization and other climate-related impacts with lead.

And we will be re-upping our campaigns around getting kids tested for lead and trying in Maryland and other states in which we work, trying to advance that work. As folks may know, we also won the Lancaster General Health University of Pennsylvania Health Systems

Day-To-Day Lead Removal Program. Their -- the hospital runs the program. We're running the contracting side to do approximately 3,000 homes through a $50-million investment.

And we're also -- through monies awarded recently in Memphis, we're going to be enhancing the work -- that work -- in our work in Memphis with Le Bonheur Hospital under a new $10-million award to do whole house and lead.

And then we are continuing to do work in New Jersey on a whole-house approach which has lead and weatherization work together and demonstrating the same in Detroit and in Providence, Rhode Island.

But one thing that was mentioned by Mayor Bowser with whom we are working with the city of Washington DC around some of their solar-related programs where we're going to be the trainer and community lead on lead and healthy housing related issues to limitation of solar. Mayor Bowser said something at the Bloomberg American Health Summit which I think is so incredibly important, and that is that mayors and governors cannot overlook the impact of lead-based paint. And so she -- she said DC would be advancing its

efforts there. And we are seeing a lot of new mayors and governors across the state honing in on where they can play a role in the eradication of lead and that includes here, in Maryland, with Governor Moore, not only through our lead programs and, thank you to HUD, our state housing department now has lead hazard control dollars in addition to Baltimore up through programs like ENOUGH that are antipoverty campaigns, campaigns to ensure the long-term lift on health and opportunity for long-term -- for low-income families.

So a quick update, please come and visit us. Ask questions about GHHI. We're always happy to have you here and mostly we're happy to learn from each of you. And I will lastly say that if you're in region 3 -- Pennsylvania, Delaware, Maryland, Virginia, West Virginia, or the District of Columbia -- we are grateful to be able to distribute $50 million on behalf of the EPA for thriving communities. And those dollars may be used by groups, local government, university. And on-the-ground frontline community-based organizations should do lead removal and healthy housing. Thank you.

MR. AMMON: Thanks, Ruth Ann.

We actually have a question from Grace, EPA.

Grace, your question?

MS. NORTON: Grace, how are you?

MS. ROBIOU-RAMÍREZ: Yeah, it wasn't a question. I was -- I was trying to clap, but it --

MR. AMMON: Oh.

MS. ROBIOU-RAMÍREZ: I think that function was disabled in Teams today. But thank you, Ruth Ann, for everything that you're doing.

MS. NORTON: Well, there you go. That is one of my favorite people besides everybody else on the call as well, of course.

But, Matt and Grace, the way people can apply for our grants, the $350,000 lead grants that could be used for lead education, exposure, reduction, and healthy housing interventions. It's GHHI.org/thriving communities. It'll take you right there to the application. We will help you if you need help in the application process. It's a low bar, I think, in terms of it's not a 700-page HUD application. Wink, wink. But it is a -- it is a no-more-than-seven-page application intended to build the capacity of communities on

the issues like this. And we are trying to get all of the money, big money out the door through application deadlines on December 30th.

And then for smaller grants of 150 and 250, that's rolling until April of '25.

MR. AMMON: Thank you very much for the update.

And I guess it's my turn now. One of the things, I'll just -- it's funny that I follow -- was following Ruth Ann because, as you know, all of our work, as I've mentioned before, is really rooted in our local grantees doing -- doing the work. It's great for -- for me to go out and see the work that they're doing, great work that they're doing on a regular basis around the country.

And I was just in Baltimore with Ruth Ann and seeing all the work that they've done and how they've integrated all this work on the ground and the various sources of funding and things of that nature. And, you know, it's sometimes hard for -- for me at HUD to catch up just because there's so much innovation and -- and, you know, I want to be able to take that and learn from it and do things to try to make and improve our

program, all of our programs on a regular basis.

And that's kind of part of my update. You know, this was a pretty incredible year for us. I think, you know, collectively we're heard from folks from around the country, you know, in very different disciplines. And this was a very successful year in terms of things which we were able to accomplish both in terms of innovations or funding or new partnerships, trying to build out what's out there in terms of funding and use that as best, quickly as we can to get it reserved and obligated to be able to use for which really are our common goals, you know, and -- and in improving communities, improving the quality of life for the residents and kids and adults that we serve on a regular basis.

And, you know, all of our work, it comes down to a person, right? That one person, that one child, you know, in terms of -- of making an impact. And for us, the beginning of the year, we had a -- a lot of money available for our grant programs, a lot of money for our grant programs. Probably more than -- not probably, more than we've ever had ever available for communities to do this work.

And quite frankly, over the last couple of years, there -- there had been a shift in terms of a lot of priorities locally in terms of what they were doing and what they were focusing on. And for us, it was a wait-and-see approach to see what would happen. And we had about a billion dollars that was available, both in terms of this appropriations '24, past '24, and then also previous reparations, kind of collectively. That's -- that's a lot of money.

And it's not like, you know, it's part -- and this is just our grant program. It's not part of the, you know, EPA infrastructure work that's going on. This is really our compendium, our seven or eight grant programs, you know, that range from Lead Hazard Control Program to the Healthy Homes Production Program to the Weatherization and Healthy Homes Program to our Technical Studies Program.

So the -- all of those kind of combined, we had, again, nearly a billion dollars available for communities -- local communities, nonprofits, Native American tribes, universities -- to do this collective work. And then I -- and I was a bit worried, but what happened was something

really amazing. There was -- there was an amazing response to all of our grant programs and that was almost not expected. We weren't -- we weren't quite sure what we would expect, but -- but all of our programs except for one had almost doubled the amount of funding requested than we had available which really hasn't happened in quite a long time. In fact, probably three years. And that meant that we -- we felt that, you know, this -- this work was still desperately needed in communities and we worked hard internally to do things which try to make it easier from the 700-page application process.

It will actually be even easier next year. But all those things kind of internally, we had a lot of work-shopping, if you will, with local grantees and everybody, just kind of listening, just listening: What -- what could we do better? What do we need to change? What do we need to improve on? And we've been making those changes and we will continue to make those changes.

So the end result is that we were able to award. So I know it's one thing to say we almost had a billion dollars available with our grant programs, but it really comes down to our

programs are competitive. They're not formally based. So you have to apply for the funding and things of that nature. And we were able to, as of -- even as of today, you know, award over 550 million -- more like 570 million to communities across the country. That's going to make a real difference in people's lives.

And the good thing is that we're -- so we're not done yet. So even though we have awarded, you know, over five -- about 570 million, we have another big tranche of dollars that we'd like to get out by the end of the year, a significant amount of money by the end of the year. And it will help support, again, not only the whole-home approach that we have with our Healthy Homes Production but also with our lead and supplemental, but with the Older Adult Home Modification Program that we have, which is, you know, a very popular program of helping people age in place. And it's a small program. It's a small program, right? It's not a big program.

Oh, let me -- Ruth Ann, you have a question? You're on mute.

MS. HANCE: The opposite thing, wanted to take my hand down. And after thinking about

this -- right? -- and after thinking about how we're going to approach the future here, you know, I don't think this will come as a surprise, I think there are really effective nonprofit organizations across this country, doing work in communities, in housing who can manage lead grants. We've gone away from having nonprofits be able to be recipients but especially in some of our harder-to-reach areas of the country and where local government is strapped themselves -- right? -- or even local government would in some instances say that it would be easier and better managed by nonprofits. Is there any movement on this, you think, as we move forward and talk about the important sustained commitment to communities, to community health, to community outcomes, and opportunity but also to how we are looking at government efficiency and getting the dollars to be most efficient and getting them out to where there is the highest need?

So I didn't mean to interrupt. I was going to talk --

MR. AMMON: That's okay.

MS. NORTON: -- ask you this question at the end, but I think this is something that is so

important to think about. You know, I -- I just know for -- I think this is so much spent on administrative dollars, and I love our local government and I don't mean anything untoward in that way. But there's sometimes ways for organizations that are nonprofits who know -- who have experience doing this to be able to more effectively, more efficiently, and quick -- more quickly get the dollars out and spend and achieve the goals in a very effective way.

MR. AMMON: Yeah. I mean, so we have always made recommendations when we are asked to provide input into bills that come to us. And so making recommendations as part of improvements towards statutory authority -- I mean, what you're talking about is rooted in our statute and we're bound by our statutory obligations and restrictions on the lead side on who we can fund.

But, again, you know, there's always opportunity, always opportunity when we're asked to provide input into such things to improve statutory language or regulatory language as it comes across.

Unfortunately, of course, as you know, is that sometimes it takes a long time. We can make

commendations and --

MS. HANCE: Right. Yeah.

MR. AMMON: Yeah. It takes -- it takes some time. But no, I appreciate --

MS. NORTON: And I --

MR. AMMON: -- I appreciate you.

MS. NORTON: But I think it's more -- I just think it's more efficient, more effective than some -- and I love CPF and going through the congressional set-asides and everything else because I think the work that's being done there really should be looked at. And as there is more and more look at things like efficiency -- right? -- and cross-walking, I really think, you know, the impact of weatherization done right or other inner -- you know, indoor air quality, thermal -- whatever we want to call it -- climate, you know, whatever you want to call that, all of those programs really, really do need real clarity on the lead work, the coordination of the lead work. My hope always is that we could get them all in the same agency to make them more efficient.

But, you know, I just think a lot of those kind of dollars do go to nonprofit organizations and get spent really well. So as you think about

long-term recommendations, because it's not an overnight, you can go to Congress and say, Hey, we'd like to change something, a great appreciation for that and amazing.

By the way, if anybody has not congratulated Matt on 33 years of dedicated service to this work, it's amazing and deserves a star in Heaven.

But I do think that's something, Matt, as you think about how we're looking at the future of really getting, as we get better and better and better about lead, in order to get to those -- that last mile even, just a -- just a recommendation.

MR. AMMON: Well, I appreciate it. I appreciate it. You know, I'm all for making comments, recommendations, and whatever. So I appreciate the comments and -- and the recommendations.

So -- so again, this was a pretty remarkable year for us and we just had a lot of -- well, all of our new grantees in and it was the biggest crowd we've ever had, which is -- which is really amazing and great.

HUD has also done a lot of incredible things, both in terms of its strategic planning

and its -- and its programs. I know I've said this a million times, but it's -- it's no longer an anomaly for the nation's housing agency to have health outcomes. That's a strategic goal within its -- within its strategic planning. And it's been embedded with -- with not only its own specific key performance indicator but also rooted and embedded in almost all of the programs.

And so the Healthy Housing connection has really been firmly entrenched in the department, not only over the last couple years but, you know, really since we've been doing this work now for, you know, twenty, twenty-five years where we've made marked improvements almost every year in some things.

And one of the big improvements we made this year was we were lucky to be able to receive funding under the Inflation Reduction Act for a new program which is called the Green and Resilient Retrofit Program. And this program, we were able to get out almost a billion and a half dollars through several rounds of funding within a year. And so these grants and loans go to -- will go to our -- have been going to housing

providers in -- in 42 states including D.C. and Puerto Rico. It really focuses on the combination of both green, healthier, and safer.

And so a lot of this is around energy and water efficiency, of course pollution emissions, generating removable energy, a lot of reducing costs overall -- right? -- cost savings, promoting green building materials, improving the indoor air quality, you know, making them healthier and safer.

So to be able to get out this amount of money through a series of grant programs throughout the year is a remarkable feat, and, you know, it really is a testament to where we were focused in terms of making sure that as we get money, we need to get it out the door and put it to good use. And this was one of the programs at HUD and the Green and Resilient Retrofit Program. It really kind of speaks to a lot of the work that was done in the department that -- that, yeah, it really focuses on both healthy, safe, and energy efficiency.

One of the other things I wanted to mention was -- was we had heard about the memorandum of understanding that -- that we had signed with EPA

and CDC. We have two of them. And, you know, it's no secret that we've had a great working relationship for as long as I've worked at HUD. It really has been remarkable. You know, the -- the three of us in terms of just, you know, what we do together and how we play off each other. And regardless of what's in codified or regulation, I mean, we've always -- we've always known what we need to do together. And we've had series of MOUs throughout -- throughout time in terms of sharing data and reporting activities.

