1 CENTERS FOR DISEASE CONTROL AND PREVENTION

2 LEAD EXPOSURE AND PREVENTION ADVISORY COMMITTEE

3 (LEPAC)

4 MEETING HELD AT THE CDC ROYBAL CAMPUS AND VIA ZOOM

5 VIDEO CONFERENCING

6 OCTOBER 17, 2023, 9 A.M.

7 PRESIDING OFFICER: PAUL ALLWOOD, Ph.D., M.P.H.,

8 DESIGNATED FEDERAL OFFICIAL, NCEH9

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Transcript Legend

(ph) - Exact spelling unknown; spelled as sounded.

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TABLE OF CONTENTS

WELCOME AND ANNOUNCEMENTS	7
MAKING FEDERAL GRANTS WORK FOR COMMUNITIES	15
STRATEGIES TO INCREASE TESTING IN CHILDREN ENROLLED IN MEDICAID	40
UPDATES FROM LEPAC MEMBERS	77
WRAP UP AND DISCUSS TOPICS FOR NEXT MEETING	109

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1 P R O C E E D I N G S

2 **MR. AMMON:** So welcome back for day two of
3 our meeting, the Lead Exposure and Prevention
4 Advisory Committee. I think everybody, you know,
5 in conversations after yesterday and this
6 morning, yesterday was a very productive,
7 fruitful, and informative day with the topics
8 that we had discussed. Very wide-ranging and
9 very timely in terms of their topics. And I know
10 everyone was very much engaged and everyone had
11 provided a lot of information, feedback.

12 I know for me in going back there's always
13 sort of an information unload to some of the
14 senior team members to give them an update. And
15 they were all very much amazed at the work that
16 we do and the work going on around the country in
17 this sphere and, you know, how really broad and
18 impactful it is, you know, of course, not only
19 about lead but also issues that extend beyond
20 that impact everyone's lives on a daily basis and
21 the fact that, you know, we have such divergent
22 organizations working toward very much common
23 goals and outcomes. And I think that's what the
24 most amazing thing is is that, you know, we all
25 may speak different -- you know, have different

1 focuses, if you will, but at the end of the day
2 we really are focused on improving communities
3 and improving quality of life and all the work
4 that goes into that.
5 So first thing we're going to do is just an
6 order of business. We're going to do roll call
7 for the LEPAC members. I'll turn it over to
8 Perri.
9 **DR. RUCKART:** Thank you. Also I want to
10 make an announcement. When you get a chance, if
11 you're in person in the room, please sign the
12 sign-in sheet on the table in the back.
13 So, yes, as Matt said, just a roll call.
14 When I call your name, just please indicate that
15 you're here. I'll start with those in the room.
16 So Wallace Chambers.
17 **DR. CHAMBERS:** Here.
18 **DR. RUCKART:** Nathan Graber?
19 **DR. GRABER:** Here.
20 **DR. RUCKART:** Kristina Hatlelid? Hatlelid.
21 **DR. HATLELID:** Here.
22 **DR. RUCKART:** Anshu Mohllajee?
23 **DR. MOHLLAJEE:** Here.
24 **DR. RUCKART:** And Grace Robiou?
25 **MS. ROBIOU:** Here.

1 **DR. RUCKART:** I'll go to our members online.
2 Tammy Barnhill Proctor?
3 **MS. BARNHILL-PROCTOR:** Good morning, I'm
4 here.
5 **DR. RUCKART:** Rebecca Fry? Mary Beth Hance?
6 **MS. HANCE:** Good morning, I'm here.
7 **DR. RUCKART:** Okay, great. Tina Hanes?
8 **MS. HANES:** Good morning. Here.
9 **DR. RUCKART:** Aaron Lopata?
10 **DR. LOPATA:** Hi, good morning. I'm here.
11 **DR. RUCKART:** Patrick Parsons?
12 **DR. PARSONS:** Here.
13 **DR. RUCKART:** I'm sorry, now I'm going to
14 our nonvoting liaison members. Patrick Parsons.
15 And virtually, Ruth Ann Norton.
16 **MS. NORTON:** Good morning.
17 **DR. RUCKART:** Good morning. Amanda Reddy?
18 **MS. REDDY:** Good morning. Here.
19 **DR. RUCKART:** Great. Stephanie Yendell?
20 **DR. YENDELL:** Yes, I'm -- yes, I'm here.
21 **DR. RUCKART:** Okay, Lauren Zajac?
22 **DR. ZAJAC:** I -- I'm here. Good morning.
23 **DR. RUCKART:** And then I wanted to mention
24 that Karla Johnson, a LEPAC member, is unable to
25 join us as well as Abe Kulungara. And so just to

1 complete the roll call here, we have Paul
2 Allwood, our DFO.
3 **DR. ALLWOOD:** Here.
4 **DR. RUCKART:** And Alexis Allen, CMS.
5 **MS. ALLEN:** Here.
6 **DR. RUCKART:** And Nick Hatch, Deputy CMS.
7 So that is everyone.
8 **UNIDENTIFIED SPEAKER:** You forgot Erika.
9 **DR. RUCKART:** Oh, Erika, I'm so -- oh, I'm
10 so sorry. Thank you for pointing that out. I'm
11 reading too fast. I'm so sorry. We have Erika
12 Marquez. She's one of our LEPAC members.
13 Apologies.
14 **MR. AMMON:** All right. Well, thank you,
15 Perri. Just before we get into our first topic
16 of the day, making federal grants work for
17 communities, I had opined about yesterday and I
18 would -- if other folks wanted to offer a little
19 bit of, you know, thoughts and insights from
20 yesterday, I think we have just a little bit of
21 time if they wanted to kind of reflect on what we
22 heard yesterday with the group. Open it up to
23 everybody here in the room and LEPAC members
24 online.
25 We don't have to do anything, but we

1 (indiscernible). Nope? Paul (indiscernible).

2 **DR. ALLWOOD:** Can I (indiscernible), Matt?

3 **MR. AMMON:** Absolutely.

4 **DR. ALLWOOD:** I just wanted to

5 (indiscernible) what was discussed yesterday

6 about the (indiscernible) and lead dust levels at

7 EPA. So we talked about floors, sills, and

8 troughs. But is there any changes going to occur

9 with the soil? Or are they going to stay the

10 same?

11 **MS. ROBIOU:** I'm not sure about -- I'll need

12 to check on that.

13 **MR. AMMON:** All right. Anything else in

14 terms of insights, comments? Anshu?

15 **DR. MOHLLAJEE:** Yeah. I was thinking more

16 about the importance of a partnership with the

17 lead service lines between the water department,

18 the public health department, and the community

19 organizations. And so I think that you would

20 hope there's interactions occurring at all those

21 different levels, but I'm not sure if that is

22 occurring.

23 And so one of the thoughts I had was that

24 perhaps EPA and CDC could joint --

25 collaboratively create a survey, perhaps, or try

to get information what was actually occurring at
1 the -- at the state level at least, and, perhaps,
2 also at the local level. And if that's not
3 possible, one thing that could also be done in
4 the annual questionnaire that's sent to grant
5 recipients is to actually ask what is your -- you
6 know, what is your public health department doing
7 around lead service line? What is the water
8 department doing?
9 That way you can get a little bit of
10 information and have a better sense of what's
11 really happening on the ground. Because there
12 does seem to be a little disconnect. There are
13 all of these great materials, there's this great
14 guidance, all this stuff, but how is that really
15 filtering down to a local level?
16 **MR. AMMON:** That's a great point. I think
17 the bottom line for me as well is that we are
18 ready and willing to be participants in this
19 great work. I know that at HUD we have a
20 tremendous amount of data related to assisted
21 housing stock, that we are ready and willing to
22 be able to provide that in terms of to anybody to
23 make sure that, as we talked about yesterday, the
24 level's a priority down to the unit level.

1 I'm ready and willing to do whatever is
2 necessary to make this work. I totally concur
3 with that.
4 Anyone else? Oh, Ruth Ann.
5 **MS. NORTON:** Hey, good morning, Matt and
6 everyone. And two things that I think are
7 important just to reiterate, I think you said
8 this is a reflection of yesterday. One, I know
9 we started the day talking about capacity. And I
10 just want to reiterate again how much support we
11 need to give our state and local government
12 capacity building and our focus as we align all
13 of these dollars around the larger framework of
14 Justice40 and Environmental Justice, really
15 understanding the capacity building that's needed
16 on how to teach people how to align, grade,
17 coordinate those dollars.
18 So the big concerns I have are on job
19 capacity and also making sure -- and I really
20 appreciate the new grants the CDC is doing in the
21 NLAPH work about building the capacity of those
22 community-based organizations to strengthen at a
23 time when so many federal dollars are coming
24 down.
25 And I just want to thank everybody who's in

1 public service here on really thinking about how
2 do we not miss the opportunity to build that
3 capacity and in this toxic legacy of lead that
4 we've struggled with. So that was a highlight
5 for me yesterday and look forward to the
6 discussion today.
7 **MR. AMMON:** Thanks, Ruth Ann.
8 Stephanie?
9 **DR. YENDELL:** Yeah. Good morning. So I am
10 the CSTE liaison. This is Stephanie Yendell.
11 And I -- we talked a lot yesterday about data
12 modernization which I found to be very
13 encouraging because that's something that states
14 certainly are putting a lot of time and effort
15 into.
16 And one thing just that I noticed I wasn't
17 really hearing is how CDC's efforts at data
18 modernization aligned with other national
19 standards, such as the HL7 Standard, the White
20 Code Standards, the Snomed Code Standards. And
21 so I welcome further discussion on what that's
22 going to look like in the future.
23 **MR. AMMON:** Thank you. Anyone else?
24 Scanning. Yes, Perri.
25 **DR. RUCKART:** I just wanted to announce that

1 Rebecca Fry has joined the call. She's one of
2 our LEPAC members.
3 **MR. AMMON:** Hello, Rebecca.
4 **DR. FRY:** Good morning.
5 **MR. AMMON:** Hello. Scanning the room,
6 scanning online if there's any other comments
7 related to yesterday's topics before we move into
8 our first topic of the day.
9 All right. Seeing none, let's move on to
10 our first topic of the day which is talking about
11 making federal grants work for communities. And
12 I'll turn it over to Paul to talk about CDC's
13 work.
14 **DR. ALLWOOD:** Thank you, Matt. Good
15 morning, everybody. So I'll start the discussion
16 here by sharing some information about CDC's
17 recent efforts, you know, really achieve what
18 this session is about.
19 But then I'll ask Ms. Wilma Jackson who is
20 our program services team lead to help me tell
21 the story.
22 And now, I'd like to maybe start by just,
23 you know, maybe using a saying that has become,
24 you know, fairly widely known, which is that, you
25 know, without vision people perish. And I start

1 this way because about a year ago, or maybe a
2 little more than that, we began thinking, you
3 know, very, very seriously about ways in which
4 CDC -- CDC lead program engaged more directly
5 with community-based organizations. And, of
6 course, the next thing that confronted us once we
7 became more or less convinced that that was an
8 important, you know, strategy that we needed to
9 embrace was how can you do it? You know, how can
10 you warp through all the various administrative
11 and procedural paths that needed to be followed
12 to be able to do that.
13 But (indiscernible) persisted and so a way
14 had to be found how to do this. And I'll let
15 Wilma tell a little bit more of the path of the
16 story. But the overall vision is that, you
17 know -- and I think you've heard this
18 consistently throughout the meeting, you know, it
19 was mentioned several times yesterday. I think
20 everybody is fully in touch with the
21 understanding that ultimately communities have to
22 be a key part of the solution on this problem of
23 childhood lead poisoning unless we can somehow
24 motivate and inspire communities to act in their
25 own self-interest.

