GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

AERIS Conference Room
October 3, 2013

Approved Minutes (11-7-13)

Members in Attendance

Patrick Connor, Karen Stakem Hornig, Pat McLaine, Barbara Moore, Linda Roberts, and Mary Snyder-Vogel (via phone).

Members not in Attendance

Cheryl Hall, Melbourne Jenkins, Ed Landon, and Delegate Nathaniel Oaks.

Guests in Attendance

Dr. Clifford Mitchell – DHMH, Shaketta Denson – CECLP, Hosanna Asfaw-Means – BCHD, Tonii Chavis – UMSON, Tina Wiegand – DHMH, Kelly Sage – DHMH, Caroline Grossman – Mirenolx, LLC, Laura Fox, BCHD, Ken Strong, Baltimore City Housing Department, Megan Ulrich – MDE, Michael Ichonowski – MD/AAP, Horacio Tablada – MDE, Ezatollah Keyvan – MDE, John O'Brien – MDE staff, John Krupinsky – MDE staff, Paula Montgomery – MDE Staff, and Tracy Smith – MDE staff.

Introductions

Pat McLaine started the meeting at 9:33 a.m. with introductions.

Future Meeting Dates

The next Lead Commission meeting is scheduled for Thursday, November 7, 2013 at MDE in the AERIS conference room. The Commission will meet from 9:30 a.m. - 11:30 a.m.

Approval of Minutes

Approval of minutes was deferred because too few Commissioners were in attendance.

Discussion

Dr. Keyvan presented the annual Childhood Blood Lead Surveillance in Maryland Annual Report for 2012. The Childhood Lead Registry (CLR) began in 1984 and includes computerized data from 1992 forward. Nearly 11,700 reports are received per month and blood lead level (BLL) test results are maintained on over 1.2 million children. Quality checks are performed monthly and semi-annually. The CLR receives a monthly list of establishments using the Lead Care point of care equipment. The DHMH list of approved laboratories is assessed on an annual basis to ensure that reports are being received. Reports are sent daily to the counties, weekly to the City, quarterly to CDC and Medicaid. A semi-annual match is done with the Maryland Refugees Program. Annual reports are prepared for the CLR, CDC and Medicaid. Information is also provided to counties and interested parties by request or when by subpoena.

Casual reports of elevated blood lead levels are occasionally reported by health care providers.
Dr. Keyvan estimates that 99+% of BLL tests are reported. For case management, daily reports of elevated blood lead levels are provided to counties. The CLR staff persons coordinate with nurse case managers, health care providers and refer for environmental inspections/investigations. If needed, support services, including legal, are identified.

Labs are followed up with daily tracking of blood lead reports. MDE also maintains an adult heavy metal laboratory reporting system, with regular reports made to CDC and NIOSH.

Subpoenas, once very few in number, are now a very large part of the routine daily work – sometimes the work of one full time person is needed. MDE has seen both an increase in the number of subpoenas and an increase in the extent of information requested. MDE processed more than 3,710 subpoenas in 2012. Processing used to take two (2) minutes but now takes seven (7) minutes on average to complete.

MDE continues to use Stellar, which is good for case management, with built in checks for duplications and quality control and a wide range of reports. However, Stellar is slow, only allows editing of one record at a time, uses Clarion software, and requires lengthy processing of CLR data before data can be imported into Stellar. Stellar is not able to provide analytical analyses. Although migration to the new CDC HHLPSS system has been planned for several years, HHLPSS is still not in place, the process to migrate data has been terminated and the CLR is now looking for other options.

In 2012, 88.7% of the reports were from 7 labs, all reporting electronically. One more lab accounted for another 2% of data, also electronically reported. Hard copies are received for about 10% of reports, from 32 labs, most by fax and some by mail. In addition, labs report any BLL of 10+µg/dL by fax, although the law says labs must report at 15µg/dL and higher.

An average of 22% of Maryland children under 6 years of age are being tested, with 0.3% of children having a BLL of 10µg/dL or higher. One third of addresses queried had no age of housing; the highest percentage of children with BLLs 5-9µg/dL lived in pre-1950 housing.

The number of children with BLLs 10+ and 5-9µg/dL went down in 2012 compared to 2011.