But I think, you know -- and Grace mentioned this -- as part of the lead -- Lead Pipe and Paint Action Plan, you know, we thought it would be good to get a codified or working relationship and, you know, more focused on -- on trying to get back to the roots of not only sharing data but actually in the field together, like literally working in the field together.

And so a lot of this MOU initiative came around (indiscernible) because of the Clarksburg, West Virginia lead in water concerns. And it was, you know, a way for us to kind of quickly engage on issues and -- and kind of recognize both terms of what I -- our actions could be, but

also in terms of feeding up information up the chain, if you will, for follow up. So it was just a good way for us to kind of say if something happens like this, we know who the point people are for quick action and things of that nature. And I think that's -- that's helpful. And so we've been doing a lot of work together after that, not only sharing information on sessions at health departments and fairs around the country, but also to enjoin enforcement work around the country. And I think that the work will absolutely continue, but it just again reemphasizes our commitment to working together, collectively sharing of common outcomes, you know, and -- and being able to really hone in on specific expertise that may be called upon for us to provide information or responses and things of that nature.

But -- but it's nice to have it. It's nice to have it in place. And, you know, we're doing others around the country. But these two in particular, I think, were pretty demonstrative of work that we've done that we needed to continue to do but also, you know, codify certain things too about if something happens, you know, what --

what's our response?

And so it's kind of nice that it actually has that responsiveness in there, not just sit down, you know, work on something collectively, but really being able to respond collectively with the expertise that we have at the -- at the various agencies.

So I appreciate everybody's work on that. And I know it's been a real highlight of the Lead Pipe and Paint Action Plan, but, again, you know, my original statement, going back to the work that we have on our -- on our -- on our grant programs. And I can't thank all of you enough. I know I've heard several times from you that you're grantees of ours, and I really appreciate that. And it really is something that has been my real life's work in terms of making sure that we are able to provide resources and be responsive to what your needs are locally.

So again I appreciate all the grantees that we have and all of the prospective grantees that we hope to bring in next year as we have subsequent rounds of funding available for everybody. Okay.

So I believe we have gone through everybody.

Does anybody have any general -- does anybody have any additional statements before we move to the next topic? And I apologize for going long as usual. That's why I went last. Just to make sure I could get everything out. No PowerPoint, just kind of thoughts to get out. But no, I -- I appreciate everybody's consideration in the updates.

So if there are not any -- any additional updates that anybody wants to provide, I'll pause here for a second. We're getting close to our time here. No other updates? I don't think I see any hands, questions.

All right. So with that, I am going to turn it over to Brian Weaver for a presentation on the Preventing Lead Exposure in Adults workgroup to talk about their report and recommendations and further discussion.

So with that, Brian, I will turn it over to you.

PREVENTING LEAD EXPOSURE IN ADULTS (PLEA) WORKGROUP REPORT ON RECOMMENDATION/DISCUSSION

MR. WEAVER: All right, thank you, Matt.

So those of you who didn't hear earlier in the call, in the morning, Brian Weaver, lead

policy advisor at the Wisconsin Division of Health Services -- sorry, Wisconsin Department of Health Services. I work within the Division of Public Health. I served as the chair for the PLEA workgroup which is -- PLEA is for Prevention of Lead Exposure in Adults. I will be presenting with Dr. Michael Kosnett. He will actually be diving into the report and kind of facilitating the discussion on the recommendations.

I will give a -- a brief introduction of the report and kind of the committee members and some of the -- lay the groundwork for this group. So next slide, please.

MR. AMMON: Brian --

MR. WEAVER: Yeah.

MR. AMMON: Can you pause one second?

MR. WEAVER: Yeah.

MR. AMMON: I -- I wanted to mention early on, up front, just giving Brian a little more context. And so I'm going to have CDC just speak on the context since the last workgroup we had was BLRV.

MR. WEAVER: Sure.

MR. AMMON: And I think we have a lot of new members.

MR. WEAVER: Yeah.

MR. AMMON: So I just want to be able to provide just some context around, you know, how that process went and how -- you know, how the process works within the -- the -- this organization in terms of moving forward with recommendations and things of that nature. So if you could pause for a second -- actually if you want to go off camera, I'm going to have CDC jump in real quick just to provide everybody a better context before we dive into the presentation.

DR. RUCKART: Yes, hi. So this is Perri Ruckart. I'm just going to give just a few -- just a process update about what -- what are the next steps and what is going to happen here. So we're going to have the presentation by the PLEA workgroup. The LEPAC members have gotten the report in advance. If they could, review it and be prepared for a hearty discussion.

So after that, then there'll be a call to vote to approve the report. And if the report is approved, the PLEA can make minor changes based on comments that we hear today and then the report will be given to CDC for consideration. And the final PLEA report will be posted on

LEPAC's website. And then anything, any recommendations that are recommended or major points that come out of this discussion will make it into the 2024 LEPAC report that we give to the HHS secretary.

So back to you, Brian. Thanks.

MR. AMMON: Thanks very much, Perri.

MR. WEAVER: Yeah, thank you, Perri.

And the report actually is available on the LEPAC website for today's meeting, December 11th meeting, if people do not have access to it at this time.

MR. AMMON: Looks like Paul?

DR. ALLWOOD: Yeah. I'm sorry, Brian. I just thought I -- I just thought of something that I think it would be kind of also important to -- to mention it. You know, as you -- you pointed to the availability of the report, that it is -- you know, it is available as a draft report on the CDC's website. So if you -- you know, if you do go up and see the report, if you really looked at it, please just keep that in mind also.

Thank you, Brian.

MR. WEAVER: Yeah. Yeah. All right. So

with the report, the official name of the report is *Prevention of Lead Exposure in Adults, Recommendations for Public Health Action*. Next slide, please.

So the PLEA workgroup was charged with examining adult lead exposure with a focus on actions by U.S. public health agencies that might prevent exposure and mitigate lead-related adverse effects. So the objectives of the PLEA workgroup was to generate this final report that we are presenting today to LEPAC for discussion and input and feedback. We are hoping, you know, to make some modifications if need be to the report and get it approved during this meeting if that is at all possible. And then it's submitted to CDC for -- for consideration. Next slide.

All right. So the PLEA workgroup was made up of subject matter experts in adult lead exposure and occupational health. Perri Ruckart served as the designated federal officer for this group. Next slide.

And just -- so a quick kind of process piece of how we'd like to move forward during this presentation. Again the outcome we're hoping for is getting the LEPAC approval of the report.

The process that Michael will lead is to review the report; looking to get comments, feedback back from the LEPAC members or discussion; and hopefully get to a point where we can get agreement from the LEPAC group to move forward with a vote. And then next slide.

And so the report -- and this is where -- how Michael will walk through the report -- is divided into five sections. These are the five sections that are -- are in front of you now. Each of these sections has recommendations for consideration by LEPAC.

So with that, I do want to turn this over to Michael because we feel like we want to dedicate the majority of the time for a discussion with the LEPAC members.

Michael. If you're speaking, Michael, you're on mute.

DR. KOSNETT: Can you hear me now?

MR. WEAVER: Yes.

DR. KOSNETT: Can you see me?

MR. WEAVER: Yes.

DR. KOSNETT: Okay, great. Thank you, everyone. We're very pleased to have -- to have presented this report to LEPAC two weeks ago and

it represents two years of having worked on this -- the concepts of the report and in writing it, it's been reviewed and discussed by and accepted by everyone on the working group committee.

And we want to allow as much time as necessary and available for members of LEPAC to react to our recommendations and hopefully to approve the report so that it can represent the second workgroup report of LEPAC in its four years of existence, the first one being the recommendation to lower the blood lead reference value. The novelty and importance of this report in particular is that this workgroup, and by extension LEPAC, is really one of the only CDC work --advisory groups or committees that has been specifically charged with examining lead exposure to all individuals not just children, you know.

And if you go back to the ACCLPP and the Board of Scientific Counselors, Lead Advisory Committee, they focused -- their charge was on childhood lead poisoning. But I think by -- very much by design, when this -- when LEPAC was established by an act of Congress, it

specifically did not narrow the focus just to children but to adults as well. And that's why our report covers everything from environmental to, very importantly, occupational exposure as well and made a number of recommendations.

Rather than take an extended period of time to go through the report since everyone has had a chance to see it and review it, we'd like to reserve the remaining portion of the time to addressing any questions or comments or suggestions or concerns that members of the LEPAC may have with an eye towards, in live time, making any corrections if necessary and having the report officially approved as a final work product of LEPAC as submitted by the workgroup.

So I and other members of the workgroup, many -- I know several of them are present in addition to Brian: Dr. Howard Hu, Dr. Remy Babich, Rebecca Tsai. I see their names on there, there may be others. I think Erika Marquez is on as well. And I apologize if I'm missing somebody, but Gary Edwards is on as well. And we'd like to all be available if necessary. Oh, I didn't know -- Alicia Fletcher is on too. Excuse -- very, very important to mention Alicia

as well.

So I am -- with that said, I like to open it up to members of LEPAC who have any questions or comments or reactions.

MR. AMMON: This is Matt. Did you -- are you going to go through the report and recommendations or just questions in general?

DR. KOSNETT: We really felt that since time is limited and we went through -- it's a forty page -- thirty-nine-page report. If we went through the whole report, then we wouldn't be leaving any time for discussion and potential vote. You know, initially the meeting was set for 30 minutes for the entirety of the discussion. So we'd like to open it -- you know, we don't want to recapitulate what's already been submitted to everyone for their reading.

MR. AMMON: Question from Amanda Reddy.

MS. REDDY: Stephanie was actually before me if you want to call on her first or I can go if you want me to.

DR. YENDELL: Oh, thanks, Amanda.

So, yeah, this is Stephanie Yendell, the CSTE liaison. And I -- first off, I just want to compliment you on this report. I think it was

incredibly well researched and it is actually going to be very -- very useful for some work that we are doing in the state of Minnesota.

The one thing that I -- I just wanted to point out that I felt could potentially be improved in the report is that you do talk about take-home lead exposure and also some recommendations around, like, expanding training, hygiene, and housekeeping requirements. But my -- my suggestion would be to make it explicitly clear that the onus for preventing take-home lead exposure needs to be shifted to the employers rather than having that be really the burden on the individual workers and having -- having that be on them to take individual actions in terms of removing boots when they get home and changing work clothes.

You know, my question is why were they allowed to leave with contaminated gear in the first place? Why is that, leaving the workplace to allow them to then have to take those individual actions? Because, of course, we think about the hierarchy of controls, those individual actions are going to be much less effective than even things like administrative controls or

engineering controls to prevent them from having personal items and clothing be contaminated which then contaminate their personal vehicles and then are brought home.

So thank you for considering that.

DR. KOSNETT: Thank you, Stephanie, for that comment. And I -- I hope it was clear that we actually referred to -- to that -- to the fact that there needs to be a change in the OSHA standards that would enhance training and -- and requirements designed to -- specifically to prevent things like take-home lead exposure.

For example, the rules that would be in effect, for example, under an adequately designed revision, such as is the case now with the new California standards, is to require people who have, you know, above a certain level of exposure to shower and to change their work clothes and to have clean lockers and to be provided, for example, with a change of work clothes so that they won't track it.

And also the California standards, which we reference, also require training on take-home lead exposure.

So that is incorporated by design.

DR. YENDELL: Okay. Thank you. I -- to me it seemed like it was more implied than maybe explicitly stated that that burden needs to be shifted.

And the other thing just from my experience working with companies is that, you know, companies, especially facilities, you know, I was thinking more of a factory-type facility versus, like, the construction industry, they're really focused on the PELs in the air standards because of the way that the OSHA standards are written. And when we start talking to some of these companies about, well, what does your dust contamination look like? even on the floor between where the locker room is and where the door is, that is a completely new and foreign standard -- or concept to -- to these companies, that they're just really not thinking about dust settling.

So I think the more that we can be explicit in calling that out and bringing more awareness to those companies, the better. Thanks.