1 What we do as a, you know, government
2 operative or, you know, whatever other sphere you
3 find yourself belonging to, it can only go so
4 far. We ultimately need people who are
5 themselves at risk for the adverse consequences
6 to realize that and to, you know, feel inspired
7 and empowered and also to bring a certain amount
8 of indignation to the situation up front. And
9 then, you know, out of that, history has taught
10 us very well that, you know, human ingenuity,
11 human creativity can lead us to some amazing
12 solutions, somehow inspire that kind of visceral,
13 you know, reaction at a very grassroots level.
14 So we decided that, you know, despite the
15 various hurdles that had to be overcome, we would
16 pursue a funding strategy that would be providing
17 funds directly to community organizations. And,
18 you know, within the CDC's system, we -- you
19 know, our funding opportunities are initially
20 built around a logic model.
21 So, you know, if the logic -- the logic
22 being that we have to clear the final strategies
23 and the activities that we would want to pursue.
24 We would have to define the short and medium --
25 the short-, medium-, and long-term objectives

1 that we're hoping to achieve. And then, you
2 know, take that to the proper stops within the
3 agency to ensure that there was sufficient
4 (indiscernible) and support.
5 So, you know, with the help of a lot of
6 people, Wilma being, you know, principal among
7 them, and she'll tell her part of the story.
8 But, you know, many, many partners within the CDC
9 but -- and even more extraordinary at some point
10 it became necessary to move outside of the CDC
11 and move to the Department of Health and Human
12 Services to be able pull this off because, you
13 know, there were all kinds of little barriers
14 that came up. Not intentionally but, you know,
15 just because of the way systems operate.
16 But our role is to essentially provide these
17 funds to community-based organizations. And, you
18 know, we -- we thought it would be hard to target
19 local community-based organizations that had, you
20 know, documented experience working with people
21 who are most impacted by childhood lead poisoning
22 are at much greater risk for the -- for exposure
23 to the hazard and also for adverse consequences.
24 And the strategies were, you know, fairly
25 straight forward. I don't think these are going

1 to be really earth shatteringly new to anybody.
2 It's like providing support and resources to
3 communities, the members of communities where
4 most of them meet, developing coalitions. We
5 could have a lot (indiscernible). Identifying
6 and engaging with multi-(indiscernible) partners;
7 connecting, making referrals to families and
8 children to resources that can help, you know,
9 prevent exposure as the case may be or reduce
10 harm if the exposure had already occurred;
11 conducting targeted outreach and marketing and
12 education; and last but not least, educating
13 communities about policies and systems that lead
14 to the problem of lead exposure in kids and ways
15 that, you know, education and engagement can lead
16 to put in policy and systems change that are
17 really essential to ensure that we successfully
18 eliminate this hazard.
19 So we started there and, you know, we're
20 pleased that we have been able to fund a number
21 of grantees, you know, under this -- this
22 brand-new (indiscernible).
23 And now, I'll turn it to Wilma and have her
24 tell you a little bit more.
25 **MS. JACKSON:** Thank you, Paul. My name is

1 Wilma. I'm the team lead on the program services
2 team and I work with Paul to bring his vision to
3 light.
4 **UNIDENTIFIED SPEAKER:** Wilma, can you move
5 closer?
6 **MS. JACKSON:** I'm sorry.
7 **UNIDENTIFIED SPEAKER:** Thank you.
8 **MS. JACKSON:** Can you hear me now? Okay.
9 Perfect. As I said, I'm Wilma Jackson, the
10 program services team lead, here in the lead
11 program, and I work closely with Paul to kind of
12 bring his vision to light. And that was really
13 to be able to fund local organizations that do
14 work in the community at the grassroots level.
15 As you know, historically we have always
16 funded states, local health departments,
17 territories, and some other (indiscernible)
18 fund tribes. But being able to actually go into
19 the community with community-based organizations
20 who actually do the work, we have not been
21 successful at doing that, my understanding, in
22 the NCEH. Other centers (indiscernible)
23 across CDC have done that.
24 So really that was the focus of what we were
25 trying to do. There were certain limitations on

1 the applicants who would apply because, again,
2 looking at who would apply, who could apply, and
3 who would be a good writer, we had to put some
4 restrictions to kind of make sure we target
5 those. And one of the main ones was to limit the
6 federal funding that certain organizations
7 receive.
8 Many of these grassroot organizations were
9 not historically funded by the federal
10 government. So putting a limit on how much money
11 they could receive from the federal government
12 ensured that we were able to get those really
13 small organizations in the community. And that
14 was one thing that helped really -- helped us to
15 really focus in on the target population.
16 Also as Paul said, we wanted those
17 organizations who demonstrated work in the
18 community and lived in the community. Some of
19 you may be familiar with the term "pass through."
20 That is something that historically happens in
21 large organizations. They are very good at
22 writing applications and grants and then they
23 pass the money on to a local organization after
24 they take a portion of the dollars off the top.
25 We did not want to do that because the

1 amount of money we were giving was already a
2 small amount. So we wanted to be able to give
3 all of the money to the entities that were doing
4 the work. So we did not allow organizations to
5 serve as a pass-through, meaning they would write
6 the grant and then they would sub it out to our
7 local organizations. We wanted those
8 organizations to be successful at applying
9 themselves.
10 And that's what we have done. As you guys
11 may or may not know, it is a three-year NOFO,
12 notice of funding opportunity. They are grants,
13 not cooperative agreements. And the difference
14 between a grant and a cooperative agreement, a
15 cooperative agreement requires more involvement
16 with the project officer and with CDC. Grants
17 rely -- it requires more of a recipient to
18 identify what they want to do, tell us how
19 they're going to do it. And that is what they
20 do.
21 We provide support and guidance, but it is
22 really their activity that they're carrying out.
23 And so when we developed the NOFO, we wanted to
24 put it in such a way that you bring to CDC your
25 ideas. You can either do a project you're

1 already working on or one you would like to get
2 started. But you bring that to CDC. We will
3 look at your application and that is who we fund
4 it. Based upon what they propose to do, that --
5 or those recipients are now the applicants -- the
6 applicants at the time, recipients now that we've
7 funded.
8 It was their idea. It was their concept.
9 We looked at it to make sure that it met the
10 intent of what we were trying to do and those
11 were the eleven that were funded. We had 43
12 applicants apply, which is very good for a
13 program that just started. Brand-new, no history
14 at all, to be able to identify from forty-three,
15 eleven that we thought were very great,
16 well-written applications and everything.
17 We used a lot of our federal partners. I
18 work closely with WIC. WIC also has a
19 community-based organization. So we were able to
20 get our notice of funding opportunity
21 announcement out to -- through WIC, through HHS,
22 through HUD, through many of our other federal
23 partners that fund community-based organizations,
24 put it out there on the street so that
25 (indiscernible) -- I'm sorry, can you guys hear

1 me? I'm so sorry. Sorry and everything. So
2 thank you. Thank you.
3 So that is really the history of it. Like I
4 said, it was something that Paul had started
5 thinking about in 2022. We did do it on a tight
6 time period. We really started writing in
7 January of '23. It was a -- it was posted on
8 grants.gov in June, actually June 1st, May 31st
9 of 2023. And it was awarded on -- when? Where
10 are we? September, October -- September 29th is
11 when it was awarded. It was started on September
12 30th of 2023. It will be good through three
13 years. So it will end September 29, 2026.
14 This is a seed program. So we look to be
15 able to fund more in the future.
16 **DR. ALLWOOD:** Thank you, Wilma, and thank
17 you to everybody that -- that contributed to the
18 success of this -- this initiative, none the
19 least of which are the 11 grantees that, you
20 know, have been -- have presented very bold and
21 imaginative proposals and whom we are really very
22 excited to welcome to this new relationship with
23 the CDC and looking forward with great excitement
24 to a successful and long-term, long-lasting
25 relationship.

1 And just to kind of, you know, maybe put
2 another perspective on just the importance of the
3 work that we all do at LEPAC, all of us that are
4 engaged in a lead poisoning prevention, lead
5 poisoning is a -- lead is a high-profile topic
6 within the CDC. And this new initiative, you
7 know, got to the attention of our new CDC
8 director, Dr. Cohen.
9 And last week -- you know, she puts out a --
10 she spotlights certain activities within the
11 agency and this was one of her spotlights last
12 week. It was not agency-wide but this -- this
13 initiative and Wilma's amazing work and
14 leadership was something that the CDC director
15 recognizes. It's one of the key and important
16 initiatives that's in line with her emphasis on
17 supporting work within the CDC, supporting
18 families to thrive and to be healthy.
19 So I'll stop there. We probably went a
20 little long. Sorry about that. You know, we'd
21 really love to hear others, you know, take any
22 questions if there are any.
23 **MR. AMMON:** Any questions for CDC before
24 we -- Nathan.
25 **DR. GRABER:** So thank you. That was really

1 terrific and I'm glad to hear that CDC's taking
2 this approach because I think it was a theme from
3 yesterday that's been pointed out multiple times,
4 how important the cooperation between the
5 communities and the agencies doing the
6 interventions are.
7 And -- but a specific question related to
8 your work: Could you elaborate a little bit on
9 what some of the goals of the grantees have been
10 and how they measure those outcomes?
11 **DR. ALLWOOD:** Yes. So I can give you just
12 a -- kind of a quick overview of some of the
13 goals. Like I mentioned earlier, there are five
14 strategies that we're trying the grantees to
15 pursue. First is to provide support and
16 resources to -- you know, within their
17 communities. Second would be to develop
18 coalitions. Third is to enhance the access of
19 people who are lead exposed or, you know,
20 significant risk for lead exposure to resources
21 that can protect them. The third would -- I'm
22 sorry, fourth would -- is enhancing knowledge and
23 skills, making people more aware of the hazard.
24 And then last but not least, we want people to
25 feel a part, do the education and the outreach to

1 try to achieve the policies -- policy systems and
2 environmental change.
3 Some short-term outcomes, I won't go over
4 the entire list. And, you know, we can certainly
5 share the logic model, you know, with the LEPAC
6 (indiscernible), for the details to be available
7 there. The short-term outcomes include things
8 like increase lead poisoning prevention capacity
9 in underserved communities; improving the age
10 limits between the funded CLPPP programs, service
11 providers, and local community organizations and
12 groups.
13 Some more intermediate objectives are things
14 like increase availability and accessibility to
15 lead hazard assessments and blood lead screening
16 and testing.
17 And long-term, our goals would be reduced or
18 eliminated risk of lead exposures in underserved
19 communities and reduced or eliminated disparities
20 in blood lead levels by race, ethnicity, and
21 socioeconomic status.
22 So this is just a quick snapshot. And it
23 can be -- we can share the logic (indiscernible).
24 Wilma, do you want to say ...
25 **MS. JACKSON:** No, I think that was superb.

1 As I keep in mind, we actually start -- our
2 recipients will actually start working with us --
3 **DR. ALLWOOD:** (indiscernible).
4 **MS. JACKSON:** Thank you. Thank you so much.
5 Our recipients actually will start -- they
6 started on September 30th. That is when we start
7 with the year one and everything. And what Paul
8 went over -- sorry, what Paul went over are those
9 strategies that were outlined in the NOFO
10 which -- in what they wrote their application to.
11 As I said, many of these recipients already
12 had these activities that they were either doing
13 themselves through funding within their own
14 organization or they may have had some
15 complementary funding from a local government or
16 from another partner or support. So what they
17 did was use -- utilize this opportunity as a way
18 to complement what they were already doing and
19 enhancing it and everything.
20 I can -- can tell you that most of the
21 eleven did have activities that directly aligned
22 to the strategies in the logic model. They did
23 have the opportunity to design their own
24 strategy. That was something we did not
25 prescribe that they must use our three

1 strategies. They were able to create a strategy
2 for -- of their own without using ours. But most
3 did align their work to the strategies that we
4 outlined in the NOFO in looking at the outcomes.
5 We did try to write it in such a way that
6 they would be successful in three years. Keep in
7 mind because this is a very short turnaround, we
8 did not write it with -- many of our states have
9 been doing this for years. So they're more
10 established. These being community-based
11 organizations, many have not worked with the
12 federal government. So we wrote it in such a way
13 that they would be able to see success in 12
14 months or 36 months, but they would be able to
15 see success.
16 And in the future if we continued this
17 project, they would be able to build upon that
18 and everything. So we do expect in 12 months to
19 be able to move forward and actually see some of
20 the great work they're doing.
21 **DR. ALLWOOD:** Yeah. And I want to share
22 something more that I think is really relevant
23 and germane, you know, within the context of
24 making grants for community organizations. So
25 this also came up yesterday. You know, they --

1 the typical process for applying for, you know,
2 CDC funds is pretty complex and time-consuming
3 and difficult. And that was one of the things
4 that we intentionally cited that we would change
5 with this funding opportunity.
6 You know, this grant program, with -- you
7 know, with the help of HHS, was written in a way
8 to make sure it's easily readable and digestible
9 and that there was a significant reduction in
10 that -- in the amount of information applicants
11 needed to put forward. That was something that
12 was deliberate to make sure that, you know -- the
13 whole part -- the part of making grants work,
14 that includes making the application easy, you
15 know, it was also taken into consideration.
16 **MR. AMMON:** Any other -- oh, Erika.
17 **DR. MARQUEZ:** I want to say first, I think,
18 commend that you thought about making the
19 application more equitable for community-based
20 organizations to apply is such an important
21 aspect because I realized that as I worked with
22 community-based organizations the skill sets are
23 varied but the passion and the commitment to do
24 the work is there. And they have a whole set of
25 skills -- skill sets that complement what we need

1 to get accomplished.
2 I guess my question, though, is for those
3 that got funded, is there part of their work --
4 how does that collaborate with existing HUD
5 programs that are functioning in these
6 communities?
7 **MS. JACKSON:** Thank you. Good question.
8 That was one of the requirements to apply for the
9 funding, that you talk about you partners and
10 your supports within the community who would help
11 you to implement your work, your point exactly.
12 Many of these organizations, they do the work but
13 they may not necessarily be as large as some of
14 our local health departments or our state
15 agencies or other entities who receive a larger
16 dollar support.
17 So that was one of the requirements, that
18 you work closely with partners in your community.
19 That was from medical providers, that can be a
20 local doctor. That was from your school board,
21 that was from your local health department, that
22 could've been from a HUD, a housing authority
23 within the community, those entities and
24 organizations in the community who, number one,
25 serve our target population in our children.