Dr. Keyvan looked at the history of 255 children with a first BLL identified equal to or higher than 10µg/dL in 2012. Of the 255 children, 148 had no previous test. Among 107 with a prior test, 28 had a 5-9µg/dL and 79 had BLLs <4µg/dL. Dr. Keyvan reported on the Lead Care I (Medically complex) and Lead Care II (CLIA-waived) machines. The number of establishments using this technology increased from 12 in 2010 to 16 in 2012. The number of tests per year (percent of all reported tests) rose from 4832 (3.6%) in 2010 to 6660 (5.0%) in 2012. Both types of equipment require manual processing; a reporting form developed by Lead Care does not match the report format used by MDE. Very few BLLs of 10+ have been reported.

MDE was asked how the CDC funding cuts had impacted the registry work. Horacio Tablada reported that MDE is using special fees and registration money to offset these losses. MDE will be developing its own software and hopes to have an RFP out in 2013. Patrick Connor noted that housing addresses were bad if 1/3 of queries did not match property on the tax assessor's data base. The refugee health blood lead assessment was not done this year; Dr. Clifford Mitchell indicated he would follow up. Amy Resnick asked why 75% of at-risk children were not screened. What about children living on the border of two states? Pat McLaine asked about screening reports for Medicaid recipients; she would like to see a report with matched data included in the Annual Report. Dr. Keyvan indicated that he was not as comfortable with the matched Medicaid data because he was not involved in the matching.

Dr. Clifford Mitchell indicated that DHMH is working to roll out the Affordable Care Act. He suggested that MDE should engage internally with DHMH on a regular basis to do the match. The Point of Care Taskforce might be

able to look at the question of screening. The "value based purchasing measure" is different from NCQA's HEDIS measure. Does DHMH align with HEDIS?

Carolyn Grossman indicated that Wisconsin had a very strong program with matching and a working relationship with Medicaid. Wisconsin set up a program to improve testing of one and two year olds (required) through WIC and improved by ten percent.

Ken Strong asked to what extent health insurance covers the initial and subsequent blood lead tests.
Barbara Moore indicated that she has not heard about any problems with BLL testing. Ken Strong indicated that some families will not get their children tested because it is "too soon" or they have no insurance coverage.
Pat McLaine noted that without state infrastructure for testing, we no longer have capacity to provide such testing.
John Krupinsky indicated that Tamarak had offered to charge $10 for filter paper testing if family was uninsured.
Carolyn Grossman indicated that Connecticut had passed legislation setting reimbursement rate for all blood lead tests.

Pat McLaine suggested that more information on outcomes associated with case management as well as factors associated with cases was needed as a part of the Annual Report.

Patrick Connor stated that laboratory quality control was a problem, citing many problems on use of proper tubes by laboratories as had been previously discussed with Paul Celli. Clifford Mitchell suggested that this would be an opportunity to engage with all labs about the proper testing equipment. John Krupinsky indicated that Quest had reported that the problem was due to use of lavender top tubes for heavy metals testing. No one knows how many of the tests reported to the CLR were done in lavender top tubes. Patrick Connor asked if DHMH supplied tubes in Maryland. Tina Wiegand indicated that DHMH did once supply tubes when the DHMH lab analyzed blood lead specimens. A limited number of manufacturers make tubes for blood lead analyses. Tina Wiegand noted that the DHMH lab had done many checks on lavender type tubes and never found increased lead from these tubes, although some capillary tubes had a very little. John Krupinsky noted that if the lab intended to conduct multiple tests on one tube of blood, that was a problem. If the lead test is done first, it would probably be OK. Otherwise, the tube could be contaminated. Tina Wiegand indicated that DHMH had done that, noting that it is possible to contaminate a sample any time you open a device (tube), although venous tube is better.

John Krupinsky noted other problems: two labs failing to report capillary or venous on the results and false positive result (capillary, reported as venous) that led to chelation. Dr. Keyvan asked what could be done with labs to encourage them to handle samples properly? Regulation or enforcement? Dr. Clifford Mitchell indicated that the approach by DHMH would probably be communication not regulation. This could be done as part of communication with the labs doing blood lead testing.

Other points from the review:
* Children in pre-1950 housing more likely to have elevated blood lead levels
*2012 saw another drop in the number of children with BLLs of 10µg/dL and higher
* CDC's Reference Value has been 5µg/dL since March 2012

The next part of the meeting included discussion with the members of the Point of Care Testing Task Force who were present for this day's meeting. Dr. Clifford Mitchell indicated that the Task Force is interested in hearing about challenges and opportunities; ideas about with whom the Task Force should talk; and whether the Commission wants to take a position or vote on the Task Force Recommendations.