DR. KOSNETT: Yeah, I -- I certainly agree. In fact one of the key advances in the Cal/OSHA lead standard is that it introduces the whole

concept of not just triggering the rules based on air monitoring, but on lead-related work including -- which is -- which is defined as lead -- as any kind of work which alters or disturbs any lead-containing material that contains greater than 5,000 parts per million or 0.5 percent. So I totally agree with you and -- and that is -- that would be a part of a -- of a necessary revision to the lead standards.

MR. AMMON: Okay. I think we have Amanda next. Yep.

MS. REDDY: Yep. Hi, thanks, everyone. And sorry for not being available earlier when I was called on.

I also want to thank this workgroup for this report and for bringing attention and such robust treatment to this really important topic of adult lead exposure.

I have several comments. I think I'll just run through all of them because I want to present them here and not necessarily to hold up a vote on this report but just to add to CDC's consideration of the material that's presented here. And these are in no particular order, just really the order of the recommendations in the

report.

Starting with Recommendation IV-4 which really calls on and calls attention to the opportunity to increase compliance with EPA's Renovation Repair and Painting program, I note here that I really commend you for calling this out. This is an important lever. I note that local level action is not mentioned here, but it is still relevant in ways that might not be apparent.

Many communities, for example, have embedded RRP into their local permitting process. I think many of us in this field are aware, for example, of Rochester, New York as having one of the most proactive and openly progressive approaches to lead poisoning prevention. One of their code officials once noted that embedding RRP into their permitting process was the best thing that they had ever done. This can really be an important lever.

And so I think, you know, as CDC is considering this or we're putting information out about what the opportunities are, there are resources that we can share on what this looks like and examples from around the country. So

that's a great recommendation. I think it could be strengthened by the additional attention to the local level action.

Recommendation IV-5, again here I think I'm -- this was the one calling on -- for more advocacy through the International Code Council and -- and leveraging code enforcement activities and housing code activities in general. It was great again to see housing code called out here. As a powerful potential lever, I commend the authors for doing that. There are several model policies that could be referenced here, including provisions in the National Healthy Housing Standard which is a set of model codes which has some language here, many other communities that have example codes.

It may also be worth noting that these codes are strongest when implemented as part of a proactive rental inspection program that acts to identify and remove these hazards before people are exposed and harmed which is when that -- that frequently happens. And again there are several resources that could be referenced here that we can provide.

Moving on to section V, the health equity

implications, and especially Recommendation V-3 about the ACOG screening. I want to amplify and echo something that I noted also, comments made during the public comment period about the effectiveness of the ACOG assessments and my concern that this is not an effective screening tool as noted by the previous commenter during the public comment period, Tom Neltnor. Many of the questions relied heavily on either the provider or the patients to have extensive knowledge of lead and to connect dots that might not be obvious.

So, for instance, in a question evaluating, you know, do you live near a point source of lead? Somebody has to, you know, rule, integrate, and apply the knowledge of what are the point sources? Do I live nearby them? Am I spending significant amount of time in other places that are nearby them? It's a lot. And every screening question -- you can walk down the list -- is like that. I think that that tool as an assessment tool could be evaluated and improved.

I also want to echo Tom's comments about the fact that there was no discussion that I saw of

proactively screening for housing-based exposures. You're really finding those lead sources and removing them regardless of whether exposure has already occurred, you know, getting rid of housing-based exposures at the time of pregnancy or preconception has the potential to not only benefit that pregnant person and the developing baby, but also to proactively set up the home environment to be safe for the baby as they grow and develop and start to crawl around.

And again, not to sound like a broken record, but it's always better to prevent exposure than to react to it. And we really need to be relying less on secondary prevention as our first line measure.

It's worth noting here, also, that as we're calling for additional screening, we need to be making sure that there are resources in place to respond if somebody is found to have an elevated blood lead level or to have lead exposure or have lead risks in their home. And that needs to be called out, I think, as well.

Tom also mentioned this briefly and I just really want to emphasize this point that the goal of increasing access to screening for pregnant

people is appropriate. It's worthwhile. There is no discussion that I saw of the potential unintended consequences. We have heard concerns that with the increase in leveraging fetal personhood bills in some areas of this country, that there could be the potential for having a documented lead exposure during pregnancy to be weaponized against or even criminalized against people who are giving birth. This is happening already around the country in the context of suspected substance abuse. Even when a baby is without harm, new mothers are being charged with what they're calling "chemical endangerment."

So it might be worth CDC just assessing the potential risk here and if there is some, factoring that into guidance for healthcare providers and pregnant patients so that we can increase and remove barriers to access to screening but not have, you know, unintended consequences.

And then finally in section VI here, for Recommendation VI-1, again I echo Tom's comments that I would encourage us not to exclude HUD and housing-based exposures from this call for CDC to collaborate with other federal partners. Even

though parts of the Office of Lead Hazard Control and Healthy Homes are specifically directed to look at children under six, they have significant expertise at the table related to housing-based exposures that can and should be leveraged related to this recommendation.

And the final comment I'll leave you with is in Recommendation IV-6 about the allocation of resources to create a unified blood lead surveillance system. Just noting that some of the recommendations in this report, like this one, may require additional or congressional action or support to really be feasible. And I just note that to say if ever in the future we're sort of using this as, you know, a progress report to say have we taken action, that there may be some additional outside actors that need to be called on here.

Thanks for taking those considerations on board.

DR. KOSNETT: Thank --

MR. AMMON: Thanks, Amanda. Oh, I'm sorry, did you want to respond or should I go to Grace?

DR. KOSNETT: I just wanted to briefly respond.

I appreciate all of those concerns and constructive suggestions. I think one of the things that in particular would be easy to incorporate, Amanda, if you had some of those references to -- to actual cities that have included the RRP rules in the coding, we'd like to point that out and that could be a minor addition just by, you know, adding a footnote or -- or whatever about that.

And in terms of the -- you know, the resources for follow-up and, you know, we -- we've made a lot of recommendations in here regarding resources and in -- of course, in case follow-up, one of the key things for adults that we did is we really felt that it was important that health departments make it available. Just, you know, blood tests for adults to come to without having to pay for it if they -- at no cost because many of the people who are illicitly exposed as adults don't have the resources or -- or may not be insured or may not be documented. And just like we -- a lot of cities go ahead and have programs for TB, for example, testing that's available to everyone even if they don't have insurance or they're not documented, we think a

blood lead test should be available because some of the -- some of the worst cases, for example, of lead exposure during renovation has occurred -- occurs when they -- you know, they take undocumented workers or workers in the informal sector regardless of their documentation.

And -- and so that -- we did address that concern in there and hope that that would be a -- I hope that -- that helps address some -- some of your concerns as well. Thank you.

MS. REDDY: Thank you. I appreciate it. Thank you.

MR. AMMON: All right, thank you both.

Grace, EPA.

MS. ROBIOU-RAMÍREZ: Thank you. Thank you very much. I -- I did have an opportunity to -- to take a look at the report, although I haven't -- because it's not been approved, I haven't shared it with my colleagues at EPA which I will do when final.

I guess I just wanted to ask because I didn't see a reference to the final EPA drinking water lead rule for the lead and copper, what's called the Lead and Copper Rule Improvements.

Specifically the economic analysis that supports that rule has some interesting information that you may want to look at. I -- again, you might have considered it and it wasn't cited directly. And I recognize that that rule was published in late October. So it might have been after the substan -- the writing on your report has been completed.

But if you're interested, I'm -- I'm willing to point you to the -- in the right direction. I know that it's a little overwhelming to find information online at times.

DR. KOSNETT: Sure.

MS. ROBIOU-RAMÍREZ: But what's -- what I think is novel there is the fact this was -- this was something that -- that EPA did that was -- you know, I don't think that we have quantified some of these benefits before, health benefits, in this matter or been able to get through the Office of Management and Budget in this -- in this way. So that's something to look at.

I also want to mention that although -- although not a -- I just want to also -- beyond cardiovascular disease which is what I just was referring to, the work that we did on ADHD to

support the various regulations that have been published this year is something that we are working to see if we can get into the peer review literature.

So that's something that it's kind of pending, but we are -- we want to get it into the literature because -- to -- to this -- to this date it's not. So but from, again, the economic analysis, not the health-based work.

So moving forward, I also just want to signal that I'm very happy this report will be done soon because we are working on some data consolidation tools and we will want to be able to speak to adults, not exclusively children, when we -- when we talk about lifelong health.

So this report will help us do that and buttress the statements that we're making. So thank you for the opportunity to weigh in.

MR. AMMON: Thank you very much, Grace, for those -- for those comments. So did I understand you correctly to say that the EPA lead copper rule contains an economic analysis of the cost benefits of reducing the exposure to adults as part of its ...

MS. ROBIOU-RAMÍREZ: Cardiovascular disease

specifically. And I wasn't sure if you included it --

DR. KOSNETT: No, we --

MS. ROBIOU-RAMÍREZ: -- or not because that --

DR. KOSNETT: That's good to know. And in fact, there's -- that's another easy -- easy fix here that --

MS. ROBIOU-RAMÍREZ: **Okay.**

DR. KOSNETT: -- I just -- if you would send us that reference, there's a report where we talk about that there's been requests -- that request other analyses have suggested that the posit -- the strongly positive cost benefit of -- of reducing adult exposures. I know that EPA has this recent analysis --

MS. ROBIOU-RAMÍREZ: Exactly.

DR. KOSNETT: That's -- I would like to include that as a reference and -- and cite it.

MS. ROBIOU-RAMÍREZ: Okay. I'll follow up with you offline.

DR. KOSNETT: Okay.

MR. AMMON: Thanks, Grace.

Next, Brenna Flannery.

DR. FLANNERY: Yes, I appreciate the

opportunity to -- to comment on this. The report was comprehensive and I learned more than I knew before on adult lead exposure.

But I have a question. I -- I noticed little discussion on lead exposure through food, dietary supplements, cookware. And I was wondering if the workgroup had considered this area for exposure to lead for adults because while it may be relatively low compared to other exposures, all adults consume food and therefore can potentially be exposed to lead from food. And so I was just wondering if the, again, workgroup considered this or considered writing about it --

DR. KOSNETT: Yes.

DR. FLANNERY: -- in the report.

DR. KOSNETT: Thank you. That -- that's a good point. We actually call on -- for collaboration between Recommendation IV- -- excuse me, VI-1 talks about CDC collaborating with the FDA, for example, to increase awareness of sources of validated lead exposure which would include things such as food, or, for example, we make -- we make mention there, I believe, about -- at the bottom of page 28, we say it's

essential to communicate about nonoccupational lead exposure. There are potential sources of lead exposure that should not be overlooked. For example, the use of certain spices and traditional folk remedies from countries outside the United States.

So we have -- we very much agree with your and appreciate your comments and we have -- we do feel that that is something that we -- we call for.

DR. FLANNERY: Thank you.

MR. AMMON: All right, thanks.

Patrick Parsons.

DR. PARSONS: Oh. Hi, Michael. Thank you very much for the report. This is a subject that we've had discussions on, you and I, for many years now. And I just wanted to ask for a bit of clarification on your proposals to have automatic refusals in processing specimens that, you know, don't have, you know, certain fields of data.

I would hope that we wouldn't end up with some unintended consequences where laboratories will not test blood specimens. You know, they'll say it's a specimen rejection criteria if it doesn't have certain information there because

that would, I think, negate the whole, you know, goal of getting these data in. Is that correct? You're not recommending that laboratories reject specimens that lack these data?

DR. KOSNETT: You know, it's -- it's a -- we had a -- we have a nuanced discussion in that, Patrick, in that we say that, you know, when they have lead, for example, the drop-down menus, when you -- when you order a test. Just like you would ask for the patient's name and maybe their phone number, you would have a field in there to -- to indicate their occupation or, you know, their work if it -- or something like that because it's been a real struggle and actually a big resource problem for the ABLES programs in many states to track all that down.

So it's a gentle nudge in that direction, however, if we explicitly state that it is the -- the health provider who orders the test says, I'm aware I should've gotten this, but I can't, it's not available, then that's sufficient for the lab to go ahead.

DR. PARSONS: Okay. So -- okay, so they -- they -- those labs would go ahead and test the specimen.