1 Number one, currently do the work. Number one,
2 advocate for this kind of work. So work with
3 those entities who live and work in the
4 community. So that was one of the requirements
5 for it. Thank you.
6 Oh, yes, Paul just reminded me. Also -- we
7 also are going to have an annual recipient
8 meeting. This was our CLPPP which is normally --
9 has historically been for our childhood lead
10 poisoning prevention recipients. We have 62 plus
11 Flint on the registry at Michigan State. We
12 always invite them.
13 We are also inviting these 11 local
14 organizations to this CLPPP and our recipient
15 meeting, December 4th through the 7th, here in
16 Atlanta, on the Roybal Campus. There is also
17 webinar access for those who cannot come in
18 person. But one of the requirements was and is
19 for those eleven to come to Atlanta locally to
20 network and particularly with local health
21 departments, state agencies, who work already in
22 their communities, who live in their communities.
23 So that will be one opportunity for them to
24 definitely network. It will also be an
25 opportunity for them to meet our other partners

1 who do this work in the community as well. So
2 that will definitely be an opportunity for them
3 to network if they don't already have that
4 connection, just start establishing that
5 connection.
6 **DR. ALLWOOD:** Also you say you heard from
7 Quanza Brooks about our Lead-Free Communities
8 Initiative and some of the resources that, you
9 know, we're developing there, including the
10 toolkit and the National Leadership Academy and
11 also building the coalition.
12 So the 11 grantees in community-based
13 organizations are hoping to be, you know, offered
14 opportunities to use those resources as well. So
15 part of the annual meeting will be devoting time
16 to meet with just them, just the eleven, you
17 know, to properly kind of, you know, engage with
18 them and figure out -- not in a way, you know,
19 writing a prescription before we find out what
20 the ailment is. We're hoping -- we'd like to sit
21 on -- you know, have discussions with them, offer
22 them resources that we are adding to our
23 (indiscernible) and then give them option to opt
24 in or opt out, you know, based upon what they
25 see, that it's all -- you know, so things like

1 the toolkit that we discussed yesterday and the
2 leadership training from the National Leadership
3 Academy.
4 **DR. RUCKART:** Excuse me. I want to make an
5 announcement. I've just been informed we're
6 going to have a fire drill here in the building
7 in a few minutes. And when that happens,
8 everyone in the room will exit through this door.
9 We'll go outside to our designated area.
10 So I don't know how long that fire drill's
11 going to last. So everyone online, just please
12 stand by. So we can keep going until the alarm
13 goes off which will be momentarily.
14 **MR. AMMON:** This is a drill, right?
15 Oh, yes, Grace.
16 **MS. ROBIOU:** I'm going to try to get this in
17 before the fire drill. TCTACs were mentioned
18 yesterday. That acronym was used, remember,
19 Matt? And I'm not sure that it was in reference
20 to this, but I did want to make sure that people
21 knew. And I think you made a comment in your
22 opening about this too.
23 I want to make sure for the record and for
24 awareness that EPA has selected 16 Environmental
25 Justice Thriving Community Technical Assistance

1 Centers -- the acronym for that
2 (indiscernible) TCTACs -- in partnership with the
3 Department of Energy. And those sixteen are
4 receiving a hundred and seventy-seven million
5 dollars to help underserved and overburdened
6 communities and to apply for federal grants.
7 So I want to -- the connection is that -- to
8 the point about helping community-based
9 organizations that are perhaps not used to the
10 federal grant requirements. These TCTACs are
11 providing training: capacity building for
12 navigating the federal grant application systems,
13 writing strong grant proposals, and effectively
14 managing grant funding.
15 So it's not -- I mean, it's -- it's funded
16 by EPA but I think that it benefits the entire
17 federal family. I just want to make that point
18 because this is kind of a novel approach and
19 it's -- it was intended to be a little bit of the
20 architecture, I'll call it, for -- before all of
21 that Inflation Reduction Act funding is going to
22 communities.
23 So in case we want to coordinate, as was
24 suggested previously, on kind of how the
25 different federal grants are layering on top of

1 each other and which communities are leveraging
2 what, I think we might want to look at that as an
3 important feature.
4 **MR. AMMON:** Thank you for that. Any -- I'm
5 about to launch into a serious discussion on
6 behalf of HUD. So I want to make sure everyone
7 gets an opportunity to talk first. I was going
8 to ask Grace anyway to do it.
9 **MS. BARNHILL-PROCTOR:** Hi, Matt. This is
10 Tammy Proctor. I have a question. We're hearing
11 a lot of great information, lot of great
12 resources and efforts to reach out to
13 communities. Have we thought about what the
14 communication plans -- are there communication
15 plans attached to some of these efforts? Because
16 a lot of times we find that, you know, federal
17 agencies were offering a lot of things, were
18 offering a lot of things, but the word is not
19 reaching those communities that we really want to
20 touch. And so if they don't know about it and
21 they don't seek it -- and so if -- one of the
22 messages that we're putting out to get
23 communities to recognize that, first, lead is
24 real, it's important, it's impacts our
25 communities and our children; and, two, that

1 there are resources out there to help support
2 communities around us.
3 So as I was thinking across the two days, I
4 was thinking about we have a lot of stuff going
5 on, but what's the communication strategy that
6 we're reaching -- we're putting out to folks to
7 say, hey, this is real?
8 **DR. ALLWOOD:** Yeah, Tammy, that's a really
9 important question. And, you know, while, you
10 know, we can share that -- you know, we feel
11 reasonably successful in our outreach efforts
12 with respect to this new grant program.
13 Something that was a concern to us also,
14 whether you reach the communities that are
15 hardest to reach and in which are all -- you
16 know, almost always the ones that are, you know,
17 at greatest risk for the hazard.
18 So I know Wilma mentioned that we did
19 outreach to WIC. You know, we also reached out
20 to our policy and partnerships office, to
21 organizations that we thought would be most
22 eligible and would be most likely to apply, and
23 then we followed, you know, the sort of required
24 announcement protocols that all of our federal
25 agencies -- but, you know, we did our best to try

1 to supplement the more formal channels with, you
2 know, kind of specific notifications. And, you
3 know, engagement with organizations that we
4 thought would be important to help us get the
5 message out.
6 But I think I'd be -- I'd be less than fully
7 honest if I said that, you know, even with that
8 amount of effort, I feel like we've done all that
9 we need to do. You know, and it is a -- and this
10 is a tough nut to crack. And I've had a long
11 career -- new to CDC but not new to government.
12 And we've all -- we've all kind of found that is
13 a challenge. People who often are -- are -- you
14 know, face the worst environmental hazards, you
15 know, have the worst outcomes. Or, you know,
16 sometimes the ones that are, you know, least
17 aware of, you know, the hazards that they face
18 and the opportunities that they have to, you
19 know, kind of seek their own health
20 (indiscernible).
21 So I'll let Wilma say a little bit more
22 about our outreach, but I'd be really interested
23 to hear from others, you know, of the LEPAC about
24 ways that your organizations handle -- they've
25 always done a terrific job. So I'd love to hear

1 from (indiscernible) at some point.
2 **MS. JACKSON:** Thank you, Paul.
3 And thank you, Tammy. That was an excellent
4 question. And I'll tell you a little -- I can
5 echo what Paul said that we have done for this
6 NOFO but also tell you what HH --
7 **DR. RUCKART:** Excuse me, we're getting the
8 fire alarm sound right now. So we will be back.
9 Please stay tuned.
10 Everyone, please take your badge, all the
11 visitors. It will be needed to get back into the
12 building.
13 (Off the record)
14 **MR. AMMON:** Mary Beth, I think -- there you
15 are. I see you. And are you on, ready to
16 present?
17 **MS. HANCE:** I sure am.
18 **MR. AMMON:** Okay, great. We're just loading
19 up the --
20 **MS. HANCE:** You all are going to air my
21 slides and advance them for me?
22 **MR. AMMON:** Yes. Yes, they are here. We
23 are seeing them now.
24 **MS. HANCE:** Okay. Ready to --
25 **MR. AMMON:** All right. And with that, we'll

1 turn it over to you. Thank you.

2 **MS. HANCE:** Great. Thank you so much. So

3 this is -- go ahead to the next slide.

4 I will say this is probably going to be a

5 fairly basic presentation for most of you all,

6 but I wanted to remind everyone what Medicaid

7 policies are and, you know, emphasize where we're

8 coming from, and, you know, kind of lay a

9 foundation for what we're doing here.

10 Also want to appreciate being included in

11 this meeting. This was -- it was really

12 interesting yesterday and I really appreciate the

13 opportunity to be part of the LEPAC. So thank

14 you.

15 So there's three things that hopefully this

16 presentation will focus on. One is a reminder

17 and an emphasis on the Medicaid and Children's

18 Health Insurance Program which is also, you know,

19 commonly referred to as CHIP as the blood lead

20 screening -- the blood lead screening

21 requirements highlight actions that state health

22 plans and other stakeholders can take to improve

23 blood lead screening rates, focusing on both

24 managed-care and fee-for-service and also

25 encourage coordination between Medicaid CHIP and

1 public health agencies to improve blood lead
2 screening rates. Next slide, please.
3 Thank you. So just a reminder and kind of a
4 baseline that all children enrolled in Medicaid,
5 which is title -- both Title 19 which is --
6 Medicaid is Title 19 under the Social Security
7 Act and Title 21 which is CHIP. And the
8 Children's Health Insurance Program states have
9 two options, one of which is to do a Medicaid
10 expansion. So if you're in a Medicaid expansion
11 Children's Health Insurance Program, you
12 basically are in Medicaid. So this is covering
13 both Title 19 and Title 21. All these children
14 are required to receive blood lead screening
15 tests at age 12 months and 24 months. So it's a
16 universal screening requirement.
17 This was established in 1993 as the result
18 of a settlement agreement in *Lois Thompson and*
19 *People United for a Better Oakland et al versus.*
20 *Burton Raiford and the United States of America*
21 court case. So -- and any child between the age
22 of 24 and 72 months with no record of a previous
23 blood lead screening test must receive them.
24 This is kind of the catch up.
25 Completion of a risk assessment

1 questionnaire does not meet the Medicaid
2 requirements. We say this all the time because
3 we had heard from our provider partners that
4 there was some confusion in the provider
5 community around us. So we are continuing to
6 emphasize that that does not meet the screening
7 requirement. It's actually a blood lead
8 screening test. Also it is not necessary to
9 refer a child to a separate laboratory facility
10 for blood lead screening test as you all know.
11 Next slide, please.
12 So we did establish a targeted lead
13 screening policy in 2012 which basically allowed
14 states who could demonstrate through data that
15 the risk of exposure to lead was concentrated in
16 a certain area of the state. So -- and we worked
17 with CDC way back when we first established this.
18 And we did have -- one state, Arizona, did come
19 in with a proposal which we worked with them and
20 we got it to a point where it was approvable.
21 Since then they have actually stepped back and do
22 not -- do not implement their targeted lead
23 screening policies. So at this point, there are
24 no states that have -- that are implementing this
25 policy nor have we received anything recently.

1 Next slide, please.
2 So reporting a blood lead screening test.
3 As you all know, state health departments collect
4 state lead screening surveillance data in order
5 to ensure that the surveillance data is accurate.
6 The results of all blood lead screening tests
7 should be reported to state health departments,
8 not just positive lead test results. We have
9 added this in kind of our general talking points,
10 again, because of what we were hearing from
11 providers that -- and from our interaction with
12 some states that -- that not all of the test
13 results were being forwarded which, of course,
14 skew the results. So this is a just kind of a
15 standard reminder that we use that all blood lead
16 screening test results should be forwarded.
17 State Medicaid agencies are encouraged to
18 work with state health departments to ensure that
19 there is clear guidance to providers regarding
20 state data and reporting requirements. In
21 addition state health departments and Medicaid
22 agencies are encouraged to coordinate data
23 sharing of lead screening data in order to better
24 identify whether children in Medicaid have
25 received blood lead screen tests. Next slide,

1 please.

2 The Medicaid data reporting. We have a

3 couple different sources of Medicaid data. The

4 first is states have to annually report to us on

5 a number of different screens that are required

6 services for children in Medicaid. And one of

7 these screens is the number of children who have

8 received blood lead screening tests. And

9 actually I -- let me step back. It's the number

10 of blood lead screening tests that are

11 administered. It is not a per capita test -- or

12 data line.

