

Interagency Lead Program Issues Study 2004

October 7, 2004 Meeting Notes
MDH Snelling Office Park, Red River Room 1-4 PM

Aggie Leitheiser, MDH, chaired the meeting. Many issues and themes were discussed throughout the meeting, reflecting the interdependent nature of the topics. Rather than present a summary of the discussion chronologically, specific issues and recommendations will be grouped into the 5 topic areas.

Topic #1: Primary Prevention.

Creation of a lead housing registry was discussed. Barriers would include costs of operating the system, possible liability of the agency running the registry, getting complete, timely, and accurate data, access to the list for high-risk/low literacy populations (who would likely benefit from it the most), and maintenance (e.g. a property that is "lead safe" today may not be in 4 years). There are models available from other states to help and local experts available (e.g. Project 504). Possible unintended consequences may be having the registry viewed as a "black list", penalizing property owners who have maintained lead-safe housing all along (if only properties with lead work are listed), and promotion of legal action by targeting properties.

The discussion also emphasized the need to increase education and awareness of the general public on lead hazards, including getting lead in home inspections (done for real estate transactions), being added to first-time home-buyer classes, and being added to trade school training classes/certifications. The overall goal is to get lead-safe work practices incorporated into daily routines for contractors, home buyers, local public health, inspectors, and others offering direct services to the public. Contractor education could be expanded, via Dept. of Commerce and other licensing bureaus, to include more lead hazard reduction awareness. There was a suggestion to license painters and remodelers as "lead safe".

Topic #2: Screening At-risk Children.

There was a recommendation for MDH to re-convene the Case Management Guideline workgroup to examine current timelines for response and screening, the role of capillary tests, and the incorporation of new research and data on test reliability. The motivation behind screening was also discussed. Some organizations view the blood test as an opportunity to educate families on lead exposure and as leverage to get permission to perform an assessment of the home for lead and other environmental health risks. Other organizations view the test as an individual medical procedure requiring strict attention to quality control and reliability.

Ongoing efforts towards physician education have had mixed results. While screening and lead awareness continues to increase, individual practitioners are still encountered who resist screening/testing for lead. Most successful efforts have focused on administrative points (e.g. providing CME and CEU credits; targeted to clinic directors) and finances (either directly to training participants or via +/- incentives such as \$30 and 5% withhold from health plans). Use of professional organizations (MMA, U of MN Medical School) was encouraged.

Topic #3: Lower Environmental Intervention Level from 20 ug/dL to 10 ug/dL.

There was general consensus that lowering the level to 10 would be most consistent with current public health research, but the associated costs with that change cannot be supported by current budgets and would seriously disrupt current efforts towards primary prevention. It would ironically be likely to reduce the number of kids receiving services between 10 and 20 by imposing inefficient regulatory costs. There was a proposal to reduce the intervention level to 15 ug/dL. Although participants seemed to agree with this, there was no formal adoption of it as a group recommendation.

Topics #4 and #5: Incentives and Funding.

There was mention made of a past task force (several years ago, Rep. Clark and several others present were involved) that addressed rental housing lead issues. Incentives were to be offered in collaboration with insurance providers. The bill did not pass.

Use of the State “Petro Fund” to support lead efforts was discussed. Given the lead in urban soils resulting from gasoline, there may be a connection between the fund and lead reduction. However, the fund has strictly targeted uses and efforts to use it for other purposes over the years have not been successful. Use of the Community Reinvestment Act, “This Old House” proposals, and establishing a revolving lead fund were also mentioned.

To help quantify resources needed to address lead caseload and to address whether the intervention level should be lowered to 15 ug/dL, per-case cost estimates were discussed. It was estimated that there are currently about 311 children under 6 years old statewide with blood lead levels >15. With increased testing and outreach, it was assumed that this value would increase to 500 kids annually. Initial efforts for estimating an average annual cost for dealing with a “typical” mandated lead case yielded the values under “current costs per case” during the meeting:

	Current costs per case	Amended costs per case
Education and Outreach	?	\$500
Environmental Case Management	\$500	\$1200
Medical Case Management	\$500	\$1000
Risk Assessment	\$400	\$500
Lead Hazard Control	\$5000	\$7500
Relocation/Medical costs	\$150	\$150
Clearance	\$200	\$200
Surveillance	\$150	\$750
Monitoring/Evaluation	\$200	\$200
Total	\$7100/case	\$12,000/case

500 cases x \$7100/case = \$3,550,000

500 cases x \$12,000/case = \$6,000,000

Assumptions for values generated at the meeting: Education and outreach and cost of housing registry not quantified. Environmental Case Management (CM) includes inspectors and compliance equipment. Medical CM only includes about 3 home visits/calls, healthcare costs. Risk Assessment and Clearance based on current market rate. LHC averages in a range of \$1000 to \$10,000 per house. Relocation and medical costs lumped together. Surveillance estimate/guess (upon later review) significantly low.

The Amended annual costs per case (second column of costs) include the following assumptions, shown as FTE's:

Education and Outreach - 4 staff (1 Minneapolis, 1 St. Paul, 2 statewide) at \$60,000 each (salary plus fringe) plus \$10,000 printing/copying/misc. = \$250,000/500 cases = \$500/case;

Env. Case Mgmt - 8 staff (3 Minneapolis, 2 St. Paul, 1 Duluth, 2 statewide) at \$75,000 each = \$600,000/500 = \$1200/case.

Medical Case Mgmt - 4 nursing staff (1 Minneapolis, 1 St. Paul, 1 MVNA, 1 MDH) at \$100,000 each plus \$2000 each for 50 local public health agencies = \$500,000/500 = \$1000/case.

Risk Assessment increased \$100 based on costs from other locations.

Lead Haz Control increased to \$7500 based on input from HUD grants.

Surveillance includes 2 database professionals, 3 data entry, and software support costs = \$375,000/500 = \$750/case.

Note: These values were generated after the meeting by MDH staff with input from others.

There was a proposal to survey participants to help reduce uncertainty in some of these estimates. The group acknowledged the need to generate cost estimates, but struggled with gaining consensus on values, given the individual complexity of lead cases. In addition, there needs to be a way to incorporate lead infrastructure and leveraging costs. For example, Maternal and Child Health programs, WIC, and C&TC efforts clearly are related to lead poisoning prevention (and in some cases, required), but will require some financial and administrative support to incorporate lead into daily protocols.

Issues/Tasks Remaining for Nov. 18 Meeting.

- ✓ Rank the Topic Area Priorities action items from Sept 2 meeting to establish focus areas for future efforts (e.g. State 2010 Elimination Plan).
- ✓ Complete discussion of funding needs, including better characterization of per-case costs. MDH will generate estimates of funding sources for other states.
- ✓ Gather alternatives for funding sources
- ✓ Formalize consensus on Topic #3: lowering intervention level from 20 to 10 ug/dL. Consensus appears to be to lower it to 15 ug/dL, and retain venous test as standard.
- ✓ Formalize consensus on any other program or policy statements that the group wants specifically stated in the legislative report