DR. KOSNETT: Right.

DR. PARSONS: I know that -- you know, there are many situations where there are some missing fields on requisitions, the company specimens, and somebody has to then reconcile that because there are, you know, mandatory fields that you need in order to generate the test report. It's a -- you know, this is, you know, your problem.

Okay. Withholding certification, that's a -- that's a tricky one. I would tell you that in New York State, which is, you know, CLEA exempt, our state agency that, you know, audits labs, surveys them, they actually will look to see that laboratories are in compliance with reporting to what we call our heavy metals registry. And so there is, I think, good coordination between the -- the state accrediting authority and the -- the heavy metals registry that -- that operates in a different part of the department of health. So -- so that's good.

But withholding certification, you know, that's like a -- you know, a penalty of last resort and is -- is only taken in very, very serious situations. What's more likely is a laboratory will receive a citation or a

deficiency that they then have to address with a plan of correction.

So, you know, I -- I think that's a very drastic measure. I understand the goal. And, you know, that -- that's laudible, but, you know, I think withholding certification that -- that's -- you know, that's a sledgehammer to -- you know, to hit a nail.

DR. KOSNETT: Yeah. Okay. I think I agree with you on that. And we could easily say something like a complementary approach. This is -- I'm looking at the sentence on page 13: A complementary approach to increasing compliance with data collection. Maybe for state health department to consider to take -- you know, to consider actions to encourage laboratories to comply with collection requested information. And this could ultimately in severe situations -- or it could ultimately include -- the penalties could ultimately include, you know, withholding certification or partial reimbursement, something like that, saying that that -- that's -- that would be not the only thing you would do, but you would have that option. It certainly will get attention in other words.

DR. PARSONS: Yeah. I understand the intent. It's how -- how you get there.

The last thing is I -- you know, I may have missed it in the report, but you didn't say anything about the OSHA quality specifications for proficiency testing which are different from CLEA and are, I think, still currently plus or minus 6 micrograms per deciliter, plus or minus 15. Correct me if I'm wrong.

DR. KOSNETT: I think -- I think that there's still a plus or minus. Yeah. Now, in the California -- plus or minus 4 remember. In California, for example, in the new standards, they -- they -- which we, you know, endorsed, they do call for tighter requirements for blood lead tests that are done as part of occupational exposure. And it would be implicit that when -- when new OSHA standards were adopted that -- that the testing would -- would have to be tighter.

DR. PARSONS: Right.

DR. KOSNETT: You know, if we're aiming for the big picture here thing, we really need to lower the permissible exposures and lower the blood lead levels. But -- but the -- you know, a key component or a mention in the OSHA standards,

they specifically do mention that certain standard -- to my understanding, I could be wrong, but I -- my understanding was that they say that the labs that -- that conduct blood lead testing have to meet certain performance standards. And it would be our hope in the process of addressing it, it would look like they would do what California did and update those.

DR. PARSONS: Right, okay. Again I applaud your efforts. Great job.

DR. KOSNETT: Thank you.

MR. AMMON: Thank you.

All right, Dr. Montañez.

DR. HUERTA-MONTAÑEZ: Hi. I appreciate the -- sorry, I'll leave my camera off, my connection is weak. But I appreciate the opportunity to comment on this report and I commend the workgroup for this incredible work. I wonder if you considered in your discussions how this best practices will translate into clinical practice.

By that I mean if you thought about collaborations with medical organizations, you know, the academy sector to increase the capacity of clinicians on, you know, culturally sensitive,

patient-centered lead prevention and management, knowing that, you know, clinicians may need to refresh their and update their knowledge on this topic, especially given that lead testing, you know, as you mentioned at the beginning, is something that we think about when we talk about children not -- not adults.

And also if -- if you're thinking about including a list of occupations that are -- are most, you know, commonly related to lead exposure, not everybody knows that, you know, what those occupations are.

DR. KOSNETT: Yes. I -- in terms of talking about outreach to professional organizations, we do actually mention that, for example, on page 20. We talk about -- we include professional associations of healthcare providers should undertake initiatives to educate workers, healthcare providers, and employers regarding aspects of the lead rule of the hazards of lead and that we have a whole section, actually two, at the culturally appropriate considerations. For example, recommendation VI-2, to enhance communicate -- is a recommendation to enhance communication about preventive strategies,

federal agencies should develop or expand partnerships with associations of health care professionals. And -- and we go into that in a -- in a little more detail.

So, yes, we do address that and we really think that that's one of the key needs is that -- there -- there has been this robust scientific evidence that low levels of lead exposure -- when I say low levels, you know, at least 10 micrograms per deciliter over an extended period of time, but possibly even lower -- needs to -- or contributes to an in -- an appreciable increased risk of cardiovascular mortality. And -- and that is not necessarily something that's been either emphasized in existing information on -- on lead, including certain things by CDC and EPA and other documents. Not -- not all.

DR. HUERTA-MONTAÑEZ: Yeah, I saw those, uh-huh.

DR. KOSNETT: Okay. And so we really think that also the healthcare community needs to be advised of that. I mean, this is a -- you know, healthcare, everyone in the healthcare community is careful to recommend to their patients that

they don't -- you know, that they don't smoke, they control their blood pressure, that they, you know, watch their cholesterol. But a risk factor like lead exposure on the job which could also be a significant contributor is not necessarily on their -- on their radar. And -- and so we do address that.

In fact, we cite a position statement by the American Heart Association which recently came out calling attention to that, which I think was very important.

DR. HUERTA-MONTAÑEZ: Yeah. And how about, you know, the health insurance companies covering for services provided by clinicians' services related to lead in adults?

DR. KOSNETT: I think they would do that now if -- you know, if -- you know, if a pers -- if an adult, for example, were to have lead -- elevated lead exposure to the point that they needed some even counseling or intervention, if it wasn't -- if it was work-related, it would be covered by worker's comp. If it wasn't work related, you know, say it was from domestic exposure, that would be covered right now. Insurance companies can't say, We -- We exclude

lead exposure. No. They -- that would be --

DR. HUERTA-MONTAÑEZ: Yeah. I asked because we still struggle with coverage for children in Puerto Rico. So it's -- it's, you know -- especially with follow-up blood lead levels and things like that, that -- the yearly or the -- the recommended well-child care is like a -- paid back as a package and -- and it doesn't matter what you do, it's the same fee. And when you keep adding all the screenings that we do, you know, you have ten minutes to do this incredible amount of things that are not even covered by the insurance.

So I wonder if with adults there's something that you've considered because it's -- it's -- medical care is very limited, you know, prevention --

DR. KOSNETT: Yeah.

DR. HUERTA-MONTAÑEZ: -- due to what's happening with the health insurance companies.

DR. KOSNETT: Well, I -- in my experiences as a clinician, I mean, I agree with you. But in my experience as a clinician, if a person has health insurance and as a provider you're concerned that the patient's anemia, for example,

could be due to lead from either external exposure, maybe from a retained bullet and that would (indiscernible) things, and you order it, the insurance company's not going to be able to say, Well, we don't cover that. No. They would -- they would have to cover it.

I mean, I'm not saying that -- that there aren't companies that -- that might challenge it or might try to, you know -- hopefully that doesn't happen, but there's no cutout to prevent lead testing from being reimbursed or lead -- treatment for lead poisoning to be reimbursed.

DR. HUERTA-MONTAÑEZ: And, finally, I wanted to emphasize what somebody else mentioned at the beginning about putting more emphasis on the responsibility of the employers because it's something that we saw here in the Arecibo case with the, you know, occupational exposure, you know, about a recycling plant.

And those families, I was, you know, helping manage over 50 families with children that were exposed through their parents but the parents were not necessarily being -- you know, their health being addressed. And I -- you know, as a pediatrician, I asked the -- the -- usually the

mother was the one that was answering the questions and -- about her husband's health and they were actually symptomatic but scared of reporting their symptoms because they didn't want to lose their job.

So it's kind of tricky, and I think, you know, the responsibility of employers to protect their employees' health should be, you know, very much emphasized because when you're in this situation, you know, this is their job, this is their income, this is the way they support their family. And it's -- it becomes a really -- an incredible struggle for them to give priority to their health.

DR. KOSNETT: I -- I absolutely agree. And one of the things that we hope will come out of our recommendations -- like Recommendation IV-6, about creating a unified blood lead surveillance system and lead poisoning prevention program -- would combine the efforts of childhood and adult programs, such that, for example, every time a child is found with an elevated lead exposure, they consider the potential occupational -- the potential exposure of the adults in the same family.

And as Dr. Tsai, who was on the call, has written in some of the sections that she wrote is that, you know, lead exposure is often a family issue. It's not limited to -- to the adults or to the children. And we believe and we have mentioned in the report that, you know, adult exposures should always raise -- or should raise a consideration to look for childhood exposures and vice versa. And that's why -- that's one -- that would be one of the benefits of a unified system.

And so we agree with you and we feel that that should be part of the public health response. It shouldn't just be limited to -- this shouldn't be siloed into adults and children necessarily. And there are efficiencies, there are economic efficiencies with combining the programs because the same data management, for example, of collecting and creating the forms and creating the databases that go into creating a childhood lead poisoning -- a childhood registry is shared with the resources necessary -- or the skills necessary to create an adult registry.

So there would be cost savings. And we say in here, for example, unified -- this is at the

bottom of page 22, a unified surveillance system would not only allow for more efficient use of limited resources, but would also enhance the surveillance system's capacity to detect previously unidentified lead exposed cases. And we cite a recent paper by Egan to that effect. And I believe that Dr. Tsai is a co-author on that.

DR. HUERTA-MONTAÑEZ: Thank you.

MR. AMMON: Great discussion by the way. Very helpful back and forth. And I appreciate everybody's comments as we -- as we continue in here. And I hope you guys are taking notes in terms of incorporating these recommendations into the eventual final report.

One of the -- just a general comment. In my -- I mean, there's an amazing amount of information and data in here. It really is a great body of work. One of the things that I'm -- I was thinking as a decision-maker in terms of what are the -- you know, this -- what are the more succinct actions or -- or what are the specific actionable items? And I didn't know if there was any consideration of pulling this into, like, an executive summary that just

specifically lists very, very succinct and specific actions. I know there are a lot of generalized recommendations. And again I'm -- I'm trying to think of, if I'm a decision-maker, making decisions on funding or specific things that need to change within our organization at the federal level, things of that nature. Is there -- is there enough in the recommendation for me to act upon it, you know, in terms of, you know, a specific actionable item?

And I'm just looking at the work we did on the BLRV which was very -- which was a single recommendation to bank on and specific action. So I'm just trying to bridge the gap here. Again, just taking a step back. I mean, the -- the data is amazing. I'm just trying to figure out is there some improvements we can make among the recommendations to be more succinct, that people recognize exactly what they need to do in terms of next steps so that there isn't any ambiguity of what the direction is and what specific things you're asking people to do?

DR. KOSNETT: Well, you know, that -- that's a great comment. And I hope it -- the structure of the report, you know, was built around

recommendations. So rather than, for example, having long discussions and narrative and -- and not necessarily connecting them to recommendations, all the narrative in the report follow -- is -- yeah, follow bold-face recommendations.

So it was our hope, within the amount of time available, for us to go in -- into details. You know, we -- so, for example, we -- we have -- almost all of the recommendations, I think, have a degree of specificity in terms of, you know, in -- in -- like, for example, enhancing recommendations, III-1, about enhancing the efforts of -- of the ABLES program and to, you know -- to require reports, clinical laboratory requests to make a concerted efforts to include occupation in the reports. That -- that's a very recurrent issue among the ABLES programs on -- we make a specific recommendation, III-2, with respect to the ABLES programs, that they have a standardized -- standardized data outlets.

You know, right now, a National ABLES program has an established standardized criteria for, you know, this is the date -- this is the questions you should ask and this is the data you

should collect so that it can be easily coalesced and aggregated across states. That's a specific recommendation that we make in III-2.

You know, III-3 calls for the unification of the adult and childhood programs and that has a certain degree of specificity to it in terms of the best practices.

