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Report

Progress in Achieving Universal Blood Lead Screening in Designated High Risk Areas of Childhood Lead Poisoning

**Prepared in Response to the Maine State Legislature
Resolve 2007
Chapter 186**

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Executive Summary

The 123rd Maine Legislature enacted, Public Law Chapter 186, “A Resolve To Achieve Universal Blood Lead Level Screening in Maine Children.” The Resolve directed the Department of Health and Human Services, Maine Center for Disease Control and Prevention (ME-CDC) to report to the Joint Standing Committee for Health and Human Services on the following:

- 1) Identification of high-risk areas for childhood lead poisoning in Maine;
- 2) Progress made in achieving universal blood lead screening in designated high-risk areas; and
- 3) Lessons learned in attempting to achieve universal blood lead testing and recommendations.

This is the second such report, the first report was delivered in 2009. The major findings presented in this report are:

- Statewide, we continue to see an annual decline in the number of children newly identified with elevated blood lead levels.
- The communities of Bangor, Biddeford-Saco, Lewiston-Auburn, Portland-Westbrook, and Sanford remain the identified high-risk areas for childhood lead poisoning.
- Several new initiatives to increase blood lead screening statewide, as well as targeted programs within the five high risk areas. were launched in late 2009. These initiatives include a targeted mailing to all Maine families with children age one and two years, contracts to the five high risk areas to support local programs to promote blood lead screening along with primary prevention activities, and evaluation of new technology that would allow for near real-time analysis of blood lead levels, either at clinics or in the office of local health care providers.
- There has yet to be sufficient time to evaluate whether these new initiatives are working. The most recent available data on screening rates is for the calendar year of 2009.
- Current surveillance data indicate that most children living in the five high risk areas receive at least one blood lead test by age 3 (62% to 77% , depending on the community), but few children receive blood lead tests both at age 1 and age 2, as required by law for children receiving MaineCare.
- A change in state law will be required to allow new technology to be use by health care providers for in-office blood lead testing. Current law requires that all blood lead testing be performed by the State Health and Environmental Testing Laboratory (22 MRSA §1319-A).

Introduction

Maine's goal of eradicating childhood lead poisoning by the year 2010 was not met (22 MRSA §1314-A). Yet, much progress has been made. In 1997, more than 400 children were newly identified as having an elevated blood lead level (by convention, defined as 10 micrograms lead per deciliter of blood or higher, or 10 µg/dL). In 2009, just over 100 Maine children were identified.

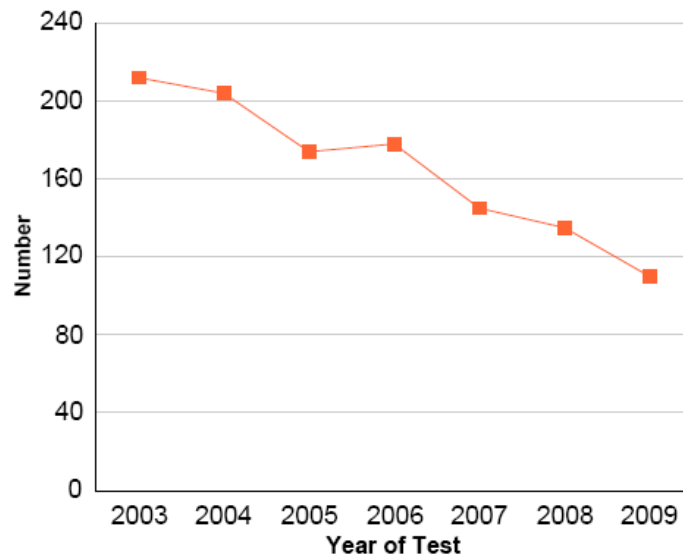


FIGURE 1. Number of newly identified children under 6 years of age with an elevated blood lead level, by year for the period 2003- 2009.