Patrick Connor asked how reliable the Point of Care testing equipment was, since the level of detection (LOD) was 3.3µg/dL. Is there a QC program for these instruments?

Tina Wiegand indicated that Wisconsin has a proficiency testing program specifically for users of point of care testing equipment and that Maryland users must participate.

Barbara Moore asked if the manufacturers have correlated results across the spectrum of results.
Dr. Clifford Mitchell indicated that Wisconsin has done this and that the data looks good. Carolyn Grossman noted that this is considered a screening device and the user must confirm any result of 10µg/dL and above with a venous test analyzed at a regular laboratory. The CDC Working Group recommends proficiency testing. Wisconsin offers two proficiency testing programs: one for CLIA approved equipment (5 samples, 3 times a year) and one specifically for point of care screening devices (3 samples, two times per year), the latter recommended by the CDC Working Group.

Dr. Clifford Mitchell asked if there was an opportunity or advantage of widespread point of care testing. Laura Fox indicated that providers had noted problems when a lab was not co-located with a pediatric practice and families did not go elsewhere to get their child tested. Tonii Chavis noted that for Baltimore Medical System, reimbursement for tests is also an issue. If they have to send families elsewhere for a venous, this is a problem. Costs can be high – a cartridge to do A1-C tests (also CLIA waived) is $6,000. Patrick Connor asked if the challenge was the blood draw or being able to analyze on site. Tonii Chavis indicated that she felt it would be better if information was available, noting that all sites do not have a phlebotomist. Barbara Moore indicated that many sites have personnel who are cross-trained. Primary care providers may not have all services available for all times.

Carolyn Grossman noted that Maryland does not recognize the CLIA waiver, meaning that providers must be licensed as a lab and must perform daily QC. Maryland is among a small group of state requiring this level of oversight (others include NJ, Massachusetts and Pennsylvania). The biggest improvement that would be expected is the increase in screening. Wisconsin has screened in WIC clinics and Head Starts with good results. Physician's offices have been among the biggest buyers. Filter paper testing improves the testing rates, but a large number of individuals do not return to get their results and so are lost to follow-up.

Reporting to MDE is required but is a manual process and may be time consuming for staff. There may be some potential for developing some compatibility for electronic reporting in the future, but it does not exist now.

Pat McLaine noted that WIC testing has long been an interest of the Commission. Barbara Moore asked about the CLIA waiver: if a hospital has a waiver, can a clinic associated with that hospital be covered by the hospital's waiver?

Barbara Moore noted that as a new process, education for providers is needed and this is a fantastic opportunity to provide education about the importance of screening. However, if the LOD is 3.3 and all BLLS of 5 and over need to be re-tested, how much will we gain?

Carolyn Grossman indicated that CDC uses the system a lot and has identified lower LODs. This may be something the manufacturers may be able to address in the future.

Patrick Connor asked about costs: Carolyn Grossman indicated that upfront cost was $2400 or less depending on how many testing kits were bundled in with the purchase. Reimbursement is an issue, particularly where EPSDT lab costs are bundled and based on a state contract rather than being billed separately. New York State requires Medicaid Health Plans to reimburse $15 for each test. In Wisconsin, providers are reimbursed $32 for the fingerstick, analysis and counseling for results. This was very useful for WIC when the markets changed and the Medicaid payment was able to help fund continuation of the program. Next month, the Task Force will speak with three states about their programs - Texas, Wisconsin, and Massachusetts. Clifford Mitchell invited Commissioners who were interested to join the next Task Force meeting by phone.

Pat McLaine thanked everyone for their input. The Commission will review recommendations made by the Task Force at a future meeting.

Announcements: Lead Poisoning Prevention Week: Laura Fox announced that BCHD was organizing lead testing on October 25 at Park West and also at the SE Anchor Library. Shaketa Denson indicated that the Coalition would be involved with the testing effort at Park West, at Story time in Wicomico County, at Mondawmin Mall and possibly at an event in Hagerstown.

Ken Strong passed out an update report on the Baltimore HUD project.

Minutes will be reviewed at the next meeting in November.

At 11:45 a.m. Patrick Connor moved to adjourn, seconded by Barbara Moore, all in favor - the meeting was adjourned.