

**Childhood Lead Poisoning Prevention Program (CLPPP)**  
**Focus Group Meeting**  
**November 4, 2015**

**PURPOSE**

The purpose of this meeting was to bring together a specific group of local partners (CLPPP case managers) to assist IDPH in developing a 5-year plan for better aligning current CLPPP services with available resources (i.e., funding and staff) and improving data management and reporting requirements.

**WORKGROUPS**

Focus group participants included IDPH staff from the Lead Program, Maternal Child Health, Environmental Health, and local CLPPP case managers. Focus group participants took part in large group and small breakout group discussions about CLPPP case management activities and services they provide under the lead program grant. Three workgroup teams were formed to address program areas related to data, clinical case management, and environmental case management.

Each workgroup team was tasked with reviewing specific program related activities or processes (focus areas) and discussing changes needed to improve or better align with current program needs. A table of the workgroup teams, assignments and focus areas is attached.

**5-Year WORKPLAN (2016-2020)**

A five year workplan (attached) was developed from workgroup team discussions. The workplan lays out priority areas for further discussion, target dates, and responsibilities.

**SUMMARY OF WORKGROUP TEAM DISCUSSION POINTS**

**DATA Group:** Priorities – accurate data in HHLPSS and HHLPSS report features that provide the data needed by LPH and IDPH users for their programs. Development of short-term work-arounds as needed until report functionality is improved in HHLPSS by the CDC.

**Priority 1:** Accurate data

**Potential Solutions**

- Change permissions so locals can make edits to incorrect data (every field)
  - Would need to add language to data management piece in contract.
  - IDPH to brainstorm positives and negatives to this approach.
    - i. Free up time for IDPH staff
    - ii. Who would have access to the data (physicians, school nurses)?

- iii. Potential for local staff to make mistakes or delete a file that we really need. IDPH to set guidelines for what is allowable.
- Research to see why information is not reported correctly into Rhapsody.
  - IDPH to work with IM to see how we can get information about which reporting mechanisms are kicked back. Are there certain labs and clinics that we need to educate? Is it a data entry issue (clinic, medical provider, lab), a data processing issue (submitting site formatting, IDPH interim processing, Rhapsody processing), a data mapping issue (IM, HHLPSS), or a database limitation (HHLPSS)?
  - Information from labs/clinics/medical providers needs to be reported correctly and timely.
    - Talk with AAG (Heather Adams) on legal mechanism to enforce that labs send in testing as stated in rule. Does IDPH need to educate labs on the law? Set up requirements for a lab to be able to test. DNR does this for wells. Should we also write into rule that the analyzing lab sends in results (reducing multiple test results) as well as date that is needed for HHLPSS?
  - Lead Program to work with local, regional and national labs.
  - Locals to assist IDPH personnel in working with clinics that might be problematic (consistently don't report addresses, or have inconsistent reporting of BLLs) in their jurisdiction. (Comment: this may be an option, but only in conjunction with IDPH personnel).

**Priority 2:** HHLPSS report features that provide the data needed by LPH and IDPH users for their programs. This would include flexibility to query data for user-generated reports from HHLPSS and the development of short-term work-arounds as needed until report functionality is improved in HHLPSS by the CDC.

### Potential Solutions

- Improved communication from IDPH on reporting needs to make sure it is clear and gets to everyone.
  - Address issues regarding only using the IowaGrants.gov contract portal to communicate updates and instructions. IDPH may need to also send out information through email (ListServe) to reach HHLPSS users.
  - Short-term: Find out the data elements most needed by LPH programs. Run a report periodically (monthly?) and send to them as an Excel spreadsheet for use in mail merges, data reporting, monitoring cases, etc. This would be a data extraction, not a summary report.
  - Provide step-by-step instructions (maybe post on IDPH web page) regarding how to use the report functions currently provided (such as running as a CSV, then converting to Excel for more functionality).
- Sample contact and follow-up letters are not helpful in HHLPSS.

- IDPH to develop sample letters for LPH.
- Develop a CDC wish list of HHLPS updates, improvements, and fixes for future versions of system, especially for reporting functions.
  - For example: Want to be able to have the program automatically open a case for capillary blood lead levels  $\geq 10$  micrograms per deciliter. Currently system only opens cases for confirmed venous levels  $\geq 10$  micrograms per deciliter. Additional case management activities occur for children at capillary blood lead levels  $\geq 10$  micrograms per deciliter that currently cannot be tracked in case details in HHLPS.
  - Ask the CDC to add more query capabilities in HHLPS to allow users to run more useful reports (specify data elements/functions desired).
- Develop a better system of tracking identified problems with HHLPS to ensure that the issues have been reported to IDPH IM and to track the resolution (or status) of the issue.
- Provide instructions on how LPH may be able to use the tracking portal to get information for grants also (e.g. by county can get lead data).
  - Better data analysis to identify numbers, patterns, what is feasible?

**ENVIRONMENT Group:** Priorities – align 10-14  $\mu\text{g}/\text{dL}$  blood lead range with CDC recommendations, owner occupied clearance times, and prevention.