There is no safe amount of lead exposure for children. Changes in cognitive function related to even low-level lead exposure have been shown to affect school performance, educational attainment, IQ scores. In particular, the association between lead exposure and IQ and future income earnings is well established in the scientific literature.¹ A 2010 study estimated that at current levels of lead exposure, each new cohort of babies annually born in Maine will suffer on average a one-point loss in IQ score. As a result they can expect to earn as an aggregate, \$270 million less over their lifetimes.²

The 123rd Maine Legislature enacted, Public Law Chapter 186, “A Resolve To Achieve Universal Blood Lead Level Screening in Maine Children.” The Resolve directed the Department of Health and Human Services, Maine Center for Disease Control and Prevention (ME-CDC) to report to the Joint Standing Committee Health and Human Services on the following:

¹ Landrigan, Phillip J., Clyde B. Schechter, Jeffrey M. Lipton, Marianne C. Fahs and Joel Schwartz. 2002. “Environmental Pollutants and Disease in American Children: Estimates of Morbidity, Mortality, and Costs for Lead Poisoning, Asthma, Cancer, and Developmental Disabilities.” *Environmental Health Perspectives* 110(7): 721–728. <http://www.ehponline.org/members/2002/110p721-728landrigan/landrigan-full.html>

² Davis, Mary E. 2010. “Economic Assessment of Children's Health and the Environment in Maine.” *Maine Policy Review* 19(1): 34-45. http://mcspolicycenter.umaine.edu/files/pdf_mpr/V19N1_DavisFIN.pdf

- 1) Identification of areas of the State of high-risk for childhood lead poisoning;
- 2) Progress made in achieving universal blood lead screening in designated high-risk areas; and
- 3) Lessons learned in attempting to achieve universal blood lead testing and recommendations.

The first report was delivered in January, 2009. This document presents the second report.

Identification of High-Density Areas of Childhood Lead Poisoning

The ME-CDC's Environmental Occupational Health Program (EOHP)³ completed a major two-year effort to compile, perform data quality checks, and geocode childhood blood lead surveillance data for the years 2003 through 2007. These data were analyzed and mapped to identify areas of the state that have "high-counts" of cases of newly identified children with an elevated blood lead level. Counts of children with elevated blood lead level (i.e., a confirmed blood lead level equal to or above 10 micrograms lead per deciliter blood, or 10 ug/dL) for the years 2003 - 2007 were mapped to the town level (see Figure 1). This mapping identified five (5) areas of the state that collectively represented forty percent (40%) of all identified cases of children with an elevated blood lead level (eBLL). These five areas are: Bangor, Biddeford-Saco, Lewiston/Auburn, Portland/co, Portland/Westbrook, and Sanford. ME-CDC further determined that roughly eighty percent (80%) of these cases of children with an eBLL were living in rental housing.

Higher counts of children with eBLLs are to be expected for towns with higher populations. To determine whether the five communities represent areas of "high risk" for children with eBLLs, we have computed a measure of the rate of lead poisoning, specifically, the percent of children with an eBLL relative to the total number of children screened for blood lead. Using this "rate" measure, we determined that the rates for these five communities are significantly above the statewide rate.

Table 1 below shows the percent of screened children newly identified children with an eBLL for the years 2003-2007 for each of the five high density areas as compared to the statewide average percent. Each high density area was determined to have a higher percent of children with an eBLL than the state average, and in some cases with rates twice the state average (e.g., 2.9 versus 1.3 percent).

³ The Environmental and Occupational Health Program (EOHP) is a program within the Maine Center for Disease Control and Prevention (ME-CDC) Division of Environmental Health. The EOHP includes the four program areas: the Maine Childhood Lead Poisoning Prevention Program, the Environmental Public Health Tracking Program, the Occupational Disease Reporting System Program, and the Environmental Toxicology Program. These four programs are grouped into a single administrative unit to promote efficient use and sharing of resources in recognition of their overlapping missions. See 22 MRSA c. 252, c. 259-A, c. 271.