In section IV, you know, we call for a real need for a revision of the OSHA lead standards. I mean, you know, the biggest source of adult -- well, I shouldn't say the largest prevalence, but the most -- the outlook, the consistent elevations at higher levels of lead exposure, our work in adults, arise from the workplace, according to ABLES data and NIOSH data. And it really needs to be revised.

And, you know, Matt, this will be the first -- this -- if one passed, this report will be the first CDC document that issues a call and acknowledges the need to revise the OSHA lead standards. NIOSH has not explicitly issued that. They talk about a defining blood lead level of five as elevated.

But the fact that this -- you know, your action today, in -- in passing and endorsing this

report, will allow groups like OSHA and EPA and others to point to the -- that CDC -- just like CDC has taken years of effort and action and HUD has taken years of effort and action to reduce childhood lead poisoning, this will be the first report that explicitly from CDC that actually says, you know, occupational exposure is -- is allowed to be -- is too high today.

DR. RUCKART: Michael, I just want to clarify. This will be a PLEA report, a PLEA workgroup report under the LEPAC. It will not be a CDC report. So just a point of clarification.

DR. KOSNETT: I'm sorry, Perri. You're right. You're right. But, I mean, in terms of it being a document that was developed under the rubric of the LEPAC that calls for it, I think it would give support to efforts by other agencies, including yours, to address adult lead exposure, Matt. I would hope it would.

And so I think, you know, granted -- and all these recommendations that have been made, we really appreciate them and a couple of the ones that we talked about today, where it's easy to include a reference or, you know, a document like that, we would do, but I would -- and -- and, you

know, the key ones, including the reference to the codes, like in Rochester, that was dis -- that were discussed earlier by Amanda Reddy, the cost-benefit analysis by EPA that Grace Robiou mentioned, talking about, which is very important to -- to say here about the -- the cost -- this cost savings associated with reducing adult exposure.

And then, finally, you know, making a minor adjustment to the issue of withholding compliance from laboratories as suggested by Dr. Parsons. We're all -- we can all do that as -- as agreed-upon things.

And I would hope that as time is coming up now, that we can turn it to you, Matt, and see if you can put this to a vote to accept and approve the report for submission as a LEPAC product.

MR. AMMON: It's a diplomatic process. I'm only -- I'm only the shepherd. This is a diplomatic process.

But -- but, no, I really appreciate certainly you commenting that -- that there have been a lot of great comments and recommendations that will be incorporated in improving the draft that we have here. Just the exact same thing as

we did on BLRV, the exact same thing.

And I think we have an amazing set of experts here that you've heard from and that you'll continue to hear from and work with. And the fact that -- and you're right. It's -- it really is no small feat to have this body of work which really doesn't exist anywhere else. So I think that's also a really pretty bold statement for not only this group but just -- just your work, everyone's work. I mean, it was, again, a group effort and I -- I really appreciate everyone's work.

So do I have any -- any -- I know we have a minute left before we need to move. Is there any other additional comments -- or recommendations actually? Seeing none, I'm seeking a motion from the body on the report. I'm looking for a LEPAC member to make a motion on the report so we can move forward with an action on it. Do I have a motion --

MS. ROBIOU-RAMÍREZ: Matt, I -- I make a motion to approve the report.

MR. AMMON: Okay. Make a motion to reprove -- approve the draft report. Seeing that motion to approve the draft report, any other

subsequent motions?

Okay. With that, let's take a vote on approving the draft report. So I'm looking for everybody to be on camera. Everyone approve -- who approves the report say aye or show your hand. Perfect. Thank you. Good. I'm going through everybody. It looks like everybody. Any -- very good, got it. Yep.

DR. ALLWOOD: So -- so, Matt, just a -- just want to -- kind of a point of order, I suppose.

MR. AMMON: Yep.

DR. ALLWOOD: It looks like we're -- you know, we have all of our voting members but also our affiliates voting on that motion.

MR. AMMON: Yeah, I know. Yeah.

DR. ALLWOOD: I think you might need to sort (indiscernible). Sorry to be the officious one.

MR. AMMON: No, that's okay. I can see -- I can see. I know it's only LEPAC members. I know. I'm looking at it and they all look like the LEPAC members voted, which is only for LEPAC members, right? I think -- I think we're covered on that. Yeah. Here we go. I see everybody. Just going to wait another second here. All right. I think that comprises votes.

Any dissents? Or abstain? None? So the motion has passed to approve the draft report. So, again, I -- I appreciate everybody's vote. I appreciate the work. As -- as Perri mentioned and as Paul mentioned, the process about moving forward now, we've received -- you all have received a number of recommendations that we expect to be incorporated into the report.

And, again, Perri talked about the process and how it goes from here. Again this is the very first time and again we look forward to seeing the updates as they are included in -- in the report. But appreciate everybody's vote on that.

And with that, we are at a break. So I will see you all back here at 4:00. Thank you, all.

(Recess)

DISCUSSION OF BLOOD LEAD TESTING CHALLENGES AND OPPORTUNITIES POST-COVID

MR. AMMON: Thanks, everybody. Before I hand it over for our next topic -- and I appreciate, Paul, you being on -- thank you, all, for -- for today. I mean, we've done a lot of work. We're coming to our last topic where we're talking about blood lead testing challenges and

opportunities. And, you know, this is really front and center to a lot of the core work that -- that we are doing in terms of continuing the work, a lot of time trying to rebuild the capacity that we lost in COVID. A lot of the funding is going toward this to try to revamp, retool, again make sure there's the right capacity.

And I see definitely a lot of challenges and opportunities in that, and I can talk from the grantee perspective, but, you know, I definitely think leading off the conversation should be from the experts: CDC.

So I'll hand it over to Paul to start off and then we'll all join in.

DR. ALLWOOD: Well, sorry, I was -- was caught by the mute button.

Good afternoon, everybody. I -- I would echo comments by our -- our chairperson. It's been a great meeting so far, and I -- you know, I -- not -- not just the last session but, you know, that -- that last discussion was -- was very illuminating in many ways, and, you know, I just want to take the opportunity now to express, you know, my gratitude to the workgroup for

putting together this draft report and I'm really looking forward to, you know, seeing the -- the updated more final version of that.

And so, like Matt said, we have seen significant impacts from the pandemic on testing. And now that we've gone, you know, a few years since the start of the pandemic, I think it's probably a good time for us to get together as a body and just talk about, you know, what are some of the -- the things that we've observed that -- that are, you know, barriers to -- to testing and what are some best practices that -- that might have evolved as a result of the current situation? What suggestions do each of you have or, you know, your organizations or even in your capacity as perhaps, you know, somebody who's not actively in the profession anymore, but, you know, just any facts that you might be willing to share about how we might address challenges of getting more children tested.

And, you know, by the way, you know, this also brings me back to the presentation we had from our colleagues up in New Hampshire this morning about one of -- one of their -- you know, one of the efforts that -- that they took it

and -- and we saw the results of that.

And then, last but not least, you know, we would also like to engage the committee -- committee members to speak about any specific populations that should be the focus of increased testing.

And so with that intro, I'm going to -- I think perhaps the way that we would do this is perhaps just go to each of our -- our members and ask if you've got anything that you would like to share or -- on any part of that. All the members received these -- these questions, you know, part of the meeting.

So, Perri, if you would help me out, maybe we just, you know, kind of run through our list of members and have each person to share out on these topics as much as you feel comfortable sharing right now.

DR. RUCKART: Sure. So do you want to talk about one question at a time? Or just each person could give their thoughts about all of the points you raised?

DR. ALLWOOD: Yeah. I wasn't quite sure how people would prefer to do this. You know, is there a preference? If anybody wants to opine on

that.

MR. AMMON: I think my guess is that, you know, we provided the four questions. Probably people are going to have, maybe, more emphasis on one versus another or just have something in general about -- to say about -- about all of them. I'd certainly leave it up to the members to decide, and, I mean, I -- I can -- I can share -- as people are thinking, I can launch into HUD's perspective if you want to, at least to start out, if that helps maybe generate some thoughts and things of that nature.

DR. ALLWOOD: Yes. Yes.

MR. AMMON: If that's okay, yeah. So --

DR. ALLWOOD: Yeah, that'd be fine, Matt.

MR. AMMON: Yeah, well, you know, I -- our guidance for testing obviously comes from CDC. That's why, you know, they're -- they're the experts in this field we're in, and we're on the -- obviously on the housing and intervention side. For us, you know, we have always tried to focus on -- on primary prevention.

And, you know, I know there's a lot of criticism for some of our programs that say we're only focusing on lead poisoned children. And,

you know, I think the only way to really get -- addressing the issue and then get ahead of the issue is really focusing on trying to increase the rates of testing.

And we know there's a lot of challenges around -- from our grantees' perspective around, you know, what are the connections that are going to make sense? You know, is it through -- through Medicaid? Is it through private insurers? You know, we do have a number, obviously, of -- of housing stock and assisted housing and public housing. That makes it somewhat easier because it's more of a -- it's more of an inventory that we're aware of and we know of. And it's a little easier for us to -- to manage that.

I think, though, a lot of our data, though, in terms of how we're doing, comes from this testing data. So it does impact, I think, down the road, in terms of when we talk about outcomes and things of that nature. I think a lot of the practices that we have seen which -- which communities have been using is really, really a local approach. And what do I mean? What I mean by that is they're not waiting anymore to have

children be referred to them from doctors or local health clinics. They're -- they're doing what they can do, going door-to-door, you know, in certain neighborhoods. We know where our target areas are.

We know that the -- the areas that we need to serve better. And we've been deploying as much as we can at the -- at the most basic level which is where -- where the folks are that we need to serve. So is it in their individual home? You know, is it certain areas, like -- like school kids? We've done a lot of work around as part of immunizations, including this as part of that.

I think anything that makes it more difficult for parents to then, you know, not do their normal thing because it's a missed -- it's a missed workday. So we try to meet them where they are if you're not aware of this.

And we've done a lot of work -- our grantees have done a lot of work in trying to, again, meet them where they are locally, no matter -- no matter where that is. And I think it's been -- it's been very successful.

But, again, for us this was a real capacity

shift because, you know, for -- during -- during COVID, you know, none of it happened. So there's just been, I think, a revamping of -- of the -- the emphasis on getting out and doing this work because we know that, you know, without it there's a lot of follow-up that won't happen in terms of interventions and things of that nature.

But -- but for us it presents a real opportunity because, you know, we want to be able to combine as much as we can, that single touch of homes where there's families that we talk to. And there's a lot of things that we can talk to them at one point, both in terms of our assistance programs and having the wraparound services related to those that we serve with our assistance program, but also -- and our grantees, as you know, are -- our Lead Hazard Control program is not assisted housing. It's (indiscernible).

But again that -- that's a way for us to kind of meet that other inventory on that other set of -- those other sets of needs for families which are -- which are at risk for not only exposure but then prevents an opportunity for us to do the interventions.

And so, again, I think grantees have been very, very creative locally about how to meet parents, children where they are. And I think that's for us something that has been -- been helpful and we hope to continue to build.

DR. RUCKART: Okay. I'm going to call on the members and give them an opportunity to give their opinions. And I want to go in reverse alphabetical order. And I say that as someone whose maiden name begins with the letter Z.

So I will go through the members in that fashion and then the nonvoting liaison members. So I will start with you, Brian, if -- if there's any points you'd like to raise.

MR. WEAVER: Yeah, sure. I'll -- I'll take this opportunity. So thank you for providing these questions ahead of time for us to reflect on them. I think a lot of blood works and blood lead testing has been mentioned earlier on the call, in the meeting today, but to emphasize a couple of things that I think through my work through Wisconsin's Childhood Lead Poisoning Prevention Program I've learned.

And so I think some unique barriers since the pandemic that perhaps we hadn't faced prior

to that is -- I think maybe one I would just highlight is the increase in accessing information, including public health information, from non-public health and healthcare sources.

I think they are missing our messaging. We are not diversified as far as our outreach as far as using social media to reach specific audiences, particularly young parents of -- you know, new generations of young parents, of millennials, and now Gen Z population. Many are old enough to become -- are having families.