**Priority 1:** Aligning 10-14  $\mu\text{g}/\text{dL}$  blood lead range group with CDC recommendations (future look).

#### Potential Solutions

- Check and validate CDC language.
  - IDPH to possibly develop message to provide to partners about new levels and process.
- Need to do a costs analysis for how many children are in this group.
- Toolkit for families that provides free materials – ideas and tips for removing lead risks (in home, nutrition, etc.).
- Redefine a process. Recommend a visual inspection for this group instead a full EBL investigation.
- Promote the use of the checklists in the current IDPH brochure as a tool for parents to use for identifying potential hazards and fixes in their homes.
  - Would need to develop a checklist – what is required under code?
  - Can this be billed under contract?

IDPH will review current CDC standards to determine if they are in line with current lead program requirements. Locals would like better guidance from IDPH on this issues so that CDC, IDPH, and locals are all providing the same information to the public and medical providers.

## **Priority 2: Owner occupant clearance times**

### Potential Solutions

- Define the process.
  - When to close long-term properties? Who should do inspection?
  - May need clarification from AAG regarding potential conflict with Chapter 68 requirements.
- ID organizations that could donate materials to homeowners.
- Use other funding programs (e.g. CDBG, lead hazard control).
- Locals develop toolkit of best practices/success stories to share with each other and homeowner.
- Provide free training to homeowner.
- Identify alternatives (e.g. not using front porch) that are more cost effective.

## **Priority 3: More primary prevention on home (not EBLL dependent).**

### Potential Solutions

- Work with schools and daycares to educate them on requirements.
- Train and empower in-house services to develop materials for a toolkit.
- Place enforcement of RRP on locals (check with rules and AAG), and communication back on enforcement activities.
- Communicate on enforcement activities.

Promote the use of the checklists in the current IDPH brochure as a tool for parents to use for identifying potential hazards and fixes in their homes.

**CLINICAL group:** Priorities – Guidance from IDPH on closing out cases, nutritional referrals, and follow up; HHL PSS alerts and notifications; better communication between IDPH, local CLPPPs, and medical providers.

### **A. Priority 1: IDPH Guidance**

- A. Closing out cases in HHL PSS when there is a change in jurisdiction.
  - Provide additional training on managing cases in HHL PSS.
  - Need updated HHL PSS manual/SOP
- B. Nutritional Referral – Can it be done through other means instead of a licensed dietician that is costly and hard to find?
- C. Follow up – how to keep track of family to make sure they follow-up, give that to the medical care provider to take care of?

**Priority 2:** HHLPSS Notifications – lack of understanding how system works in sending out alerts, issues with timely reporting of blood lead results.

- Additional training on functionality of the system and how it works.

**Priority 3:** Open Communication - two way between LPH CLPPPS and IDPH

- Physician knowledge of current recommendations, communications at state level
- Let IDPH know when you see out of date documents, website links, etc.
- Contract language to improve, modify (ex: requirement vs recommendation or guidance)
  - IDPH will revisit the contract, we will identify minimum (baseline) for the program.
  - If there are other things locals want to do above minimum program requirements, we encourage that, but may not provide funding for it.
- Care coordination – better relationships with healthcare providers and locals.
- Lead Poisoning Brochure overhaul – tailor brochure to give to families, healthcare providers specific information. Current brochure is comprehensive and provides information for many audiences. Create message specific flyers or information pieces that can be distributed to a narrow audience.

## Childhood Lead Poisoning Prevention Program

Workgroup Team Assignments 11/4/2015

Process	Team	
<b>Blood lead data and reporting (HHLPS)</b>	Andrea Bentzinger, Emily Scheafer, Carolyn Schaefer, Lorna Bimm, Janet Lemmermann, Kathy Leinenkugel	<p><b>Start:</b> Test is reported by a lab  <b>End:</b> An accurate record of blood lead test in HHLPS</p> <p><b>Focus areas:</b>            Blood lead test data            Electronic reporting (getting data into HHLPS)            Ensuring quality/accuracy of data            Level of access (ability to make edits)</p> <p>What reports do you need to do the steps?</p>
<b>Environmental case management</b>	Paul Watson, Jennifer Sheda, Ann Olson, Mary Rose Corrigan, Rossany Brugger, Stu Schmitz	<p><b>Start:</b> Child has an EBLL  <b>End:</b> Property passes clearance testing</p> <p><b>Focus areas:</b>            Property and lead contaminants            Housing requirements (ordinances/laws)            Initial and clearance inspections            Follow-up until cleared</p> <p>Do we need to revisit what an EBLL is?            What reports do you need to do the steps?            What are some limitations and potential solutions?</p>
<b>Clinical case management</b>	Kevin Officer, Michelle Clausen Rosendahl, Mike Prideaux, Sue Drake, Analisa Pearson	<p><b>Start:</b> BL test result in HHLPS  <b>End:</b> Case is closed (meets case closure criteria)</p> <p><b>Focus areas:</b>            Timely testing and retesting            Notification of BLLs            Home visitations            Nutrition</p> <p>When do we need to send letters and by whom?            What reports do you need to do the steps?            What are some limitations and potential solutions?</p>