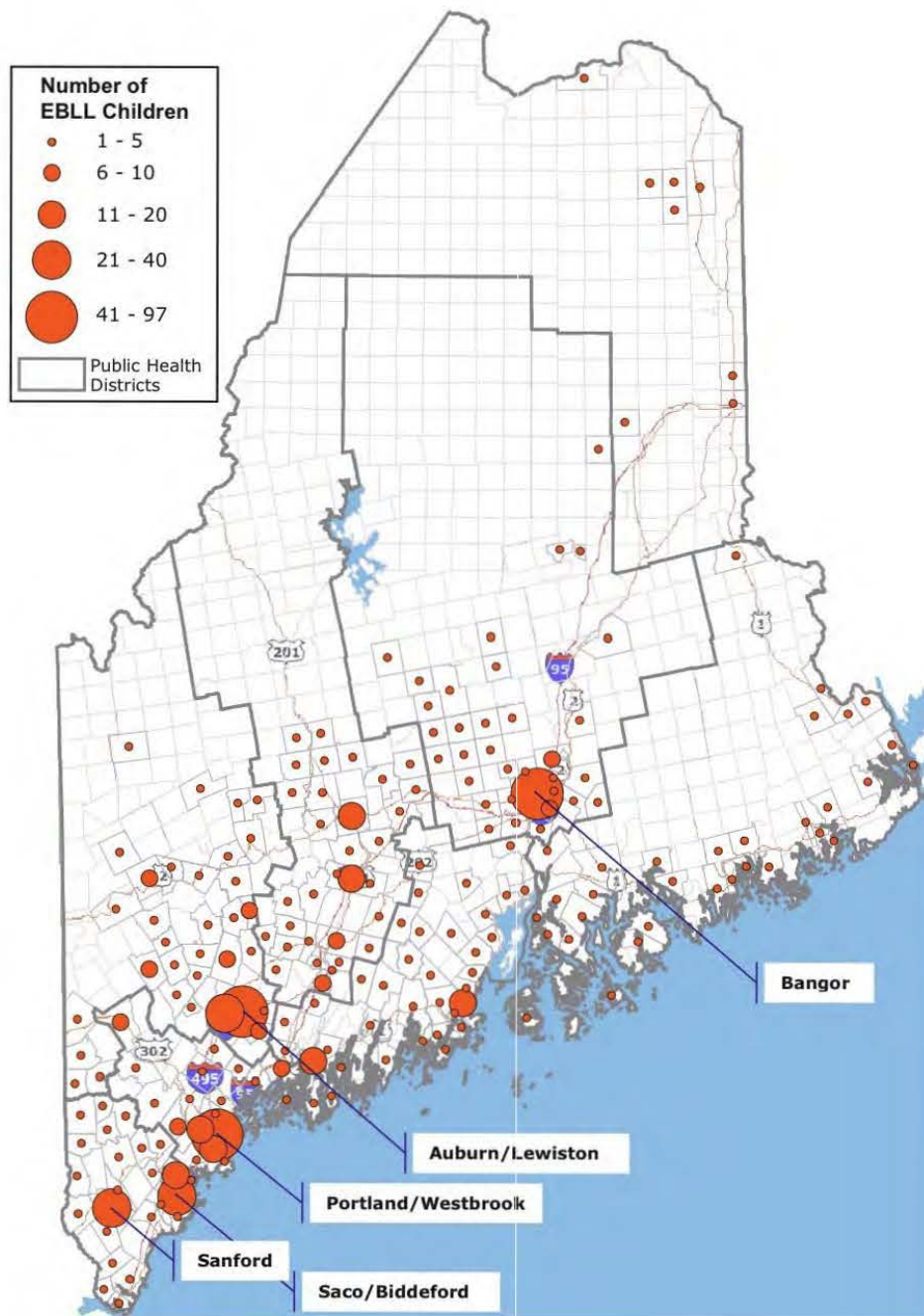
Table 1. Percent of newly identified children under 6 years of age with an elevated blood lead level for identified “high-risk” communities for the period of 2003-2007.