13 As you can see from the second bullet, it

14 captures all of the blood lead screening tests

15 paid for by Medicaid for children continuously

16 enrolled for at least 90 days regardless of the

17 delivery system. States are to report screens

18 paid for through fee-for-service, managed-care,

19 you know, any mechanism for children enrolled in

20 Medicaid.

21 In 2020, the data showed that 43 percent of

22 children, ages one to two -- so we're -- you

23 know, we're matching this with the children where

24 the testing is mandatory -- enrolled in Medicaid

25 receive blood lead screening tests. This was a

1 decrease from 48 percent in fiscal year 2019. Of
2 course that isn't surprising, given the impact of
3 the COVID public health emergency.
4 We're still looking carefully at our data.
5 Similar to what was shown yesterday as a result
6 of the point-of-service test, our data is showing
7 things that are similar. We were showing an
8 increase for '21 and then a drop for '22 and
9 we're still doing a little bit of analysis and
10 we're actually collecting the next year's data.
11 So we want to do a little more digging before we
12 discuss kind of where we are with real data.
13 The other thing I just want to mention is we
14 are concerned -- or I guess not concerned. A
15 drawback of our data is that what we have is just
16 what Medicaid pays for. We have -- through the
17 416 and also through claims data that states
18 submit to us, we only have access to blood lead
19 screening tests that are paid for by Medicaid.
20 We strongly suspect that there are children in
21 Medicaid who are receiving blood lead screening
22 tests for -- that are paid for by other sources.
23 And so that's an area where we're working with
24 states and encouraging states to do data matches
25 and, you know, states can submit data to us for

1 data -- that includes a data match as part of our
2 data collection.
3 The other thing I would like to add is that
4 we have filed for a set of quality measures
5 that -- and the workgroup that recommends
6 measures to be added to that core set last year
7 recommended that the HEDIS blood lead screening
8 test measure is added. So for the '23 course
9 set, which coincidently state Medicaid agencies
10 are reporting on now, that will include the blood
11 lead screening measure.
12 Again, we're encouraging states to consider
13 working with their other state colleagues outside
14 of the Medicaid program to collect additional
15 data to better capture the number of -- you know,
16 more accurately depict the number of children
17 enrolled in Medicaid who are getting blood lead
18 screening tests and not just rely on tests that
19 were paid for by Medicaid. Next slide, please.
20 So the CHIP program, the Children's Health
21 Insurance Program also has a screening
22 requirement. Blood lead screening tests for
23 children in separate -- in separate CHIP programs
24 should be conducted according to the periodicity
25 schedule selected by the state. The Bright

1 Futures, which is the most commonly used
2 periodicity schedule, recommends blood lead
3 screening tests at 12 months and 24 months for
4 children at risk or in high prevalence areas.
5 So children who are in separate CHIPs who
6 have not adopted the EPSDT do not have the
7 universal screening requirement that children in
8 Medicaid does. States that offer EPSDT benefits
9 for children, again, like I said, follow
10 Medicaid's universal screening policy. And we
11 really do encourage states to align their
12 Medicaid and CHIP policies. Next slide, please.
13 So just to highlight that there were -- that
14 there has been some Office of Inspector General
15 interest in this area and they in the past couple
16 years have issued two reports. The first looked
17 at the number of children receiving -- enrolled
18 in Medicaid receiving blood lead screening tests
19 in five states and then the second was looking at
20 the follow-up for children who had an elevated
21 blood lead level in those five states.
22 So they've made a number of recommendations
23 which we are working on addressing and have been
24 working with CDC on this as well as have started
25 conversations with the American Academy of

1 Pediatrics. Next slide, please.

2 So we have highlighted historically a number

3 of state actions that state Medicaid programs

4 could undertake to improve blood lead screening

5 rates and these are not, you know -- I mean, of

6 course, we suggest they use them in this space.

7 They are not unique or targeted to blood lead

8 screenings, but we have repeatedly reminded

9 states that there are things that they can do.

10 And these are kind of the areas that we have

11 focused on.

12 So the first thing is to understand where

13 your state stands, to look at data and to review

14 the lead screening data which I mentioned before

15 which is from the 416, which is the annual

16 mandatory reporting, as well as T-MSIS which is

17 the data system where states submit their claims

18 data. And, of course, in the next year, we'll

19 also have the quality measure data as well.

20 We've also encouraged states to review

21 language explaining blood lead screening

22 requirements and to make sure that it's

23 consistent in all coverage materials, manuals,

24 periodicity schedules, and websites. We strongly

25 encourage our Medicaid agency partners to

1 interact with other state agencies, particularly
2 state health departments, lead poisoning
3 prevention programs, WIC programs. You know, we
4 will encourage states' Medicaid agencies to reach
5 out to these state partners and to develop
6 relationships with them.
7 Also to leverage partners, you know, in
8 general, leverage arrangements of pediatric
9 providers, local AAP chapters, local health
10 clinics, FQHCs. In the Medicare phase, which
11 I'll talk about in just a minute, there are
12 requirements for performance improvement
13 projects. And states have a lot of flexibility
14 in the topics that they can choose for these
15 performance improvement projects. And we've
16 suggested the mechanism that states could use to
17 track blood lead screening rates and to look for
18 improvement.
19 We've also suggested that states include
20 pilot lead screening improvements of the quality
21 metric for managed-care plans under their QAPI
22 and managed-care quality strategies. So next
23 slide, please.
24 So here are some additional actions that can
25 be used. Through the Children's Health Insurance

1 Program, there are health services initiatives
2 that are available. And a number of states have
3 used those. So that is a real lever that can be
4 used. And as I mentioned, in managed care there
5 are a number of different levers. There's the
6 PIP that I just mentioned. There's
7 pay-for-performance. There's state directed
8 payments. And there's also fee-for-service
9 payment incentives. Next slide.
10 So what is a health service initiative which
11 I just mentioned a minute ago relating to the
12 Children's Health Insurance Program? So this is
13 a state designed program for improving the health
14 of children, including targeted low-income
15 children and other low-income children. It must
16 directly improve the health of low-income
17 children but may service children regardless of
18 income. So it's not limited to children enrolled
19 in the Children's Health Insurance Program or
20 Medicaid. It is considered an administrative
21 expense. So this is coming out of the Children's
22 Health Insurance Program. There is a 10 percent
23 cap of administrative expense. And if a state
24 has flexibility in this cap, they can pursue
25 these health service initiatives of which one

1 could be worked in lead screening space.
2 So lead prevention HSIs can include an
3 impetus to increase blood lead screening rates
4 such as coordination with public health
5 departments regarding outreach and education and
6 lead abatement.
7 And just to bring this back to yesterday's
8 conversation, this is an area where if a state is
9 interested in leveraging outreach, you know,
10 there's a number of different places but this
11 could be a place where there could be a mechanism
12 to leverage outreach and to leverage some dollars
13 if a state has room in their cap to coordinate
14 with the state health department or other
15 agencies around outreach. Next slide, please.
16 So a number of states have used the Health
17 Services Initiative to address lead abatement
18 because Medicaid does not cover lead abatement.
19 So this highlights how an HSI can provide
20 coordinated and targeted lead abatement services.
21 There are currently six states who have approved
22 HSI SPAs to provide lead abatement services.
23 Next slide, please.
24 So getting into levers that exist in our
25 different -- in our managed care program. So

1 states and managed-care plans can design and
2 implement incentive payments to encourage plans
3 to consider specific lead screening initiatives,
4 to increase screening rates, and report the
5 Medicaid HEDIS measure.
6 So these -- this has to happen at the state
7 or the plan level. This can't be, you know -- is
8 not part of what CMS can require. But there is
9 flexibility to do this at the state or plan
10 level. In addition states can create a
11 pay-for-performance incentive arrangement. This
12 would include setting performance-based targets
13 or thresholds for Medicaid managed-care plans
14 based on specific blood lead screening targets.
15 So states -- we encourage states who are
16 interested in any of these to meet with their
17 managed-care plans to develop and implement
18 performance-based arrangements specifically
19 designed to improve blood lead screening rates.
20 And, of course, we here at CMS are available to
21 help provide additional information to states who
22 are interested in using any of these different
23 levers that we've just talked about. Next slide
24 please.
25 So another managed-care payment lever are

1 state directed payments. We have over 70 percent
2 of Medicaid beneficiaries enrolled in
3 comprehensive managed care, and states and
4 managed-care plans can work together to implement
5 contracts and payment strategies designed to
6 improve blood lead screening rates. Federal
7 match is available for state Medicaid programs.
8 For payment rates and methodology, it's designed
9 or modified to incentivize payment providers to
10 improve blood lead screening rates and design
11 payment arrangements to better support blood
12 screening initiatives.
13 So this could include incentives with bonus
14 payments and performance targets to reach set
15 blood lead screening targets. And there are
16 different levers that can be used. So again, you
17 know, if -- states have a lot of flexibility in
18 their managed-care program, and we encourage
19 state -- these agencies to think about this and
20 to engage in conversations with their
21 managed-care plans. Next slide, please.
22 Slide, please.
23 **MS. KHAN:** I moved it. Is it not showing it
24 seems? States that provide coverage --
25 **MS. HANCE:** I'm not seeing it. I'm not

1 seeing it. Maybe I'm having a delay.

2 **UNIDENTIFIED SPEAKER:** We see it here in the

3 room. It moved.

4 **MS. KHAN:** Okay. Is it still not showing

5 for you, Mary Beth?

6 **MS. HANCE:** There we go. I got it. I got

7 it. Yep. Sorry, I was pulling up my own.

8 So skipping the fee-for-service, you know,

9 there aren't as many children enrolled in

10 Medicaid pay-for-service anymore, but there are

11 still levers that exist.

12 So states that provide coverage through

13 fee-for-service have some more flexibilities

14 within the Medicaid state plan. States can

15 establish value-based payment arrangements that

16 improve quality and access to care. Such

17 arrangements can pay providers enhanced rates or

18 supplemental payments to support better access to

19 lead screening, including participating in

20 targeted lead screening programs, data reporting,

21 improved screening rates, and associated health

22 outcomes. Next slide.

23 So our next steps. So we continue to work

24 with partners in this area. We have been working

25 with CDC on a number of these different issues.

1 We also -- and we have had a series of -- or I
2 guess series is a little strong. We've had a few
3 conversations where we've addressed these
4 different issues with states and we've included
5 CDC on the call and this may be familiar to -- to
6 states that are listening today. And we
7 definitely will do this again to just remind
8 states of the Medicaid requirements, different
9 mechanisms that exist to improve them as well as
10 ways that states can work together.
11 We're in the process of updating our
12 guidance that we issued in 2016. And we also
13 have a Connecting Kids to Coverage campaign which
14 is really using stakeholders in the community to
15 amplify messaging. And we have used them
16 repeatedly to emphasize, to remind both Medicaid
17 and CHIP beneficiaries and their families of the
18 lead screening requirements but also to just
19 amplify the importance of blood lead screening
20 tests and to remind them of the Medicaid
21 requirements. And we will continue to do this.
22 And this is another place where I was thinking
23 yesterday that we could think about amplifying a
24 message that if there are places where CMS can
25 play a role.

1 As I highlighted earlier, we also recommend
2 states continue to take -- to undertake efforts
3 in this space. You know, the first thing, of
4 course, they can do is to look at their lead
5 screening data. They can also ensure that their
6 materials are all consistent and consider
7 coordinated efforts with stakeholders, and
8 consider initiative highlights highlighted -- to
9 be highlighted, including HSIs, using different
10 levers in both managed care and fee-for-service.
11 And, of course, CMS is available as needed. So
12 thank you very much.
13 **MR. AMMON:** Thank you, Mary Beth. All
14 right. Let's start out with questions for Mary
15 Beth. Perri.
16 **DR. RUCKART:** Would you mind if we just have
17 our next presenter which is also on the same
18 topic and then do questions?
19 **MR. AMMON:** Not a problem.
20 **DR. RUCKART:** Okay, thank you.
21 **DR. WILLIAMS:** Thank you, Mary Beth, for a
22 very informative presentation. Thank you for
23 this opportunity to speak with you today about
24 CDC's Childhood Lead Poisoning Prevention Program
25 CORE Goal project.

1 I'm Dr. Trina Williams of the Lead Poisoning
2 Prevention Surveillance Branch at CDC. So now
3 we're going to go forward to take a look at the
4 CDC's CORE health equity goal which is increasing
5 blood lead testing in children enrolled in
6 Medicaid. Next slide, please.
7 In a -- as a response to the inequities with
8 the COVID-19 pandemic, CDC developed an
9 agency-wide CORE strategy, forward first, to the
10 four main organizing components of the CDC health
11 equity strategy.
12 The "C" is to cultivate comprehensive health
13 equity science and to ensure that our data, our
14 evaluation, our surveillance, and our research
15 includes health equity.
16 The "O" is to optimize interventions and is
17 to ensure that those specific populations with
18 high risk and/or were historically underserved
19 are included in our promising practices.
20 The "R" refers to reinforce and expand.
21 Robust partnerships are essential.
22 Our "E" is to enhance capacity and workforce
23 engagements so that we could cultivate a
24 multidisciplinary workforce and include climates,
25 policies, and practices for broader public health

1 impact.