So just I think one of the barriers that we've understood, maybe not just because of the pandemic, but like we've seen in recent kind of -- like the recent election, just the ability to reach certain populations effectively in our messaging. We might be missing some of those key components. So I think that's something that absolutely needs to be studied and looked into further. I don't have anything specific to -- to offer there.

And as far as strategies and best practices, I think, you know, what we have found is that there isn't a specific silver bullet or something you can just do it immediately and you'll have a

dramatic impact. It has taken us to work years and sometimes decades building relationships, primarily -- or one of our key stakeholder groups is Medicaid and working directly with our state Medicaid office. That is something that I think is a best practice if -- if state agencies, state programs are able to work closely with them, they really can have quite an impact as far as reaching a high-need population of children enrolled in Medicaid under the age of six. So I think that's an important one.

And then maybe specific populations that should be focused on for increased testing. The obvious one is, you know, low-income children who are living in older housing, particularly rental properties, I think, continues to be our key audience, those parents and caregivers of those children. I think that's super critical.

And I mentioned in our -- in the Wisconsin update other populations where we see a higher prevalence of lead poisoning, and that is in our children who are in the foster care system. Recent immigrant refugees are coming to -- to Wisconsin. We are seeing a higher rate of -- of lead poisoning in that population, but small

numbers.

But, again, I think it's important to highlight where we see perhaps a greater chance are those children being exposed to lead, making sure we're addressing that.

And then this has been brought up a couple of times, I just want to emphasize it: pregnant adults who are at increased risk for lead exposure. I think that's another key audience that we need to be talking more about.

And I think there's been recommendations throughout this meeting about revi -- looking at the current recommendations that CDC and ACOG and -- and updating those to be something that others could look to in reference and to use.

So thank you.

DR. RUCKART: Okay. All right, thanks.

Next will be Megan Sparks. If there's anything you'd like to add or discuss.

DR. SPARKS: Kind of piggybacking off of what Brian just said, we have found in a sort of post-COVID environment that working very closely with our -- our Medicaid MCOs to kind of building inroads with our families that may have lost some trust with public health through the pandemic. I

know that that's been a huge issue in our -- our region. So testing has understandably declined when people aren't coming to the health department to get any services anymore. That includes testing.

So we've actually been essentially doing grand rounds with the MCO case managers to provide education since they work most closely with their families. And we've seen some movement from families to be more amenable to getting those -- those recommended testing done. But I think trust, lost trust in public health generally has been a problem in a post-COVID, ongoing COVID world.

In addition, like, one of our possibly easiest ways to get kids tested prior to COVID was to jump into their -- their WIC appointments when they're doing hemoglobin and to get a capillary test right there.

When WIC started doing some telehealth visits, we saw a significant decline in not only kids getting their risk assessment for lead exposure done but getting their capillary screening done. So that's -- that's been an issue. And, again, that lost trust has been a

reason why we can't communicate effectively with families anymore.

So we've been outreaching community members and community organizations that have better relationships with their families than we do. I meet with our school nurses. So we're a large county and we have well over a hundred thousand students. And so we have lots of schools all over the place and I meet with our school nurses quarterly.

And they've been one of the best partners in communicating not just lead education but all population health issues relevant to families. They were on it when I reached out to them about the -- the cinnamon contamination in the fall last year. They were the easiest and best ones to disseminate that knowledge and they did it quickly and efficiently. And almost as soon as we sent it to them, we were getting calls from families asking questions.

So I think kind of spreading our knowledge out among partners that we don't traditionally work with -- community groups and organizations -- or even groups that we have worked with previously, finding a partner that

better suits our needs, like working directly with MCO case managers as opposed to some of the administrators that come to the larger Medicaid MCO meetings has been more successful for us.

And I -- I would agree that we need to outreach as far as specific populations. I -- we really need to outreach obstetrics to reach more pregnant persons and increase the testing there. We don't see that hardly at all. And most people that we talk to are astonished that that's -- that's a recommendation that's getting missed.

So I think that's going to be our next frontier once we get through our testing clinic.

DR. ALLWOOD: (indiscernible)

DR. RUCKART: Okay. Okay, thank you.

Moving on to Jeff Sanchez. Anything you'd like to add?

MR. SANCHEZ: Sure. I'd like to kind of share a project we had worked on where we were providing free blood lead testing based on this housing code Patrick (indiscernible) was talking about earlier where we were identifying properties that had been cited for (indiscernible) through the code enforcement program through LA city. And they subsequently

would go and they would partner with the clinic to have them just receive free blood lead testing even though they were part of the clinic and they reimbursed for the LeadCare II tests.

We also provided incentives to the families to remove those barriers to get to that lead test. So -- so what we're essentially trying to do is just remove what we know is common barriers of why kids, the parents don't actually make it to the clinic for testing. And if they were -- we sent them, then the clinic, again, just -- just tested. And they still went through their screening guidelines that the clinic was providing, a couple of clinics were providing.

We were surprised to find that they were still using a lead questionnaire for -- for their screening and still had questions about, you know, do you have lead pipes in your home? and what type of jobs do you -- do you have that might involve lead? They were unaware of what even occupation -- I think we heard this earlier today about what occupations even warrant -- you know, kind of warrant a -- a risk for lead or take-home exposure.

So again we kind of removed the bat as well.

We found that kids that actually had been part of their service, if they were even part of a zip code that we had sent, we asked them to test them anyway so they -- their -- they're existing patients. And we found several kids who actually have -- had blood leads above -- well above five that would not have been tested otherwise. And I think that those (indiscernible) really a great opportunity to realize that.

I had just one other point I was going to make. It was about, you know, let-us-help advocacy about how do we inform families to go in and become advocates for -- for their -- their health and their children's health? And we found that there was either just miscommunication about when they were going in to ask for -- to get their kid tested for lead. There was just no -- not a clear understanding of what they were asking for. So there's some kind of miscommunication around, Oh, maybe they're asking for a test about their -- their diabetes or some other blood lead test or blood tests.

So anyways I guess my point there was just that I think, you know, there's really an opportunity here for us to think about, you know,

what -- what are the actions that are -- exist already of clinics when it comes to, you know, families coming in and asking for a blood lead test, again from that self-advocacy.

And I do know that, you know, obviously we were providing LeadCare II tests. We were able to provide them. But not that necessarily we have to be supplementing a health care center with -- with free testing, but, like I said, to be able to remove that barrier and -- and get an insight was -- was extremely valuable.

The other thing I was going to point out was just the -- I think the pregnant women -- California has had -- made a few attempts to include pregnant women in the Childhood Lead Program. And -- and I (indiscernible), when I think of the recommendations about pregnant women, we realize that we're kind of in two -- two groups here. We have a -- our childhood lead programs that define a -- an individual at risk based on their age and then we have our occupational lead programs that are based on what kind of work they're involved in.

And then there's this middle section of people that are kind of not part of either. And

I think pregnant women is -- is part of that. So I think that might add to why -- some of our struggles with why we don't see enough guidance or -- or, yeah, just legislation around how do we get pregnant women and other individuals that again fall in this middle category that's not tested for lead?

So those are -- those are my thoughts.

DR. RUCKART: Great. Thank you.

I'll go to Grace --

DR. ALLWOOD: Thank you.

DR. RUCKART: I'll go to Grace Robiou next. Anything you'd like to add? Grace?

Okay, we can circle back if -- if she has anything to add. Let's go Mikki Meadows-Oliver.

DR. MEADOWS-OLIVER: Hello. So I think that -- when I was thinking about the -- I'm in Connecticut and we have a law on the books that people are supposed to be screening at one and two. And as we know already, too, there's Medicaid screening -- or children on Medicaid supposed to be screened at one and two. So for many of our children, they're getting screened but what we found is that for people -- or children that go to clinics that serve Medicaid

children, they're being screened at the highest rates and sometimes the kids in our private practices are not being screened as much because they -- they live in more affluent areas. The providers in those areas don't necessarily think that they are at risk. And as I heard someone else mention before, they're doing more screening with questions rather than blood lead testing in a lot of our private practice suburban areas. So I feel like that is a barrier.

Also I think some of the loss of the trust that's been mentioned before, we have seen a lot of vaccine hesitancy. And I think along with that vaccine hesitancy, we've seen just hesitancy around being screened for certain conditions and lead poisoning is one.

It's a condition that, as we all know, doesn't have a lot of outward effects. And so when parents don't see oftentimes that there are physical effects or things that are physically affecting their children, maybe they're thinking it's not much -- as much of a problem so they are not always taking it as seriously, and they might decline or even refuse lead testing.

So we have found that that is a barrier as

well. And unfortunately a lot of these parents -- some of these families might be some of the ones who are living in the oldest housing stock here in Connecticut because we have plenty.

In our larger clinics, some of the things that we found that have been working as far as best practices have been quality improvement projects really. We have lots -- I'm in an area that has lots of colleges, so we have students doing quality improvement projects. And some of the quality improvement projects that they've done have been around scree -- chart reviews to make sure that children who are supposed to be screened for lead are being screened for lead and those who aren't being screened for lead, those providers are being contacted to kind of figure out maybe why they were not being screened. So we found that that has worked to increase our screening levels.

And then lastly, I do believe that someone else mentioned immigrants and refugees. And we have a refugee clinic, as well, as part of our larger hospital clinic. And so all of those children who come to the refugee clinic, if they're less than six years of age, they are

screened for lead poisoning, and we pick up quite a few children there.

And I think that was it for me.

DR. RUCKART: Okay, thank you.

I'll go to Aaron Lopata.

DR. LOPATA: Hi. So, yeah, I think this discussion is really helpful. Again I think -- and this is -- you know, I may have said it earlier, I work obviously in HRSA, the Maternal & Child Health Bureau, but I'm also a pediatrician. I practice part-time. And it does feel like there needs to be -- I mean, I think it's interesting that the idea that not all pediatricians are -- and actually let's say family practice clinics as well, but any providers of these children that there is -- there are some that are not doing screening. They make it look like they don't need to do screening.

And so, one, I think it's important to go to the -- because a lot of kids will -- if they don't go to the health department or if they don't -- aren't a part of a certain program -- you know, a lot of kids obviously do see their pediatricians or parents will take their kids to

the pediatricians for well visits. And so it's really critical when you have that point of -- you know, at that point of care to be able to screen and if needed do the testing. And I wonder if, you know, the combining the -- and I also find it interesting that the rates be better for patients who have Medicaid than with private insurance.

So I think it just kind of stresses the importance of keeping the -- communicating with pediatricians, private practice providers, nurse prac -- pediatric nurse practitioners, physician assistants that -- remind them of the critical -- that it's critical to build -- to screen for lead.

And I'm also wondering as -- you know, we work a lot at MCHB with AAP. We also work a lot with ACOG. And so I think, you know -- I think there's a tendency for us to think of lead -- lead poisoning as a child -- childhood issue and we're not always thinking of it as -- as what I thought was helpful to have, especially adult testing as well, but the idea of testing during pregnancy is something that we could also bring up and stress, talk about it with ACOG and try to

improve communication there as well.

And I'm also wondering, having the ability to work with, like, EPA and HUD on mapping and, you know, being able to have an understanding of where are the hotspots? where are there -- is there evidence of high prevalence? And that can be due to just old buildings, old architecture, use of lead paint. And if you know that and then communicate that to a pediatric or family practice offices in those neighborhoods, then they might do testing automatically since they're in a high prevalence area.

And -- and then the last thing again is making sure that any -- I guess especially in high prevalence areas that federal programs, whether, you know, it's a Head Start, Early Head Start, Home Visiting -- Home Visiting Program, Healthy Start Program where they are working closely with families in this age range, from their early childhood, that they are -- especially if they're aware that they're a high prevalence area that they're making sure to ask these questions when they talk to them about have you gotten tested? is your pediatrician testing? and kind of just making sure that there's good

communication there. And then just taking advantage of every point, whether there's a (indiscernible) between a public health provider or a pediatrician or a private practitioner and making sure at all points that informa -- those questions are being asked.

And again I think mapping would really help that too. Not only having mapping but they have to share with pediatric offices and federal program staff. Thanks.

DR. RUCKART: Okay, thank you.

I'll go to Gredia Huerta-Montañez.