Selected Area	Number Screened	Number eBLL^(a)	Percent	95% CI
Bangor	2,096	41	2.0	(1.4 – 2.6)
Biddeford/Saco	2,229	44	2.0	(1.4 – 2.6)
Lewiston/Auburn	4,162	119	2.9	(2.4 – 3.4)
Portland/Westbrook	5,146	110	2.1	(1.7 – 2.5)
Sanford	1,660	34	2.0	(1.3 – 2.7)
Statewide*	54,422	565	1.0	(1.0 – 1.1)

^(a) eBLL = elevated blood lead level;

* Excluding high risk areas

FIGURE 2. Number of newly identified children under 6 years of age with an elevated blood lead level, by town for the years 2003- 2007.



We have recently updated this analysis with the most recent five years of combined data (2005-2009), and these results are summarized in Table 2. The rates for children with eBLLs in the communities of Bangor, Portland/Westbrook, and Sanford have dropped from the 2003-2007 combined years, though they remain above the rate for remainder of the state (which has also dropped). The drop in rates for Portland/Westbrook is most noteworthy. Rates for both Biddeford/Saco and Lewiston/Auburn remain relatively unchanged compared to prior years.

Table 2. Percent of newly identified children under 6 years of age with an elevated blood lead level for identified “high-risk” communities for the period of 2005-2009.

Selected Area	Number Screened	Number EBLL	Percent	95% CI
Bangor	1,998	30	1.5	(1.0 – 2.0)
Biddeford/Saco	2,172	41	1.9	(1.3 – 2.5)
Lewiston/Auburn	4,134	116	2.8	(2.3 – 3.3)
Portland/Westbrook	4,973	65	1.3	(1.0 – 1.6)
Sanford	1,576	24	1.5	(0.9 – 2.1)
Statewide*	53,286	464	0.9	(0.9 – 1.0)

* excluding high risk areas

Progress toward universal blood lead screening in designated high-risk areas

A. New Initiatives Launched

The ME-CDC has launched several initiatives since the last legislative report that, among other objectives, were intended to promote increased blood lead screening statewide as well as in high-risk areas. These initiatives were largely made possible by the Lead Poisoning Prevention Fund, established by the Legislature in 2005 (22 MRSA §1322-E).⁴ One initiative was a statewide targeting mailing to all families with children between ages one and two years. The mailing consisted of a brochure designed to inform families about lead paint hazards. It included an offer of free lead dust test kit, and a postage-paid return card to request more information, including how to get a child’s blood tested for lead. A second initiative was the establishment of contracts to community groups called Health Maine Partnerships, located in each of the five high risk areas. These contracts provided local communities support for targeted outreach efforts to tenants living in

⁴ The Lead Poisoning Prevention Fund is a nonlapsing fund established for the following purposes: a) Contracts for funding community and worker educational outreach programs to enable the public to identify lead hazards and take precautionary actions to prevent exposure to lead; b) An ongoing major media campaign to fulfill the purposes of the educational and publicity program required by section 1317-B; c) Measures to prevent children's exposure to lead, including targeted educational mailings to families with children that occupy dwellings built prior to 1978; d) Measures to prevent occupational exposures to lead for private and public employees; e) Funding an assessment of current uses of lead and the availability, effectiveness and affordability of lead-free alternatives; f) Funding for educational programs and information for owners of rental property used for residential purposes; and g) Implementation of the lead-safe housing registry by the Department of Environmental Protection pursuant to Title 38, chapter 12-B. The Fund is supported by a 25 cent per gallon annual fee imposed on manufactures and wholesalers of paint sold in the State of Maine. <http://www.mainelegislature.org/legis/statutes/22/title22sec1322-E.html>.

neighborhoods identified as having the highest burden of lead poisoning. ME-CDC additionally undertook an evaluation of a device that can perform rapid blood lead level determinations suitable for use within either a clinic or medical office setting to increase screening in high risk areas.