2 Across all of the CDC division, there have

3 been a hundred and fifty CORE commitments. As

4 part of the DEHSP division CORE commitments, we

5 are concentrating on the "O" of CORE today which

6 is optimizing those interventions and

7 interventions for health equity.

8 Therefore in 2024, the goal by DEHSP will

9 increase the blood lead testing rates up to

10 50 percent for children ages zero to three years

11 in -- who are Medicaid eligible. Next slide,

12 please.

13 Our CORE goal milestones collect baseline

14 data from select Child Lead Poisoning Prevention

15 Programs, our CLPPP recipients, who are

16 implementing blood lead level testing

17 interventions and strategies. We have 62

18 recipients as of now and also Flint, Michigan.

19 Also another CORE goal milestone is to

20 engage and educate local communities on the best

21 practices for increasing blood lead testing among

22 children who are Medicaid enrolled, based on

23 evaluation findings. Next slide, please.

24 When we look at our summary of recipient

25 strategies, there are 9 recipients that reported

1 39 strategies. Our wonderful nine are
2 California, Indiana, Maine, Michigan, Ohio,
3 Oregon, West Virginia, Wisconsin, and Washington
4 D.C. And they reported 39 strategies are being
5 pursued to increase blood lead testing among
6 children enrolled in Medicaid.
7 Our strategies cover a broad range of areas
8 that include education and training of healthcare
9 providers, targeted outreach, expanding
10 partnerships -- partnerships again -- to increase
11 capacity and resources for blood lead testing.
12 Next slide, please.
13 The first strategy, education and training
14 of healthcare providers, these are some key
15 examples that the 9 recipients shared: live
16 educational webinars to managed healthcare plans;
17 physician engagement through e-mails, events,
18 meetings; they focused studies with Medicaid
19 health plans; and education and training and
20 materials to pediatricians, family physicians,
21 community health workers and on and on and
22 provide report cards. As well as some of them
23 call them scorecards as well. Next slide,
24 please.
25 Another key strategy is ongoing education

1 and outreach, but targeted outreach. And so some
2 of them have implemented plans known as the PDSA
3 model where they actually plan the intervention.
4 They do the intervention, they study it, and then
5 they act upon it. And they're piloting these
6 targeted interventions in high-risk ZIP Codes.
7 And then there's outreach and education to
8 Medicaid enrolled children that's also happening
9 in the targeted counties. Next slide, please.
10 Another example of the strategies that the
11 nine recipients were sharing with us is expanding
12 partnerships to increase capacity and resources
13 for blood lead testing.
14 Partnerships are very key. We've already
15 had some meetings with Mary Beth.
16 Thank you, Mary Beth.
17 We also have an upcoming meeting that's
18 happening November 30th with our community of
19 practice that I'll be announcing a little bit
20 later.
21 Another key partner is the Special
22 Supplemental Nutrition Program for Women,
23 Infants, and Children. Our WIC programs, our
24 recipients are working with the big programs
25 within their states. They're also doing

1 presentations and are highlighted on the websites
2 and (indiscernible) are being sent out amongst
3 the American Academy of Pediatrics database.
4 They also have a national committee for quality
5 assurance; also some key partners and
6 managed-care organizations, which Mary Beth had
7 mentioned; community-based organizations, which
8 is very important in tying in all of the
9 different elements that we mentioned about the
10 branch with our new community-based partnership
11 grants with the eleven that are coming forward;
12 additional housing authority, making sure HUD is
13 at the table. These partnerships are essential.
14 Next slide, please.
15 Therefore in order to expand on the
16 partnerships we created through those nine
17 recipients, something known as the community of
18 practice. And a community of practice is a group
19 of people who share a common interest, common
20 concern, and a problem in a specific domain and
21 collaborating to learn from and improve their
22 actual practices. They work together as a team.
23 Next slide, please.
24 And together they build a culture that
25 fosters relationship, fosters trust, fosters

1 respect across the participants. Overall
2 benefits of the community-to-practice approach
3 is -- examples are contributing to the design and
4 implementation of the CDC's Child Lead Poisoning
5 Prevention, CLPPP, and CORE goal project;
6 recruiting and co-creating with our key
7 partners -- such as CMS, Medicaid, WIC -- using
8 data to continuously learn, adapt and improve;
9 cultivate leaders with unique CLPPP leadership
10 skills; and focus on key elements of the grant
11 that they've been funded to do such as their work
12 plans, their strategies and activities. Next
13 slide, please.
14 The values of community-to-practice concept.
15 One of the historians and authors of this concept
16 is Dr. Wenger. And this is an example. We have
17 some references about getting more information on
18 this concept. It was started in 1998.
19 Communities of practice provide five critical
20 functions.
21 Their education is definitely one because
22 we're collecting and sharing information amongst
23 each other. Support by organizing interactions
24 and collaboration among the members. They are
25 cultivating and assisting groups to start and

1 sustain their learning. They're encouraging one
2 another by promoting the work of all of the
3 members. And you're integrating by encouraging
4 the members to use their new knowledge for real
5 change in their own work setting, which is very
6 essential and important. Next slide, please.
7 Additional benefits of a community of
8 practice is reduced time and costs to achieve key
9 information that we're updating through the CORE
10 goal project. Knowledge sharing and distribution
11 is quicker and efficient. Coordination,
12 standardization, and synergies across all
13 organizational units is very, very important.
14 There's multiple units that's at play.
15 Reduced, reworked and reinvention. Innovation is
16 so important in sharing amongst each other. It
17 is essential learning from one another, lessons
18 learned. And they're creating additional
19 innovative initiatives and alliance-building
20 which is also very important. Next slide.
21 So our next steps: Ongoing evaluation of
22 recipients' strategies, our CORE community of
23 practice strategies. We have recipient quarterly
24 data submissions that we've asked them to submit
25 with our CLPPP surveillance team who's doing a

1 great job in analyzing the information.
2 Participating recipients will provide their
3 lessons learned at the midpoint and the end of
4 the project, and a final report will be
5 distributed by September '24.
6 Now, we're also going to take the lessons
7 learned, take the report, and disseminate success
8 stories that are going to be -- emerge throughout
9 this process, promising practices among the
10 community of practice and other outcomes so that
11 all 62 CLPPP recipients by the end of this project
12 period will benefit from all of the lessons
13 learned. Next slide, please.
14 We're also going to continue collaboration
15 with key partners such as CMS, WIC, and other
16 subject matter experts that will be engaging
17 with, calling on, talking with, learning from,
18 and working with our surveillance team to assess
19 predictors for blood lead testing on children
20 that are in Medicaid using our CMS line level
21 data.
22 They're also going to be utilizing approved
23 data access through the CMS ResDAC which is the
24 Research Data Assistance Center. And then the
25 results will inform program efforts to increase

1 blood lead testing among children who are
2 enrolled in Medicaid. Next slide.
3 As we're about to start the questions, I
4 want us to think about what are additional key
5 stakeholders or essential partners that can be
6 involved in the future community-of-practice
7 meeting. Who needs to be at the table is also
8 what is very, very important. Next slide,
9 please.
10 Acknowledgments. Main thing here at our
11 branch is teamwork. And I happened to put a list
12 together. Everyone achieves more. There's three
13 co-leads for this. I am to serve as one of the
14 co-leads.
15 Our other co-lead is Dr. Ayana Perkins
16 through the Division of Environmental Health
17 Science and Practice. And she's a DEHSP chief
18 health equity officer here at CDC.
19 Another co-lead is Cheryl Cornwell who's
20 with our surveillance team here in the branch.
21 And we also have strong support from our
22 branch leadership such as Dr. Allwood as well as
23 all our team leads are a part of this workgroup,
24 and then our nine CLPPP recipients who are
25 excellent, as I mentioned, and sharing all of

1 their information: California, Indiana, Maine,
2 Michigan, Ohio, Oregon, Washington D.C., West
3 Virginia, Wisconsin. We're very thankful for
4 them and our subject matter experts who are
5 Medicaid and WIC and then this group is going to
6 continue and continue expanding as we move
7 forward in our efforts. Next slide, please.
8 These are our key references: Wenger, which
9 I mentioned early, the Communities of Practice:
10 Learning, Meaning, and Identity. New York:
11 Cambridge is just one of the references as well
12 as Etienne and Beverly Wenger-Trayner also wrote
13 *Introduction to Communities of Practice: A Brief*
14 *Overview of the Concept and Its Issues*, in 2015.
15 And then the CDC's Communities Practice Resource
16 Kit which was created June 13, 2020.
17 So these are additional references that we
18 wanted to share with everybody today. Next
19 slide, please.
20 Thank you all for listening. We greatly
21 appreciate it.
22 **MR. AMMON:** Thank you, Trina, and also thank
23 you, Mary Beth, for your presentations. Before
24 we go to a break, I want some opportunity for
25 people to ask any questions on the two

1 presentations. I'll open it up for the group and
2 online. I knew it. Nathan.
3 **DR. GRABER:** All right. I was trying to
4 give somebody else a chance. You know I always
5 have something to say.
6 This is very terrific. I want to thank all
7 of you for these incredible presentations. And
8 you asked a very specific question which I'll
9 answer. You said, What other stakeholders should
10 be involved? And I'm -- one stakeholder I didn't
11 see anybody mention were the state Medicaid
12 medical directors which is a very active and
13 collaborative network across the county and
14 they're very interested in these projects.
15 And I'm also -- I'm very interested in the
16 data-matching aspects that I think, Mary Beth,
17 you had spoken about and how that matching works,
18 like which direction does it go? Is it from the
19 state lead testing data? The Medicaid data?
20 Both? Like how does it -- it may be too specific
21 of a question for this group but it's something
22 I'd like follow up on.
23 **DR. WILLIAMS:** Absolutely. Cheryl Cornwell
24 is our surveillance lead and one of our co-leads.
25 And her information was previously in the slides.

1 And you can send her an e-mail. I'll give you
2 her information today as well. Thank you.
3 And thank you for sharing about the state
4 Medicaid directors. That's an excellent --
5 excellent recommendation. We will follow up on
6 that. Thank you.
7 **MS. HANCE:** Yeah. And just to piggyback on
8 that, actually the combined presentation that we
9 made -- I think it's been a year and a half or so
10 now -- was actually to our state Medicaid medical
11 directors. And thank you for reminding us
12 because that is definitely -- they're a great
13 group to engage with and, you know -- and they're
14 also looking across the states and have a lot of
15 partners. So that is really helpful.
16 So for our data, you know, since -- there's
17 mandatory reporting for the annual -- you know,
18 what we call the 416, which is the form that
19 captures annual screening. That's done by the
20 Medicaid side. And then, starting in 2024, the
21 lead screening measure that's on the child core
22 set will also become mandatory. Until 2024 that
23 reporting is optional.
24 Given that, you know, our lens has been for
25 the state Medicaid agencies to reach out to the

1 health departments and to work -- you know,
2 knowing that in many cases there's going to have
3 to be a data-sharing agreement in place, but that
4 may vary from state to state. But because of
5 that mandatory reporting, that's where we've been
6 thinking it could be initiated by the state
7 Medicaid agency. But there may be, you know,
8 through the -- through CDC's activities and other
9 efforts where the reverse would also be
10 beneficial.
11 But, you know, the main thing is to start
12 those relationships. And hopefully if you're
13 starting the relationship, data gives you what
14 you need to be able to figure out where we're not
15 reaching kids. And so hopefully just looking at
16 data will naturally evolve as a first step once
17 you establish those relationships.
18 **DR. WILLIAMS:** Absolutely. And also just to
19 add to what Mary Beth is saying, we're ongoingly
20 having this CORE of community-of-practice
21 activities. And November 30th we've invited Mary
22 Beth to sit down. We're going to meet with the
23 nine recipients so we can really talk more and
24 collaborate more together on all the different
25 recommended state actions that require Mary

1 Beth's presentation as well as the -- talk about
2 the surveillance data and different things like
3 that and work collaboratively on these efforts.
4 Thank you all.
5 **MR. AMMON:** Thank you.
6 Anshu, did you want a -- question?
7 **DR. MOHLLAJEE:** No. I was just going to
8 respond back to Nathan, but I think Mary Beth
9 kind of covered it because in California -- it
10 took us a while to get started in order to share
11 the data. So even the data use agreement took
12 several years, to be quite honest, to make our
13 interagency agreement and then our two business
14 use case proposals. And then to get to the
15 nitty-gritty of, you know, getting the enrollment
16 file, taking our data. We don't have a unique
17 identifier. So how are we going to match the
18 information? So there's more that I can talk
19 about and probably will be talking about in the
20 future too.
21 **MR. AMMON:** Thank you.
22 **MS. ROBIOU:** Well --
23 **MR. AMMON:** Grace.
24 **MS. ROBIOU:** Thank you. That was fantastic.
25 I -- I'm learning about -- about the systems in

1 place for blood lead testing. But I recently ran
2 into something that surprised me. I understand
3 that there's no legislative authority that
4 requires or allows WIC funds to be used to
5 conduct blood lead testing, screening. And
6 rather the funds, I guess, are used to -- or WIC
7 funds are used to do testing on eligibility for
8 WIC, which I guess is -- anemia, I guess, is the
9 primary testing done for that.
10 I don't know what people think of that.
11 Like, is that okay that WIC funding cannot be
12 used for lead testing? Or should that be
13 something that the LEPAC or the CDC can look
14 into? It just seems to me that when you've got
15 somebody at the clinic, you know, or at a
16 facility and you -- they are there for whatever
17 service it is that the government is providing,
18 it seems like everything should be made available
19 to them to receive the testing that they -- that
20 they -- that they need.
21 It seems to me that we should be looking at
22 the barriers that exist for doing the things we
23 all believe are right. And if there are any such
24 barriers, identifying them to the people who can
25 make such changes in legislative authority.