DR. HUERTA-MONTAÑEZ: Hi. Thank you for these questions. And many of the things that -- that we wanted to share were somehow mentioned. But something that we've done in Puerto Rico is, as I mentioned, we had a -- an ECHO on lead prevention and management. But then we continued developing CME activities for pediatricians and other clinicians caring for children to make sure that they -- they refresh their skills and knowledge related to lead.

We also -- something that I -- I think it's really important is outreaching pediatric residents. So -- so we've done that. But -- but

also going even, you know, earlier, we created these elective rotation for medical students interested in pediatrics. Pediatric environmental health with much emphasis on lead prevention and, you know -- and increasing their knowledge about lead among other important environmental health topics.

So outreaching medical students, outreaching pediatric residents, and then physicians in practice and then also nurses. And, of course, providing them with incentives as, for example, CME credits. It's really key.

Of course, while, you know, reimbursement for primary care preventive service in pediatrics continue being this slow with all the things that we want and must do on these well-childcare visits definitely is a barrier for prevention, including secondary prevention of lead which is what pediatricians can do in terms of testing.

And then -- so this is something that should always be on the radar in terms of how can we address those barriers related to reimbursement for pediatric services because there's -- in Puerto Rico, nationally, there is a -- you know, a shortage of pediatricians. That is to worsen

definitely within the next five years in Puerto Rico. 60 percent of our pediatricians are about the age of 60. So they're going to be retiring within the next five years. So that's a huge problem.

And then also the -- low-risk perception about lead among parents definitely was mentioned and that's -- that's something that we need to continue addressing.

So -- and also the physician's perception that they cannot really do anything about lead, so why testing? is something that we've seen. So educating them about the resources available on the little things that can be recommended that can have a huge impact is really important. So our surveillance system in Puerto Rico has emphasized the role of the clinician and supported the role of the clinician in -- in this process. For example, they conduct a very comprehensive environmental interview to these parents and provide the education, knowing that the clinician doesn't have in ten minutes to go over all the -- just going over lead is going to take ten minutes of the well-childcare visit. So -- so that's something that -- that has really

worked for us.

And we're using social media a lot. It's not only once. We're doing in our Puerto Rico AAP chapter website, you know, our Facebook, we -- you know, we post messages related to lead prevention. We sent via What's App to our clinicians that are part of the group text messages re -- and messages related to, you know, testing, why they should test. Very specific messages, short. And we cre -- we created a video that we promote among them. So if they don't have time to educate about lead, just share this QR code with your parents, ask them to scan them with their smart phone, and ask them to watch it so they can understand why lead testing is important. And sources of lead and everything that they should know about lead, it -- it's in that animated video. That video was posted on the Department of Health website as well.

So those little things can -- we're hoping that are going to continue having an impact. We do have very close collaborations with WIC, Head Start, Early Head Start. And we do have an advisory committee that has, you know, EPA, HUD, AAP, and PEHSU.

So the role of PEHSU has been key, and I believe that every state should, you know, emphasize on those collaborations with -- with PEHSU and supporting PEHSU.

So -- but, yeah. So social media, outreach, and trainees collaborations that we continue building and strengthening and, again, trying to see how we can better support clinicians in their role of -- of preventing lead among their -- their communities. Thank you.

MR. AMMON: Okay, great, thanks.

Kristina Hatlelid, anything you'd like to add?

DR. HATLELID: Thanks, Perri. I really appreciate this discussion. I don't have anything more to add. So I will -- I will cede to -- to the other members. Thank you.

DR. RUCKART: Okay, thank you.

Mary Beth Hance, anything you'd like to share?

MS. HANCE: Thanks very much. The only -- I will just lean a little bit on some of the things that we've already heard and really appreciate hearing coordination between Medicaid and public health programs.

One thing that I would lean in on there, which I didn't hear as much about, is data sharing because that is also important to -- you know, to know if -- you know, kind of how much -- how successful you are in reaching children and if there are specific geographic areas where children aren't being reached.

So really encourage you all to think about data sharing in lots of different directions but definitely between public health and Medicaid.

So thank you very much.

DR. RUCKART: Okay, thank you.

Rebecca Fry. Rebecca, are you on?

Okay, we can circle back if she wants to participate.

Brenna Flannery.

DR. FLANNERY: Hi there. Yeah, so in FDA foods, we test for lead in food and not necessarily in people. And so for these questions, I don't have an answer necessarily from my agency. But just based on experience and reading, I have some suggestions.

So suggestions for addressing challenges, one thing that I have heard today is -- is really communicating through -- through schools and how

effective that can be. And so I wonder if there's a way to partner with the Department of Education to spread more awareness on lead exposures and the need to get tested in children specifically through -- through schools.

And I also I just thought that the idea that Megan Sparks had talked about in Kansas, how people can get -- how the children can get their blood lead tested when they have their back-to-school immunizations. I wonder about some sort of mobile blood lead testing center. For example, the dentist has a mobile center that comes to my daughter's school and she gets her teeth cleaned at school currently. Could we have something like that through the health departments or through some sort -- or through the states to target specific schools even based on the risks or people who typically don't have their -- their children tested to be able to have the kids tested at school?

I had also wondered about partnering. I mean, we had talked a lot about Medicaid and Medicare, but I also wonder about part -- partnering with private insurance to incentivize the lead testing in children. I know the

insurance company I belong to will pay me a gift card if I do preventative care on myself, like cholesterol testing and blood pressure and weight, et cetera every year. Could private insurance incentivize doing blood lead testing in children for -- for people? That may be one way to increase testing.

And then when I think about specific populations to focus on for increased testing, much of what I had come up -- had already come up with has been talked about. But I -- I did read in Pediatrics in October that in a population of -- of children who already have increased blood lead lead -- blood lead, you know, based on the CDC reference values, so they were above -- above that value, the follow-up testing rate was only 66 percent. And so I think that we already know that those children have elevated blood lead levels. I think that that's an opportunity to -- to increase testing would be to work with that population, specifically if their -- if some sort of case management of those with elevated blood lead levels.

I also know that insurance companies for -- for -- again for people who have private

insurance, I'm aware of this, do have certain programs where they will follow up if a child has extensive medical needs and they'll provide case management. Could we look to, you know, Medicaid or private insurance companies to provide this type of follow up when a blood lead level is elevated?

And then finally I am going to second, third, and fourth what everybody else has been saying about testing -- increase testing in pregnant(inaudible). That is where the exposure to children begins, in utero, and so I just want to -- to second that as well.

So those were my ideas and I appreciate the opportunity to -- to comment.

DR. RUCKART: Great, thank you.

Gary Edwards.

MR. EDWARDS: Sure. Boy, it -- it's been great -- it's been great listening to all the comments and -- and I don't have a lot to add, but I -- I hear the common thread. Needs to be better communication, better information sharing. I'm sort of surprised, I guess, being a layman, but I -- I always -- I think of my doctors as always being, you know, knowing almost

everything, right? Well, I'm hearing, well, a lot of them aren't being trained on lead or should be trained more. And that's -- that's fine.

So I loved all the comments. And sounds to me like, again, the common thread is communication and sharing. I am very interested in the part about pregnant -- pregnant (inaudible) needing to get reached -- reached too. That's a -- sort of a primary source. I -- I love this -- I love this conversation. Appreciate it. Thank you.

DR. RUCKART: Okay.

Tammy Barnhill-Proctor.

MS. BARNHILL-PROCTOR: Hi. I just have a few things to add. As, you know, many of you know, I'm from the Department of Education. And I supervise the work of early learning which focuses on children from birth through age eight. And we do partner with the Department of Health and Human Services, their administration for children and families, as someone mentioned earlier, with the home visiting and Head Start and the childcare program. But what I would like to just encourage for -- for the -- for the group

to continue to use the department as a -- for messaging. We don't have -- as a department, we don't have the overall authority to push to states and local districts to -- to actually go in and do lead screening. But through messaging and through some of the grant programs that we put out, I think we could -- we could expand the knowledge and encourage those school administrators and families to focus in on some of the challenges that young children face when it comes down to blood level, testing of blood levels in young children because we all know the impact of those around learning.

But I also would just encourage EPA and CDC when you're out there -- and someone spoke earlier -- and you're identifying hotspots that you could potentially pay the department for us to send a message to some of our grant -- our grant programs and our state and local agencies to just bring the awareness that, you know, there are hotspots for lead exposure.

And so just thinking about -- as I sat here today thinking about all of the -- we have a couple of community -- full-service community schools programs and promise neighborhoods where

we could get the message and continue to push the message of the importance of lead testing for young children. And today sitting here, hearing about the lead in adults was a good eye-opener for me. And so continuing to share those specific messages that you would like to see us push out to our grantees and some of our state and local agencies.

And so that's what I have for today.

DR. RUCKART: Okay, thank you.

I'm going to circle back to Grace Robiou. Are you on? Is there anything you'd like to add?

Okay, what about Rebecca Fry?

Jeff, if you don't mind, I'm going to go to the liaison members and then circle back to anyone who's already had a chance to speak.

So let's start with Lauren Zajac.

DR. ZAJAC: Hi. This has been a great discussion. I don't have much to add to what's already been said. So many great points and ideas.

I guess the only thing I wanted to highlight is -- I -- I know I'm looking forward to the implementation of potential new point-of-care devices that Paul Allwood mentioned earlier as a

result of the Lead Detect Prize. Because really anything that could be done to decrease barriers to point-of-care testing, especially making the machines and tests available and affordable for, you know, smaller pediatric practices, I'm just really excited to see where those winners of the prize take the next steps.

And that's all.

DR. RUCKART: Okay, thanks.

Stephanie Yendell, anything you'd like to add?

DR.YENDALL: Yeah. Just I will start out by echoing some comments that were made by others. You know, a comment that Brian made that collaborating with Medicaid really should be sort of a -- a default position in the standard and then the importance of specifically doing data sharing with Medicaid agencies is incredibly helpful in identifying kids that are enrolled in Medicaid but not otherwise tested or states that are able to collaborate with programs, like their vital records, to identify kids that are missing from their blood lead database.

Another piece that -- that was mentioned is that certainly it's really helpful for --

especially for getting kids back in for that follow-up testing is when there is a clinical outcome that we can point to the health care providers. So in the State of Minnesota we have started doing the in-home lead risk assessment with a -- a full environmental testing at 5 micrograms per deciliter. I know a number of other states are doing that as well.

And when healthcare providers know that their patients are going to be receiving a service if they get that follow-up venous test done, then they are much more likely to -- to do that because it does not have a real outcome and a benefit to their patients.

Something else I wanted to mention is, you know, we sort of alluded to it before and had a little bit of a discussion around the pros and cons of doing the capillary testing through a higher complexity laboratory. That is something that in our current state, where the point-of-care devices have been unreliable and they've been subject to multiple recalls and there are some trust issues with those point-of-care devices that are currently on the market, having the option for healthcare

providers to do capillary testing at the higher complexity laboratories has been really valuable for us to be able to continue that continuity of offering capillary testing and not having that be only a choice between point-of-care testing and venous testing.

A challenge that we are facing is that we have seen CDC issue cuts of about 10 percent across the board to CLPPP funding. This certainly makes it challenging for us to be able to take on any new quality improvement projects or look at ways to really do what we're doing better when we're facing cuts in funding at the same time that we're seeing massive increases in our staff and costs.

And then when we're looking at audiences, two audiences that I haven't heard anyone mention yet, one is kids who might be older than the -- the age one or two where we typically see kids being exposed to lead from housing but that have pica. And so kids that have pre-existing developmental delays that come along with pica behavior may continue to be exposed to lead in their environment much longer than the -- the ages one and two where we think of having a -- a

peak in lead exposure and kids that don't have that behavior.

The other group that we haven't specifically talked about is that we see a lot of kids who are older, again, than the typical one and two years old who have familial ties to South Asian countries. Unfortunately a lot of these kids are eating spices that were hand carried from a South Asian country and they're -- so they're having either exposure in the U.S. or they're traveling and they're visiting family members. So especially in the Indian-Bangladesh is where in -- in my state where we've -- we've seen that, that they have that larger -- those lead exposures even though they're, again, older than the -- the typical age one and age two. You know, from those dietary exposures.