Target Mailing Campaign: Approximately 20,000 brochures were sent out statewide to families with children between ages one and two years in October, 2009. A second mailing of 25,500 brochures, including an offer of a free lead dust test was performed in the spring of 2010 (April – June). These mailings were supported by a more targeted distribution by community groups in the high risk areas. Thus far, a total of 67,000 brochures have been distributed. These mailings have resulted in more than 1,000 requests for free lead dust test kits. These mailings have also resulted in about 2,900 requests for more information, including 658 requests for more information on screening a child's blood for lead. Thirty-one percent of these requests came from high risk areas.

Contracts to High Risk Areas: Funds from the Lead Poisoning Prevention Fund are used to provide contracts to community coalitions (Healthy Maine Partnerships) in the five high-risk areas to promote identification of lead hazards, and to support landlord and tenant education and outreach. Approximately \$31,000 is being allocated to each high-risk area. The first funds were provided to communities in the summer of 2009. While the major focus of the Lead Poisoning Prevention Fund is primary prevention (preventing children from being exposed, rather than identifying children who have been poisoned via screening) many of their activities do promote screening. Examples of community efforts to promote screening include:

- Bangor is undertaking efforts to identify neighborhoods with high rates of lead poisoning, and using their code and assessing officers to target the largest apartment owners with the most distressed properties. These buildings are then targeted for additional outreach for the landlords and tenants to instruct them on how to maintain a lead-safe living environment. Targeted outreach is also occurring to local pediatricians serving these neighborhoods and through neighborhood media, such as the Thrift Shops, the Growing Place, and other places with public notices. Outreach through media (such as Channel 7 nightly news, MPBN and Bangor Daily News) is ongoing.
- Activities in Biddeford/Saco to promote screening include the development and distribution of materials including lead poisoning prevention advertisements for the Saco Cinemagic theatre. The ads ran for 13 weeks, playing at least once before every movie, for a total of over 600 ads per week. Biddeford/Saco are additionally working with WIC, HeadStart, Section 8, Safe School/Strong Fathers Playgroup, Families READ, and the Public Schools for distribution of materials.
- Portland identified two high-risk neighborhoods (East Bayside and Parkside). Efforts were launched to educate tenants in the East Bayside Neighborhood, while the partnership with Parkside Neighborhood is still being established. A partnership with the City of Portland Minority Health Program has been established and community forums were held for the Somali and Latino

communities in the spring of 2010. Theatre ads were created and placed at the Westbrook Cinemagic. The ad ran for 17 weeks and played at least one time prior to every movie, a total of over 600 times per week this summer. A partnership with Catholic Charities was established to educate new immigrant arrivals. Packets of information were compiled and sent to all 700 childcare centers in Cumberland County. The packets included information on the importance of blood lead screening. Childcare centers in Portland were also invited to have free lead blood testing (through the City of Portland) for children under age 2. A handbill with local information and resources was created, printed and distributed inside of the State lead brochure for parents of young children. Five hundred of these were distributed to parents who have children enrolled in early HeadStart in Cumberland County, to WIC clients and to parents through the visiting nurse program.

- The communities of Lewiston and Auburn have partnered with the Lead Safe Community Committee and the Healthy Homes Healthy Families. Healthy Homes Healthy Families is collaborating with Catholic Charities of Maine and United Somali Women of Maine to provide more culturally appropriate prevention information for their clients. Healthy Homes Healthy Families also collaborated with the Neighborhood Housing League to sponsor a class on lead poisoning and pest prevention for downtown residents of Lewiston. Additionally, Healthy Androscoggin is mapping the addresses of the class attendees and home visits, along with those of the Lewiston Auburn Lead Program consults, to verify that efforts are targeting the high risk areas. Healthy Androscoggin also worked with the Maine Childhood Lead Poisoning Prevention Program and Bates College faculty and students to organize a discussion with members of the Somali Bantu community about lead poisoning and to promote blood lead screening. The objective was to determine potential causes of lead poisoning and to develop effective communication strategies with the Somali Bantu population. Local PSAs were developed and have started running on Great Falls TV, the public access television station in Lewiston/Auburn.
- Sanford has worked with local community partners to distribute information on lead poisoning at Child Care Services of York County's Family Fun Day and National Night Out. Additionally, they have partnered with a Safe Schools Healthy Students grant and the Sanford Adult Ed/Families READ program, presenting to the Safe School Healthy Students playgroup, run in collaboration with Strong Fathers. The same presentation was used with the Families READ program through Sanford Adult Education. The Alliance for Healthy Families has been distributing materials to Sanford/Springvale families and educating them during home visits. The strategies for a Stronger Sanford's Youth Group will complete a door-to-door "Bucket Brigade" during April vacation. The group will distribute cleaning supplies needed to control lead dust, such as a bucket, sponge, and other supplies for wet wiping of surfaces.