1 **DR. WILLIAMS:** Excellent point.

2 **MR. AMMON:** Yep, excellent point.

3 **DR. WILLIAMS:** And just to let you know,
4 previously I also was the program director for
5 the Louisiana CLPPP. And one of the things that
6 we did is we worked extensively with WIC. And
7 through that model that we implemented that you
8 just stated, we were able to test 2,000 children
9 and 75 percent were first-time lead testers at
10 the WIC clinic.

11 So, yes, that is definitely a wonderful idea
12 and something that we'll be working towards
13 addressing. WIC is the next subject matter
14 expert that we have already invited to
15 participate with the community-of-practice
16 quarterly meetings. Thank you, Grace. Yes.

17 **MR. AMMON:** Erika.

18 **DR. MARQUEZ:** I just -- I think I -- I have
19 two questions but I think if you answer the
20 first, it'll help me with the second one.

21 Mary Beth, you mentioned that there is a
22 2024 reporting requirement. Can you clarify what
23 that reporting requirement is?

24 **MS. HANCE:** Sure. So starting in 2024, all
25 of the measures on the Medicaid and CHIP child

1 core set are going to be mandatory for states to
2 report on as well as the behavioral health
3 measures on the adult CORE set. So we recently
4 issued a final rule about that and we're in the
5 process of putting out some additional
6 information for states. But for the past ten --
7 apparently ten years, state reporting on these
8 Medicaid quality measures have been optional.
9 But, you know, due to congressional action
10 in 2024, all of the child core set measures will
11 become mandatory, which includes the lead --
12 the HEDIS lead screening measure which was just
13 added and states are reporting on for the first
14 time for the 2023 reporting.
15 **DR. MARQUEZ:** And then for the CMS 416
16 report, do state -- is that just claims data that
17 they're currently reporting for lead then?
18 **MS. HANCE:** Yes. It's -- well it's claims
19 and managed care combined. But, yes, it is -- it
20 is comprehensive reporting for all children
21 enrolled in Medicaid for at least 90 days
22 throughout a year.
23 **DR. MARQUEZ:** And is that report available
24 publicly? Or do we have to reach out to our
25 Medicaid office to receive that report?

1 **MS. HANCE:** It is, yep. And I'm happy -- I
2 can -- I will -- in just a minute I'll pull it up
3 and I can drop the link. But, yes, we have it.
4 It's reported annually. And we have both
5 national and state data reported on our website.
6 So you have the -- so you have the -- you know,
7 all the historical data as well. So I'll put
8 that link in the chat.
9 **DR. MARQUEZ:** Okay. Thank you.
10 **DR. ALLWOOD:** Thanks, Matt. I'm going to
11 (indiscernible) Wilma.
12 **MS. JACKSON:** Yes, hi. Thank you. This is
13 Wilma again, here at the CDC. And I do not speak
14 for WIC but I do want to tell you that we have
15 been working very closely with them to build a
16 partnership and a relationship.
17 To Grace's point, their funds cannot be used
18 to test, however, what they do do and we have
19 worked on is how do we use them at least to help
20 do a referral? Because the children will go to
21 the WIC clinic, is it possible that you can refer
22 them then to us to be tested?
23 **UNIDENTIFIED SPEAKER:** (indiscernible)
24 **MS. JACKSON:** Exactly. Exactly. So that is
25 one thing we can do.

1 Another innovative way -- and I hope I don't
2 misspeak -- that we, in talking to my WIC
3 colleague, have looked at doing is perhaps some
4 type of cost share whereas WIC dollars cannot be
5 used 100 percent to pay for the testing, but if
6 there's a way by which part of the funding -- we
7 can give a portion of the dollars through our
8 CLPPP funding to the WIC program, to the WIC
9 clinic when their child is there, then they can
10 put a portion of it -- because a lot of it is
11 about administrative fee, who is paying for that
12 particular test and administration of that
13 service?
14 So that is something we're looking at too, a
15 mechanism by which maybe we can cost share. A
16 portion of the dollars will come from the CLPPP
17 portion, a portion of the dollars will come from
18 the WIC program. Because, again, it is about
19 testing a child, like Grace said, because they
20 are already there in the clinic and not doing
21 extra to send them to different places, but
22 utilizing every possible mechanism while we have
23 them there in front of us to reach out and test.
24 **MR. AMMON:** Yes. Follow-up, Erika?
25 **DR. MARQUEZ:** This is Erika. I just want to

1 mention that in our state we got invited by our
2 WIC state office to up -- to update their state
3 plan so that a referral was being made for lead
4 testing. But I can't emphasize the importance of
5 some type of cost sharing. I think it's too soon
6 for us to know if it's made a difference in our
7 lead testing in our Medicaid numbers.
8 But, you know -- I mean, I appreciate they
9 even reached out to us to be able to make that
10 decis -- to move that forward and got our input
11 to do it. But cost sharing can be really
12 important to move things forward.
13 **DR. WILLIAMS:** And also about community of
14 practice, they also have some innovative ideas
15 that the nine recipients are already sharing
16 about working with WIC. And so that would
17 definitely be a very fruitful discussion, lessons
18 learned, and working collaboratively on these
19 assignments is essential as well.
20 All right, thank you all.
21 **MR. AMMON:** All right. With that, why don't
22 we take a ten-minute break until eleven. We're
23 slightly off but we don't have any more formal
24 presentations. It's just us talking. So it will
25 be fine. Thank you.

1 (Break taken)

2 **MR. AMMON:** All right. Thank you very, very

3 much. This is the exciting part of the agenda

4 where I have a list of names in front of me as

5 part of the member updates and also the liaison

6 updates. So I can go down the list here and just

7 say if you have an update or what the update

8 might be. Some also have a presentation.

9 I believe I actually did one. And I'm going

10 to be surprised to see what I provided because

11 I -- I remember I did a couple last week. So

12 this should be pretty fun. But with that, the

13 first person on my list is Wallace.

14 **DR. CHAMBERS:** (indiscernible). I don't

15 really have many updates. I just started with

16 the Cleveland Department of Public Health roughly

17 about seven months ago.

18 For those who are local health departments

19 out there, I would make a strong recommendation.

20 What we've done far as assisting with compliance

21 with lead hazard control orders is we initiated

22 putting affidavits of facts on properties. And

23 what that does is it's when somebody has a lead

24 hazard control order, you go down to the county's

25 recorders office and we place it on the property

1 to let whoever knows who's buying or transfer the
2 property that a lead hazard control order exists. And
3 that helped tremendously in us getting compliance.
4 And another thing we did was in the city of
5 Cleveland we also stepped up our enforcement
6 action and we've been taking a lot of these
7 landlords to court, which is also assisting in
8 compliance. So unfortunately at the health
9 department, we don't give out much money. We're
10 pretty much an enforcement arm. But those are
11 two major things that I would recommend for any
12 CLPPPs out there. Thank you.
13 **MR. AMMON:** Well, let's -- I'm going to bounce. So
14 I really apologize for this, but it's fun. Nathan.
15 **DR. GRABER:** How about in alphabetical
16
17
18 order?
19 **MR. AMMON:** Or else I'd be going first. But
20 now --
21 **DR. GRABER:** Yeah. All right. So, you
22 know, I p ersonallydon't have a lot to report.
23 You know, I sit on this c ommittee as a -- under
24 my academ title. For m y work I have taken on a

25 role with the New York State Department of Health

in the Medicaid program as a pediatric medical
1 director which I think, you know, this meeting
2 has certainly opened up my eyes quite a bit and
3 I'm very excited to head back there and look to
4 see what we currently do and what we can
5 additionally implement.
6 But I think one thing I'd like to talk about
7 as kind of an outsider to this, but -- is that in
8 this here in New York State, that a budget
9 included a requirement for a New York State
10 rental registry and proactive inspection program
11 to identify lead hazards, which is -- it's a
12 program that was designed and developed in
13 Rochester, New York and has been implemented in a
14 number of different jurisdictions.
15 And by allowing the local health departments
16 to target high-risk communities, they will
17 require -- and it's under -- it's in public
18 health law actually, we require them to register
19 their properties and conduct proactive
20 inspections. And those inspections can be done
21 either by the local health department or by
22 contractors for the landlords. And those
23 inspections -- those inspections will take a
24 visual look at the property, looking for lead

1 hazards.

2 If they don't identify any, they're actually

3 going to require them to do dust wipe samples in

4 the home. And -- and if the dust wipe sampling

5 identifies a hazard, it will have to be cleaned

6 and retested. And if the -- if the visual

7 inspection finds hazards, they have to be

8 addressed.

9 And so one other really great thing about

10 this program is that it includes money to provide

11 to the landlords, to the property owners of these

12 rental properties to address those lead hazards.

13 So there'll be funding available to get that done

14 so that it removes a very big barrier for getting

15 a lot of this work done and also getting --

16 allowing accept -- or enabling acceptance of the

17 program among the property-owner community.

18 The other thing that I think is really great

19 is that the state -- it seems like the state

20 health department isn't dictating the programs,

21 you know, in a very fine level to the local

22 health departments. They're giving a lot of

23 control for decision-making as to, you know,

24 which communities to target and how to run their

25 programs at the local level, which I think is a

1 really important aspect of the program.
2 Also because we know in listening to this --
3 these presentations and discussions over the last
4 day and a half is that, you know, it really
5 requires a lot of local consideration to be
6 impactful, whether it's, you know, the lead
7 service line replacements or the proactive foam
8 remediation programs or inspection program, you
9 know, it really requires community buy-in in a
10 very broad level with lots of stakeholders.
11 So I think this is two really important
12 aspects of this program. And so we're excited to
13 see how it rolls out.
14 **MR. AMMON:** That's great. And we are very
15 much a fan of their prerental property
16 inspection. Cleveland, we worked a lot with
17 Cleveland to have them implement as well.
18 So maybe I'll go around the room as a
19 regular order with the members and then I'll go
20 online with the members and then the liaisons.
21 Kristina.
22 **DR. HATLELID:** Thank you. So just to
23 reinforce what I'd said before and what you
24 probably all know about CPSC. We deal with
25 consumer products. We do have a focus on lead in

1 children's products. We have a couple different
2 laws and regs that affect that. We regulate most
3 parts of most children's products at a particular
4 level. But what we do mostly is in enforcement.
5 So we are actively at the ports. We screen
6 tens of thousands of shipments and products every
7 year and including an emphasis on finding lead.
8 And that continues to be one of our big
9 enforcement programs.
10 The other thing is that in the last year or
11 two, we hired a -- I want to get her title
12 right -- diversity risk manager. And that person
13 is in our technical directorates. She's to help
14 us in our teams, in our programs to identify and
15 address safety disparities among vulnerable,
16 diverse, disenfranchised, and disadvantaged
17 communities. Not just for lead but including
18 lead and other chemical hazards. And that's
19 something we're doing agency-wide and in
20 particular it is helping with our technical and
21 our data work.
22 **MR. AMMON:** Thank you.
23 Grace?
24 **MS. ROBIOU:** Are you sure? I --
25 **MR. AMMON:** Are you sure?