So this is something that I really want to kind of hold up the work that New York City has championed of trying to put together registries so that we can talk much more comprehensively across the country about these instances where we are seeing spices in products that were -- you know, even if they were imported for personal use by a family from another country, they're not

subject to FDA regulations.

But I would really like to see, even in areas that we might not have a U.S. agency that has authority, we can certainly have influence and put pressure on other countries to make their food supply safer as well and then pairing that with making sure that we're getting those kids tested if they are in the United States, that we can identify those sources of lead exposure to be able to -- to trace back when there -- when there are food sources from another country.

Thank you.

DR. RUCKART: Okay, great, thanks.

Amanda Reddy, are you on?

MS. REDDY: Yep, I'm here. I want to amplify and agree with so much of what has been said about messaging and testing pregnant (inaudible) and mobilizing point-of-care to meet people where they are about the, you know, lack of adequate funding to support the -- the states and others. So just respond to all of that.

I did want to say a little bit more about a few things I haven't heard as much about. You know, somebody mentioned the loss of trust in government and I think that's certainly true

across the board. You know, specifically around this -- this lead issue.

I want to also raise up that it's not helping, but there's a lack of access to data around lead here. I think there's a -- a growing lack of trust in the data when we see disparities, gaps closing in some of the national data and that's not the experience of communities and what they're seeing in their neighborhoods.

And then also just the lack of access to data when we have, you know, CDC data that's currently three years old. Until just a little bit ago, it was -- it was five years old. And in many states that's the case too. Where there's not access to data at a fine enough geographic level, it's often many, many years old. It -- it becomes less meaningful and I think there's a lost opportunity to mobilize community partners who could be real allies in getting more kids tested and -- and more people tested in general.

So I would urge CDC to work on that data transparency and access. Issue and leverage not only your own internal resources for the data that CDC puts out, but hold your grantees accountable.

But to Stephanie's point, also that means they need funding, right?

Stephanie, your point is not lost on me that that lack of capacity to put out timely data is going to be exacerbated by the funding cuts that states are experiencing. But I think it's important.

A few promising approaches that I haven't heard mentioned or want to mention again, we heard earlier today -- I think I mentioned about the role of requiring lead testing as part of school documentation. We've had some interns do some analysis here of CDC data in places with and without school documentation, showing that that actually does appear to drive increased -- significant increases in testing rates and so really exploring opportunities to encourage that strategy in places where the regulatory environment is favorable to that.

We've also seen some communities piggybacking on efforts of lead service line replacement. So, for example, Wausau, Wisconsin is one that I can call out, where they, as part of their outreach that they're doing to recruit homes and -- and rural homes in lead service line

replacement efforts, they're getting people connected to other lead services including finding out if there are children in the home or we visit the home and whether or not they've been tested for lead. So I think there's some significant opportunities there. And they're not the only ones who have shown that kind of partnership.

I also just want to raise up, too, that I hope that we continue to encourage states and -- and localities across the country not to just guess at why testing is -- is lagging in a lot of places but to actually engage in communities meaningfully and really listening deeply so that we can actually design solutions that are targeting the real problems.

We've seen some communities start in the healthy housing field to use what's called the human-centered design or a user-centered design approach to engage a community around issues like this. And it can really unlock innovative solutions that we never would've thought of with all of the reading and all of the smart -- all of the brain trust that we have in the room today and all of our years of experience. So I'd

really encourages us to also just continue asking and not -- not just assuming we know.

Thank you.

DR. RUCKART: Okay, great.

Let's see. Patrick Parsons.

DR. PARSONS: Yeah. I just have a few comments to add from a laboratory perspective. Just thinking about those questions about, you know, the barriers to getting children tested and, you know, addressing those challenges and increasing rates of testing.

Once you get that child tested, to get that blood specimen collected, it goes to the lab. And despite all of the great technology to measure lead at even lower levels, the quality of that result is only as good as the quality of the specimen that's collected.

And if we're talking about capillary blood specimens, then we've got some very, you know, unique challenges in making sure that that blood sample is a high quality so that we don't end up with false positives and wasted time trying to follow up on things that -- that should have been -- you know, that shouldn't have happened in the first place.

So I really appreciate Stephanie's comment about leveraging capillary blood testing with high-complexity labs because that is a viable option. And so, you know, how do we ensure that we get the best quality specimen? Much of the research that was done on the -- you know, you know, the, you know, prevalence of false positive results was conducted in the 1990s when the level of concern as it was then was lowered to ten.

And I don't think we have very good data on, you know, what the level of false positives are at 3.5. And so I think that, you know, there should be some focus on in-house training of collecting viable capillary blood specimens and -- and maybe some research to look at the -- you know, the problem of false positives. And it's going to be a problem regardless of whether you're sending it to a high-complexity level or you're using point-of-care testing device.

So we often forget about, you know, the quality of that specimen. If it's contaminated, there's not a whole lot that I can do about it. They're going to report a biased result.

But thank you to Stephanie for, you know,

mentioning the -- the option of using capillary blood lead testing with high-complexity labs. And that's it for me. Thanks.

DR. RUCKART: Okay. Ruth Ann Norton. Ruth Ann, are you trying to speak?

Okay, I'll go to Abe Kulungara.

MR. KULUNGARA: Hi. Yeah, so, you know, at the outset I did mention, you know, work with CDC and MCHH to help support different jurisdictions, both, you know, I mean, state jurisdictions and territorial jurisdictions, specifically health agencies. So I'm going to summarize what we've been hearing from -- from these agencies.

So in terms of attributing it to a specific agency, but we've heard things like the need to publish the dashboards, including testing numbers by -- at the county level, again not available in some states; increasing testing through outreach efforts whether it's Head Start, WIC, or local public health. And for the states that have tribal communities, the need to engage tribal communities. And some -- some state health agencies have robust tribal liaison offices, so working with those offices to have better outreach with tribal communities.

Then finally partnership with refugee health is something, you know, folks would also talk about.

So that's it from ASTHO's end.

DR. RUCKART: Okay, great.

Is there anybody else who would like to add anything? We have just a few minutes.

Yes, Jeff.

MR. SANCHEZ: Perri, thanks.

Yeah, actually just realized that I didn't mention a couple things. One is in thinking about the last bullet question about what communities to -- that we could focus on. I think -- what I was going to say about historically with schools, I think because the (a) the population has been a little bit older. I think that as nationally we have moved to a lot of school districts having pre-K programs, I think really kind of being able to focus -- if we wanted to prioritize working with -- with schools especially public schools that -- I think that pre-K -- those that have moved to -- to incorporate pre-K, I think is a really great opportunity to -- to restart those conversations.

And then last is -- because I mentioned it

earlier is maybe -- again our housing departments are citing for -- for, you know, potentially disturbing lead-based paint as part of a repair. That could be done through data sharing and referrals to get those kids tested for lead.

So I -- I again want to reiterate the importance. I think it's another community -- another group population that I think we could prioritize as working with our housing departments where -- where they are citing through complaint-based or proactive code enforcement.

That's it.

DR. RUCKART: Okay. Well, we are right at time. So I will turn it back to Matt.

WRAP UP AND DISCUSS TOPICS FOR NEXT MEETING

MR. AMMON: Thank you, all, very much for really great conversation. And, you know, as I wrap-up, I -- I think I failed to say to the new team members -- and I apologize for that, so welcome new LEPAC members. It's a family, and we appreciate conversations we've had today.

And just to -- kind of thinking, kind of go back over what we talked about, you know, first, we started out with really just a great

presentation from the New Hampshire crew. And really that serves as a model for the rest of the country. And it's -- we're always looking for really good ways to raise up something that works locally and raising that up and trying to move that forward to be a catalyst for change in other communities in terms of -- of models of practice. So appreciate the info from Gail and Nicole.

And then we heard from Tom Neltner who talked about a couple things. One, he talked about lead in water. He also talked about the Lead Exposure Risk Index. He did mention about the adult exposure -- lead exposure and the PLEA recommendations. He also mentioned universal testing. Couple other things, but also mentioned about the MOU with HUD, CDC, and EPA.

And then we heard a lot from the LEPAC members on really an incredible list of things which we've all done or are working or looking forward to work on in the next months, the next fiscal year -- or this current fiscal year. And it really does show the -- the broad expansion of all of our collective work in that we are working on. And really again, I mean, it just highlights the fact that we all may be working in different

disciplines, but we all have the same common outcomes.

And so -- so with that, it's good for us to talk and understand and listen to what other sectors are working on and doing and appreciate the great work that is being done around the country.

And then, of course, we heard from the PLEA workgroup where we heard and talked a lot and offered recommendations into the draft report and then voted on to approve the draft report. And so that'll move forward.

And then this discussion which was, you know, really eye-opening. I think that when I was thinking of the -- the discussion earlier on and thinking how this would -- would cascade into it, I think there's just a lot for us to talk about and learn from and really challenge ourselves in terms of what we need to continue to do to -- to continue this work.

And we heard, I mean, so many recommendations I stopped writing. I mean, obviously, we had talked about communication and info-sharing and outreach that's tailored, you know, to a more specific population which I think

we all need to understand and learn from, you know, focusing on still looking to test Medicaid and little children.

Building trust was a big theme coming out of COVID. So that was a really big theme. Collaboration with WIC is important, extending out our partnerships and maybe modeling new partnerships that we haven't thought of before which is really to extend this work, which is always helpful to think outside the box. Outreach to doctors, I think, is always in this, building code work which is -- which is something which is pretty unique.

I think there are certain areas which have really good housing code and housing court which can be an important avenue into not only doing work but also promoting testing and education through schools which, you know, I had mentioned early on when I started, about -- about meeting parents where they are. And when we go out into communities in doing our work with HUD, we have these build projects. We always do testing of kids and always around, again, childhood immunizations in schools.

And it's kind of funny how we -- we were --

we're partnering with an organization to do it and then we get like a backpack, but they didn't know what -- how to get the backpack. Like, they didn't know what they would have to do to get the backpack. Blood lead testing. So it's kind of funny. Funny for -- not funny for the kids, the kids were screaming, but it was another way you kind of integrate kind of existing infrastructure and including this work as part of that.

And, you know, about mobile testing. Somebody had mentioned that. And years ago, years and years ago, probably almost 30 years ago now, I was in charge of doing all the enforcement for HUD, lead enforcement. And as part of our settlement agreements with -- with property owners, these large multifamily owners, was helping fund some of the screening and outreach. So we had -- we had kind of collected this monies together and for a city, Minneapolis, they purchased a -- a mobile blood screening lab. It's called Leady Eddy. If you've ever seen the van, that -- that came from our enforcement efforts.

But again that's meeting people where they are, and I think that's kind of an important

theme really is -- is how do we continue to be flexible in what were doing on a regular basis? and how we continue to meet the needs that exist in the population still around exposure to lead and being able to stay on top of it, both in terms of being able to provide testing and then the appropriate follow up of the clinical management side and then again partnering with organizations that have our funding to them to complete the cycle, if you will, in terms of housing intervention.

So I really appreciate the -- a lot of the communication and the talk and the engagement that you all presented today. I look forward to the next meeting. I think internally we'll kind of talk about next topics of -- of what we will talk about, but I appreciate everyone's time today and discussion today.

And I do want to make sure if I didn't miss anything. Perri or Paul, did I miss anything before officially closing out the meeting?

DR. ALLWOOD: No, Matt. I think you covered all. I was just coming on to say -- you know, just also say a quick thank you to all of the members, you know, and -- and the others who

participated in this meeting. You know, this is a -- this is a success because of all of your efforts. And as Matt said, I really appreciate the -- the good ideas. You know, people are very generous in sharing their thoughts and their experiences and, you know, all of that is going to be, you know, taken into -- into full consideration as we decide, you know, how and where we might be able to incorporate some of those ideas as far as the CDC's program is concerned.

So thanks again, everybody, and we look forward to seeing all of you again at our next meeting.

MR. AMMON: And with that, I will close it out. Thank you, all, very much. This concludes this LEPAC meeting for December of 2024. Thank you, all, very much. Take care.

(Adjourned at 5:09 p.m.)

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