ME-CDC outreach to providers servicing high risk areas. Maine CDC's Childhood Lead Poisoning Prevention Program (ME-CLPPP) made a presentation to pediatric providers at the Eastern Maine Medical Center pediatric grand rounds, reaching many provider groups in Bangor. Screening data was shared, along with recommendations for targeting screening of high risk children. ME-CLPPP staff worked closely with Head Starts in both Biddeford and Sanford to assist children with obtaining screening, and provide in-service education to home visiting and family advocate Head Start staff. ME-CLPPP staff additionally met with pediatric providers that serve large numbers of immigrant/refugee children in the Lewiston/Auburn community to inform providers of their increased risk for lead poisoning and share screening guidelines.

Evaluation of technology for real-time blood lead testing. One way to increase screening rates may be to host blood lead testing clinics or enable health care providers servicing these communities to perform in-office blood lead analyses. One device that is used for this purpose is the LeadCare II portable blood lead screening device. The LeadCare II allows for a near instant analysis of a capillary blood sample for lead. This allows a health care provider to provide results to the patient immediately. If the levels are high, the patient can be referred to a laboratory for further tests.

Several states have allowed this technology to be used by health care providers including California, New York, New Hampshire, Illinois, Iowa, Massachusetts and Missouri. Unfortunately, experience from these states suggest that decreased reporting of data to the state health department (data necessary for computing screening rates) was often an initial impediment to the successful introduction of this technology. In some cases, additional time and staff were needed to encourage reporting of data by health care providers.

Because ME-CDC has an interest in potentially using this technology to run blood lead screening clinics in high risk areas, a LeadCare II instrument was purchased for evaluation by the State Health and Environmental Testing Laboratory. The evaluation included running blood lead samples in parallel on both the LeadCareII device and a standard laboratory instrument. The evaluation suggested that the LeadCare II device is indeed portable, easy to use and operate. It also has the benefit of requiring a smaller sample of blood than that needed for the conventional finger-stick capillary sample sent for laboratory analysis. The LeadCare II device is accurate within the typical blood lead levels we see in the state. The blood lead results are most accurate if run immediately on site rather than transporting samples back to the laboratory for analysis. One limitation of the LeadCare II analyzer is that it doesn't have the ability to store or electronically transmit patient data. These data would need to be recorded separately and submitted to the ME-CDC, increasing the risk of errors, failure to report and added data-entry work by ME-CDC. Currently, all blood lead test data are transmitted electronically to the ME-CDC surveillance database from the State Health and Environmental Testing Laboratory. Despite the above limitations, the use of a LeadCare II device in high risk areas for screening difficult to reach populations appears feasible and promising.

B. Current Screening Results

The initiatives described above were first launched during the fourth quarter of 2009 and continued thereafter. The most recent available data on childhood blood lead screening rates is through calendar year 2009. Consequently, there has yet to be sufficient time to measure any potential impacts of the new initiatives on screening rates.