1 **MS. ROBIOU:** All right. So I actually sent
2 a PDF to the LEPAC e-mail so that you can all
3 distribute this and so you don't have to take
4 notes, you can just look for my document later.
5 Plus that document has hyperlinks to the relevant
6 webpages so you can access the information.
7 But I'd like to take maybe just five minutes
8 to go through the main things that have happened
9 since the last meeting. So my threshold was
10 December 2022 to this meeting.
11 So I want to start with a few activities
12 from my office specifically. We put out in April
13 a web tool that collects outreach and educational
14 resources in different languages about
15 heavy-metal exposures from cultural products. So
16 this is lead and other metals in cookware, in
17 really just dust and other materials that are
18 used that present a risk to children, but, as we
19 discussed, to adults as well. So that's
20 available and the hyperlink is in the document.
21 Also, I think I mentioned this yesterday,
22 but we asked our Children's Health Protection
23 Advisory Committee, our own FACA, to provide us
24 with recommendations on lead and community
25 engagement. So we'll hear back from them in

1 about eight months.
2 The focus of those questions is on
3 increasing awareness about lead through effective
4 outreach and education, ensuring that EPA uses
5 its various authorities to address the multiple
6 sources of lead holistically. And also there's a
7 component of how to effectively conduct
8 participatory science research.
9 Okay. In the lead paint -- lead-based paint
10 category, we've talked already about the dust --
11 dust lead hazard standards yesterday. But
12 there's also the lead-based paint workshops that
13 are occurring. In fact there was one -- there's
14 one today and another tomorrow. And this is
15 about detection and exposure to potential lead
16 hazards from the existing residential lead-based
17 paint work. So these are mostly about revisiting
18 the federal definition of lead-based paint.
19 I'll skip over to air next. EPA is
20 revisiting it's -- what we call our Integrated
21 Science Assessment for Lead. So this is our --
22 like a massive kind of science-based solutions
23 document about lead, particularly in air. So
24 that document went to our chartered Clean Air
25 Scientific Advisory Committee earlier this year.

1 And I'm here to tell you that we will be
2 releasing the final lead integrative assessment
3 in 2024. We don't have a date for that yet.
4 In the community awareness category, there's
5 a number of community lead awareness sessions
6 that are happening nationally. These are
7 educational sessions in communities especially
8 vulnerable to lead exposure.
9 There's kind of two types. One is
10 understanding lead, like your very basic
11 sessions. And then there's, like, a
12 train-the-trainer for community-based
13 organizations. And that's happening across the
14 country. In fact, I was in New Mexico a month
15 ago and we gave one on tribal, the tribal
16 communities, which was great.
17 In the enforcement and compliance arena, our
18 enforcement people released a toolkit with
19 strategies for developing partnerships,
20 conducting community engagement and maintain
21 ongoing communication with communities where
22 enforcement activities are planned or ongoing.
23 So this is trying to improve how we go about
24 doing enforcement in light of the needs of the
25 community. Again the hyperlink would be in the

1 document.
2 In the water arena, yesterday you heard
3 about the lead service line work. But there's
4 also money that has been given to EPA to beef up
5 the state revolving fund. I think Kira Smith
6 mentioned that. So there's -- that might be
7 actually kind of another area of representation
8 next time, I'm thinking, for the next meeting,
9 what -- what is happening in that area. This is
10 funding to -- for communities to improve their
11 drinking water distribution systems.
12 Let's see. There's mapping work underway at
13 EPA, what they call hotspots mapping for lead.
14 And there's also improvements in lead modeling.
15 There's three models that have been improved
16 with -- and, I guess, in doing this with CDC in
17 some states, state participation, and, I guess,
18 this is related to soil and dust ingestion and
19 respiratory part of the position. So if you're
20 interested in that, I can give you more
21 information.
22 And let's see. I think I'm on the last
23 page. Sorry about that. All right. I did want
24 to -- in reference to the question about soil
25 earlier, I have a partial answer and I'll get you

1 more on the other part, but we are -- back in
2 June we solicited comments in our agency comments
3 on an update to the residential soil lead
4 guidance. This is for superfund sites and what
5 we call RCRA sites. So this is, like, for
6 mediation. So just kind of more extreme
7 circumstances.
8 But that is underway. So I didn't know that
9 when I -- when you asked the question about soil.
10 And then in the mid-Atlantic there was a lead
11 strategy developed among a series of mid-Atlantic
12 states, emphasizing reducing exposures and
13 disparities in communities.
14 The last thing I don't have on a piece of
15 paper -- but I was told that I could mention it
16 verbally -- is that we will be announcing a
17 endangerment finding for avgas. It's coming out
18 tomorrow most likely. So as soon as we have that
19 announcement publicly available, I'll be able to
20 distribute it to the LEPAC tomorrow.
21 I don't know if that was a lot of good
22 information or not, but I'm happy to answer
23 questions.
24 **MR. AMMON:** Thanks, Grace. We'll probably
25 do questions at the end.

1 **MS. ROBIOU:** All right.

2 **MR. AMMON:** Erika?

3 **DR. MARQUEZ:** I'm excited to report that in
4 Nevada we were able to get almost $2 million
5 dollars in ARPA dollars to build capacity across
6 the state. And so within that funding
7 opportunity, we are going to be distributing 25
8 LeadCare IIs into our Medicaid provider offices
9 across the state.

10 And I think what I'm more excited about,
11 even that portion of it, is that we're going to
12 be able to use these dollars to build capacity
13 for our health districts across the state. So
14 currently of the five that exist, only one has
15 the ability to do a lead risk assessment. And so
16 now we'll be working with our rule providers and
17 our other urban centers to try to build that
18 capacity. So that would include training at the
19 health district level. And so we're really
20 excited about moving that work forward over the
21 next year.

22 **MR. AMMON:** Thank you.

23 Anshu?

24 **DR. MOHLLAJEE:** I thought I would continue
25 with the concept of partnerships. And so I want

1 to highlight a couple of things that we've been
2 doing. We've been working with the Department of
3 Social Services who has data about lead found in
4 childcare facilities and working with them about
5 how to get that information out to our local
6 Childhood Lead Poisoning Prevention Programs
7 within California and our health jurisdictions,
8 but then ultimately how to get that information
9 back to families. So that has been an ongoing
10 process to do that.
11 We've also worked with the Department of
12 Healthcare Services who's in charge of Medi-Cal,
13 of making sure finally that their blood lead
14 testing and anticipatory guidance includes the
15 new BLRV value. So that's taken a while, but we
16 finally have that in place.
17 We've also been really working on a whole
18 suite of publications and materials for providers
19 and for families around anticipatory guidance.
20 And so that's been an ongoing effort actually in
21 the work that we've done serving providers.
22 They've said that they haven't had that guidance
23 material or they're unclear of where to find that
24 information, what should they be getting to
25 families, things of that nature.

1 And then also empowering families too, that
2 if you get your blood lead test, how do you, you
3 know, keep that information together. Know when
4 you need to get your follow-up testing, things of
5 that nature.
6 And then I think by telling you what the
7 subject for lead poisoning in California next
8 week, it's about protecting your family from all
9 sources of the lead air pollution, including
10 aircraft and shooting ranges. So we look forward
11 to the endangerment finding tomorrow.
12 **MR. AMMON:** Thank you. Those are all of the
13 members here in the room. So let me go online
14 with teams and Tina.
15 **MS. HANES:** Good morning, everyone. I'm
16 Tina Hanes. I work for the Department of
17 Agriculture Food and Nutrition Service. I am at
18 the national office, which is located in
19 Alexandria, Virginia. My update will be brief
20 but it is related to the blood level screening.
21 Our certification and eligibility branch in
22 November of 2022 sent the updated lead cutoff
23 values for determining lead risk of participants
24 based on the CDC guidance from 2021. And all WIC
25 agencies are required to use these new cutoffs to

1 evaluate risk. They were supposed to do that by
2 October 1st of this -- of -- they're going to be
3 doing that by October 1st of 2024, sorry.
4 The national office is strongly encouraging
5 states to begin using these new cutoff values.
6 And we believe most states are. But we have
7 state plans due in a couple of months and we'll
8 know exactly how many states have revised the
9 cutoff values at that time.
10 And that's all I have. Thank you.
11 **MR. AMMON:** Thank you. Mary Beth?
12 **MS. HANCE:** Sorry I had double-muted myself.
13 So most of my updates were included in the
14 presentation, but just to highlight a couple
15 things. So I put in the chat, which hopefully
16 everyone can see, but I can also follow up with
17 CDC directly. I shared the link to our 416 data
18 as well as to the child CORE sets which includes
19 the 2023 CORE set list as well as a link to our
20 final rule. And the language in the cover page
21 includes the highlight around mandatory reporting
22 beginning in 2024.
23 For our kind of next steps that are
24 underway, we will continue to work with CDC as
25 you heard. We have lots of ways that we're

1 hoping to work together and we will continue to
2 do that and to think of ways that we can amplify
3 our message to different groups that we both work
4 with as well as to engage with AAP.
5 And we also are working to update our 2016
6 state health official letter to -- as that needs
7 to be updated. So those are -- that's kind of
8 more immediate on the horizon for us. Thank you.
9 **MR. AMMON:** Thank you. I want to pause a
10 second here in the rotation. I'm going to hand
11 it over to Perri.
12 **DR. RUCKART:** Mary Beth, thanks for that. I
13 just want to let you know that those of us in the
14 room don't really have access to the chat. We're
15 not seeing the chat. I don't think we'll have
16 access after. So if anybody -- Mary Beth and
17 others -- have put information in the chat that
18 they would like to be shared, please send it to
19 LEPAC@CDC.gov. Thank you.
20 **MS. HANCE:** Great, thanks. I'll do that.
21 Thank you.
22 **MR. AMMON:** Thank you. All right, next up,
23 Tammy.
24 **MS. BARNHILL-PROCTOR:** Hi. I'm from the
25 Department of Education. And we continue to --

1 some of my colleagues sit on committees with EPA.
2 And while we don't have the activities that
3 really target lead, we do continue to put out
4 information that comes from EPA and HHS and CDC
5 in our Ed infrastructure and sustainability news
6 that goes out monthly.
7 We would encourage you guys to continue to
8 share the information because we are committed to
9 informing communities and informing our school
10 communities about the importance of lead
11 screening and prevention and abatement and also
12 as we talk about our environmental sustainability
13 in our school system. So we would encourage you
14 guys to continue to share that information.
15 And as I have been sitting on this meeting
16 for the past two days, I started thinking on how
17 can we intentionally think about engaging some of
18 our stakeholders to hear some of the information
19 and some of the resources that are available for
20 communities. And so I was thinking about our
21 National Association of Elementary School
22 Principals would be a good group to just begin to
23 hear the importance because we know the effects
24 of lead on children oftentimes have some students
25 ending up in our special education programs in

1 our school systems.

2 And so I am just encouraged by the last two

3 days and hoping that as I go back to my

4 colleagues and have an in-depth conversation,

5 I'll be coming back to the committee and sharing

6 some strategies for how we might engage some of

7 our partners at the local level so that we can

8 really be supportive on increasing the screenings

9 for lead. So thanks.

10 **MR. AMMON:** Thank you.

11 Aaron.

12 **DR. LOPATA:** Yeah. Thank you. So, again,

13 I'm from HRSA. I'm specifically from -- within

14 HRSA, Maternal & Child Health Bureau.

15 And I would say that -- first I've learned

16 such a great deal over yesterday and today.

17 So -- and I'm new to the committee, but I've just

18 learned a lot. And I want to bring that back to

19 my colleagues as well at HRSA.

20 In terms of what HRSA's doing, most of what

21 we have been doing -- I kind of noted this

22 yesterday -- has been getting information out to

23 providers. So we have a lot of our programs --

24 well, we have the Health Center Program which is,

25 of course, they have health centers all across

1 the country in underserved areas, as I'm sure all
2 of you know. And then we also have a -- and MCHB
3 have a close -- which is Maternal & Child Health
4 Bureau have a close relationship to the American
5 Academy of Pediatrics and we have access, are
6 able to give -- put out information to
7 pediatricians across the country.
8 And so in terms of activities, I know
9 HRSA-owned health centers and CDC put out a joint
10 letter earlier this year, in January, that went
11 out to all the health centers, physicians, and
12 nurse practitioners and all of the clinical
13 staff, talking about the importance of testing
14 and -- testing as well as screening.
15 And then I know that they also did -- CDC
16 did a presentation for all health center staff,
17 clinical staff across the country last, I think,
18 October or November again providing them with
19 links to information about prevention and
20 screening.
21 So I think that we are definitely good at
22 doing those things, but I'd still like to
23 investigate further about what we can do more in
24 terms of amplifying the messages that we've been
25 talking about the last couple days in terms of

1 testing and screening. And I think where there's
2 opportunities also within the communities, we
3 have place-based programs like home visiting
4 where people, you know, go into people's homes
5 and talk to them. There may be an opportunity
6 there.
7 Our Healthy Start program also does work
8 within the homes but absolutely within the
9 community, across the communities.
10 And also I want to check in with our
11 rural -- Office of Rural Health Policy and see
12 if they're doing anything actively to promote
13 screening and testing in the rural areas as well.
14 So we are doing things. We are definitely
15 getting messages out in partnership with CDC.
16 But I think there's a lot more that we could be
17 doing. And I'd love to go back and figure that
18 out and maybe even be able to present at some
19 point what I find out and help make further
20 connections and partnerships.
21 **MR. AMMON:** Thanks, Aaron. And Rebecca.
22 **DR. FRY:** Hi, everyone. Like Aaron, I'm new
23 to this committee. And I'm learning so much.
24 Apologies that I'm not there in person.
25 I can give you a description of some of what