Screening rates for one and two-year old children have generally remained relatively stable since 2003 within each high risk area. Figure 3 below illustrates the trend in screening rates for two of the high risk areas (Portland/Westbrook and Lewiston/Auburn).⁵

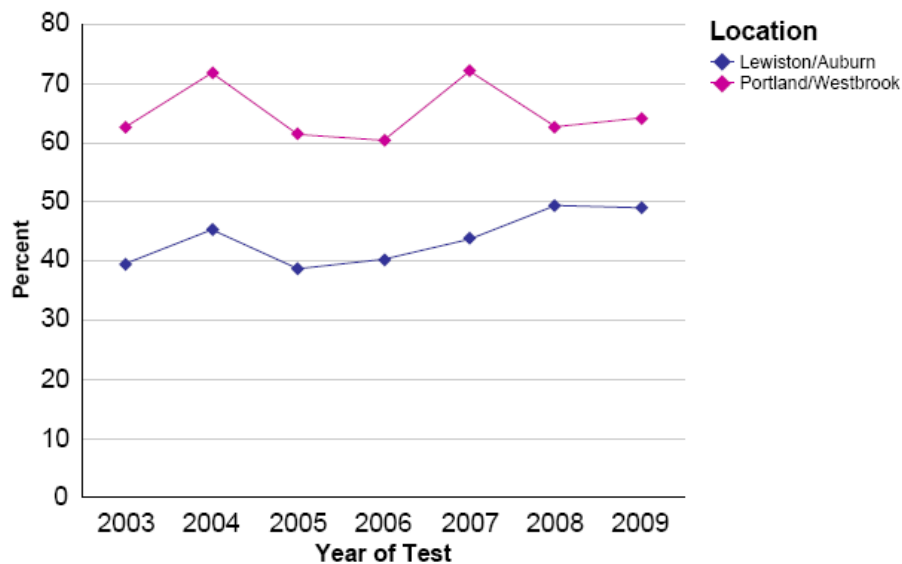


Figure 3. Blood lead screening rates for 1-year olds in the communities of Portland/Westbrook and Lewiston/Auburn for the years 2003 – 2009.

⁵ To view trends in blood screening rates, visit the Maine Tracking Network to access surveillance data on lead poisoning (<https://tracking.publichealth.maine.gov/>).

Screening rates in the five high risk areas range from 43.6 to 71.7 percent for one-year olds, and 26.4 – 33.8 percent for two-year olds. Table 3 below summarizes recent data on screening rates for each of the five high risk areas and for the two age groups required by law.⁶ These screening rates – averaged over a five-year period – provide a baseline to use in assessing progress toward increasing screening rates in future years. The difference in screening rates between 1 and 2 year olds suggests most providers appear focused on making sure that a child has a least one blood lead test by age 3. Current surveillance data indicate between 62% to 77% of children living in the five high risk areas have had at least one blood lead test by age 36 months.

Table 3. Percent of one-year old and two-year old children screened for blood lead prior to initiation of efforts to increase screening (2003 – 2007) and post initiation of new efforts (2008-2009).

High Risk Areas	Age Group (months)	Population	Number Screened	Percent Screened
Bangor	12 – 23	1,764	1,068	60.5%
	24 – 36	1,844	525	28.5%
Biddeford/Saco	12 – 23	2,229	1,225	55.0%
	24 – 36	2,234	589	26.4%
Lewiston/Auburn	12 – 23	3,580	1,561	43.6%
	24 – 36	3,438	1,024	29.8%
Portland/Westbrook	12 – 23	4,013	2,549	63.5%
	24 – 36	3,975	1,090	27.4%
Sanford	12 – 23	1,209	867	71.7%
	24 – 36	1,138	385	33.8%
Statewide Average	12 – 23	70,159	33,517	47.8%
	24 – 36	70,360	16,324	23.2%

Lessons learned and challenges and barriers to improving screening in high risk areas.

One notable challenge to increasing screening rates in some of our high risk areas is the recent increase in immigrant populations. This is especially a challenge for the Lewiston/Auburn community where the secondary immigrant Somalis represent an increasing proportion of identified cases of lead poisoned children. Children of African descent now represent sixty percent (60%) of lead-poisoned children in Lewiston/Auburn. In 2005, children of African descent represented forty percent (40%) of cases. There were no cases of lead-poisoned children of African descent during 2003 – 2004.

⁶ 22 MRSA S1317-D - As required by Section 1905(r)(5) of the Social Security Act and the federal Omnibus Budget Reconciliation Act of 1989, the state lead testing program must require the testing of blood lead levels of all children covered by the MaineCare program at one year of age and two years of age. The program must require the testing of blood lead levels of all children not covered by the MaineCare program at one year of age and two years of age unless, in the professional judgment of the provider of primary health care, in conjunction with the use of the lead poisoning risk assessment tool, the child's level of risk does not warrant a blood lead level test.

Barriers to screening within this ethnic community are many. Examples include:

- Awareness. Use of lead paint in Somalia was rare and many immigrants have not heard of lead paint. The two Somali languages do not have a direct translation of the word “lead”.
- Cultural barriers to blood testing. Some Somalis have been resistant to the idea of removing blood from their children. Traditionally, seeking health care services was assessed for acute, severe disease. The concept of preventive health care is a new one for this population.
- Physical barriers to screening. Often a blood lead test would be ordered at a physician’s office, but the actual blood draw would occur at a hospital laboratory. In these cases the Somali family often need transportation from the physician’s office to the hospital lab for both themselves and an interpreter.
- Language barriers. It is often difficult to communicate the need for blood lead testing to parents who may not be literate in their own language.
- Magnitude of the problem: There is no accurate data on the number of Somali children in these locales. Additionally, recording of ethnicity from the lead results is often incomplete or misleading (black vs. African vs. Somali). For that reason it is not possible to calculate screening rates within this community.

Attempts to address these barriers have begun. The use of a LeadCare II analyzer in ME-CDC hosted clinics in the Lewiston/Auburn area may be especially helpful in increasing screening rates in this community.

The LeadCare II analyzer may also be a useful device for health care providers to perform in-office blood lead determination. This could potentially address the physical barriers to blood lead screening for practices that must otherwise send patients to an off-site laboratory to obtain a blood lead sample. It also will allow provider offices to inform patients of the results, rather than have to attempt contact with the parent weeks later. As previously stated, allowing health care providers to perform in-office blood lead analysis would require a change to state law. Maine’s Lead Poisoning Control Act requires that a blood sample taken from a child by a health care provider or laboratory to test for blood lead level must be sent to the State Health and Environmental Testing Laboratory for analysis (22 MRSA §1319-A). A major advantage of this provision of state law has been timely and comprehensive reporting of blood lead data to the State’s Childhood Lead Poisoning Prevention Program – the program responsible for providing services on all cases of childhood blood lead poisoning.⁷ This reporting has become completely electronic and largely automated such that, unlike many other states, Maine does not require a staff person to perform data entry of reports submitted from multiple laboratories or provider offices. Data quality checks have become largely automated.

⁷ Services include arranging for a home visit by a public health nurse to instruct the family on how to control lead hazards in the home, counseling the family about lead poisoning, arranging for inspection of rental properties by a licensed inspector trained to identify lead hazards in the home, assisting with relocation of the family in necessary to protect the child, issuing an order to abate lead hazards if necessary, and ensuring that lead hazards are successfully abated before a rental unit can be re-occupied.

It may be feasible to expand the State's existing IMMPACT II system to enable any providers who chose to use the LeadCare II device to electronically transmit blood lead data directly to the State's Childhood Lead Poisoning Prevention Program. IMMPACT II, which is managed and maintained by the ME-CDC Immunization Program, is a secure, confidential, Internet-based informatics system that enables authorized users enter and access information related to a person's immunization status and/or well child visits. It is in widespread use by health care providers in Maine.

We believe it is feasible to build functionality to manage blood lead data in IMMPACT II. It also appears feasible to provide views of State's existing blood lead data using IMMPACT II. Thus, providers would be able to both enter blood test results from using LeadCare II and would be able to retrieve any confirmatory blood lead test as well as testing history. If Leadcare II use is coupled with use of IMMPACT II for electronic reporting of test data, the use of this new device could occur with minimal additional data processing burden on the State and minimal fiscal impact. Because medical providers would have access to whether a child has not had a previous blood lead test, blood lead screening may increase. The challenge of maintaining good reporting of blood lead test data could be insured by making use of LeadCare II conditional on maintaining good reporting.