1 we're working on. So I'm at UNC Chapel Hill in
2 the School of Public Health. I have strong
3 partnerships with our DHHS in North Carolina.
4 But I'll talk about some of the things that we're
5 doing at the school and then can also report back
6 later once I connect up with our partners at the
7 state.
8 Some of the things that we've been working
9 on, you may have heard that UNC was in the news
10 for finding lead on campus. And I was the
11 scientific liaison for the school, helping them
12 to deal with that issue. We've been working on
13 describing how that was identified, total number
14 of lead samples, lead exceedances, but also
15 putting together a list of best practices for
16 universities for thinking about protecting
17 student staff from lead. So that, you know, will
18 be hopefully being submitted soon.
19 I also run our NIEHS-funded superfund
20 research program. And the focus of that program
21 is on -- primarily on private drinking well water
22 as a potential source for chemicals in the
23 environment. That includes lead among other
24 things. So we have several initiatives through
25 that to work with communities who are in North

1 Carolina who are potentially exposed to lead or
2 other toxic metals in their drinking water:
3 provide them with filters, provide them with
4 educational materials.
5 And as others have described, lead exposure
6 is one that touches all communities and in many
7 cases is an area of environmental injustice. So
8 doing much work to try to prevent that.
9 We've developed a tool called EnviroScan
10 which is -- you can get at EnviroScan.org where
11 we can look and overlay lead contamination in the
12 state with other variables, like poverty or
13 access to medical care. And so we're using that
14 tool, again, to promote environmental justice and
15 identify communities where lead might be high but
16 information about lead may not be reaching those
17 communities.
18 We're also working with clinicians, both
19 maternal-fetal medicine and pediatricians to
20 increase awareness of lead. And particularly,
21 working with those clinicians to launch a -- both
22 via monitoring as well as water sampling testing.
23 So, for example, pregnant women who are seen at
24 UNC with partnering physicians can have a water
25 sample that's tested for free. If it comes back

1 high, we provide a tabletop filter for them.
2 And then one of the last initiatives is
3 working with the Home Visiting Program, the
4 MIECHV Program in North Carolina where we're
5 helping them to develop educational materials and
6 questionnaires for the home visits that can
7 increase awareness around, you know, lead
8 exposure, again, as well as other toxic metals
9 that can be present in private drinking well
10 water.
11 I just want to thank everyone for -- well,
12 happy to be part of this committee and have
13 really learned a lot. And so anyway, appreciate
14 that. Thanks so much.
15 **MR. AMMON:** Thank you. And right before we
16 go to our liaison members, I'll give you an
17 update real quickly. This is Matt.
18 Just couple main things. One we awarded --
19 we have -- we were given a new program to run and
20 awarded monies from it. It's called the Green
21 and Resilient Retrofit Program, which does energy
22 efficiency upgrades and climate resiliency
23 upgrades to low-income rental properties. That
24 was one of our biggest ones. We also published
25 in the Federal Register a notice for including

1 radon as part of our environmental review
2 process. The biggest, of course, is that we made
3 a historic amount of money available to
4 communities as well as nonprofits and others. It
5 was $880 million this year in our funding which
6 includes about eight different programs: our lead
7 hazard control programs, our healthy house
8 programs, Healthy Home Capacity Program, our
9 technical studies program, our older adult home
10 modification grant program. We also are doing a
11 demonstration for risk assessments in -- in
12 units. So a whole gamut of that work.
13 And also we published a housing needs
14 assessment. We do this on a regular basis and
15 it's published at huduser.org. And this
16 particular one was on native Hawaii-, native
17 Alaska-, and Pacific Islander-type housing. And
18 we use that a lot in terms of how we think about
19 designing our programs and how also we target.
20 So those are -- the biggest one of course is
21 the funding. We actually still have a second
22 round of funding that is out right now, available
23 for communities. If I can remember this, I think
24 we have the lead hazard control capacity out now.
25 We have Healthy Homes production. We have touch

1 studies. I think those are all due late October.
2 They're still -- there it is. And they did this
3 work -- oh, I can't see.
4 But the one thing, too, just a small note is
5 I'm on objective (indiscernible) for 4-B. This
6 is Strengthen Environmental Justice. This is for
7 their department. So the vast majority of the
8 goals that we have in 4-B are not related to my
9 office at all. So this is a HUD-wide strategic
10 plan and this is just a couple of the
11 accomplishments from a very broad and vast set of
12 milestones and objectives related to
13 environmental justice at HUD.
14 Thank you. So with that, I'm going to turn
15 it over now so we can hear from our liaison
16 members. And I'll start with Patrick.
17 **DR. PARSONS:** Thank you, Matt.
18 Again, I'm the liaison for the Association
19 of Public Health Laboratories. And APHL's been
20 very active with state and local public health
21 labs, helping them to adapt to the new blood lead
22 reference value.
23 I actually serve on the elemental analysis
24 workgroup for APHL. And they conducted a survey
25 of state and local public health labs to get a

1 sense of what strategies are being implemented to
2 adapt to the new blood lead reference value. For
3 example, we have been able to help laboratories
4 adapt by producing a one-pager and moving towards
5 a lower amount of background lead in, you know,
6 what contributes to the blood lead results.
7 So I think I mentioned previously that, you
8 know, it was set at a half microgram per
9 deciliter. That was set in the early 1990s.
10 We think it's feasible to move to .2, and so we
11 are recommending that for laboratories.
12 Other strategies include tightening quality
13 assurance and quality control at the lower level.
14 And the good news is that there is a document
15 that is shortly to be published by the Clinical
16 Laboratory Standards Institute that updates a
17 very detailed language what laboratories need to
18 do. And embedded in there is the new blood lead
19 reference value as the upper limit of the
20 reference interval. So that's, I think, good
21 news.
22 The one thing I didn't get to ask about, you
23 know, was the EPA's proposed lowering of the dust
24 lead clearance levels. And that is going to have
25 an impact on laboratories for the following

1 reasons. When you set something at 3 micrograms
2 per square foot or 5 micrograms per square foot,
3 that is going to be below the limit of detection
4 for flame atomic absorption which is the dominant
5 method used to analyze dust wipes. And so what
6 kind of impact is that going to have? Well, for
7 example, in New York, more than 93 percent of our
8 dust lead, you know, wipe analyses are a form of
9 using atomic absorption. And so that technique
10 could be obsolete overnight and that would force
11 a change to techniques based on ICP optical
12 emission which is a much more expensive test.
13 And we're not sure what capacity exists in
14 accredited laboratories to adjust to that. So --
15 but I was able to, you know, communicate this to
16 Grace, and she's going to take this information
17 back to EPA.
18 One other aspect of the -- you know, the
19 dust lead and wipe analysis is that the wipes
20 themselves have lead in them. Lead is a
21 naturally occurring element. You're going to
22 find it everywhere. And right now the background
23 level of lead in wipes that's considered
24 acceptable is 1 microgram. So that's -- another
25 key aspect of laboratory analysis is what can we

1 get away with in terms of blanks from the
2 materials used to collect dust or the reagents?
3 It all adds up. And so that's another piece of
4 information that we need to communicate to EPA as
5 they consider (indiscernible). So that's, you
6 know, the -- a sum-up from the laboratory
7 perspective.
8 **MR. AMMON:** Thanks, Patrick.
9 And we'll switch to online. I see Lauren
10 Zajac, yep.
11 **DR. ZAJAC:** Hi, everyone. I'm Lauren Zajac,
12 a pediatrician and currently at Mount Sinai in
13 New York City. But I'm the liaison from the
14 American Academy of Pediatrics. And thank you
15 for having me. This has been a great meeting. I
16 echo everyone's previous kudos, learned so much.
17 In terms of AAP, we are in the process of
18 updating both our lead poisoning prevention
19 policy statement and technical report. You know
20 the drafts are in progress, being reviewed by
21 stakeholders. And I don't have a timeline, but
22 those are forthcoming.
23 We're also working on some videos. One is
24 provider facing, about the importance of
25 screening and testing and also interpretation of

1 the new blood lead reference level. We are also
2 working on parent facing videos on lead
3 poisoning.
4 Our Council on Environmental Health and
5 Climate Change, we have our council meeting
6 coming up in a few weeks. And as part of the
7 council, there is a liaison from EPA, from CDC,
8 and we continue to look forward to conversations
9 with our -- with our partners.
10 Yeah, I think that's it. Thank you for the
11 opportunity to be here.
12 **MR. AMMON:** Thank you. Stephanie Yendell.
13 **DR. YENDELL:** Yeah, hi. Good morning. I'm
14 Stephanie Yendell. I work for the Minnesota
15 Department of Health, but I am the liaison for
16 the Council of State and Territorial
17 Epidemiologists.
18 I just wanted to mention that CSTE does have
19 a number of workgroups as well as committees that
20 touch on the issues that are important to folks
21 that are in this room and pertaining to lead.
22 That does include the Environmental Health
23 Committee, the Health Equity Committee.
24 But within Surveillance and Informatics
25 there is both an Electronic Laboratory Reporting

1 workgroup and an Electronic Case Reporting
2 workgroup which are working hard on data
3 standardization across both lead as well as other
4 conditions. You know, it's really a broad base,
5 looking at all conditions and what data elements
6 need to be standardized.
7 So within that, there is a Data
8 Standardization Work Group that is collaborating
9 with CDC on standardizing the core case data
10 elements for all reportable conditions and has
11 been working on a variety of data classes that
12 they are working through what the required
13 elements should be for each of those components.
14 And then I just wanted to mention I'm really
15 excited to hear that there -- the lead HEDIS
16 measure is going -- or has returned and is going
17 to be a required element. One thing just as
18 epidemiologists, we really think about how we
19 break down the data and the HEDIS measure in the
20 past and, you know, looking through the past
21 reporting, lumps together testing for one- and
22 two-year-olds in the reporting.
23 And that's something that we've certainly
24 noticed there is a huge gap in the testing that's
25 provided for one-year-olds versus two-year-olds.

1 And so we really see that providers are a lot
2 more reluctant to test kids that second time at
3 age two if they've already tested them at age one
4 and it was a nondetectable result.
5 So just something to keep in mind as we're
6 talking about analyzing data, looking at data
7 measures trying to improve testing rates, that
8 the way that we subdivide those data does make a
9 very large difference in how the data look and
10 where we need to focus our efforts in improving
11 those testing rates because, of course, that
12 initial blood lead test where a child shows an
13 abnormally high level of lead is often the point
14 of entry into the public health system for those
15 families and access to all of the resources that
16 we've been talking about. So thank you.
17 **MR. AMMON:** Thank you. And Ruth Ann?
18 Oh, she had to drop off? Amanda had to drop
19 off too. So do you want to give the update for
20 Karla?
21 **MS. ALLEN:** Sure. This is Alexis on the
22 behalf of Karla Johnson. So just an update from
23 Marion County Public Health Department in
24 Indianapolis. They are working on a project.
25 It's in the beginning stages of development. But

1 they will be using AI to empower residents to
2 make housing choice appropriate for their needs.
3 That housing registry will be marketed to
4 healthcare providers as well as school community
5 agencies.
6 And other interested parties will go to a
7 link and input an address. Publicly accessible
8 lead-related information regarding the home will
9 be scraped from the internet and summarized for
10 the individual. The individual will have the
11 opportunity to drill down into information that
12 they are interested in for more information or
13 they can chat with a chatbot if they prefer.
14 They have begun conversations with the water
15 utility to get information that they may need
16 regarding lead service lines that would pulled
17 from this project as well as the state agencies
18 that also have information regarding lead in
19 homes.
20 They have selected a vendor. It will be
21 developing the scope of work and SOPs. Again,
22 this is in the beginning stages of development.
23 So they have spent a month long working with this
24 vendor to explore the concept and where they need
25 to get to to dive into this project a little bit

1 deeper.

2 So that's her report.

3 **MR. AMMON:** Great. We made it through

4 everyone, I believe, which is great. You know, I

5 really appreciate the updates. I mean, it's --

6 like I said, there are things which we have on

7 the agenda and there are things which aren't on

8 the agenda which really was the forum to talk

9 about it. And it's amazing the amount of work

10 that is going on.

11 I think a lot of it, of course, we've all --

12 we all know that a lot of it needs to be work

13 coordinated. And I think not so much aligned, we

14 know that, but coordinated. There's a lot of

15 work that I see. And even -- even -- I know I

16 didn't get a chance to talk about making federal

17 grants for communities because of the fire alarm,

18 but much of how we think and all of the programs

19 that we have really are from what we hear the

20 needs are from communities, right?

21 And whether that is, you know, from its

22 essence, you know, what is our program? You

23 know, what policies do we have? Is this -- are

24 these what communities need or do they need

25 something else? You know, what is it do they

1 need?

2 And there has been a lot of change in

3 communities that we have seen. And, you know,

4 for us it's trying to fit something now, like

5 what are the realities on the ground in

6 communities? That really impacts how we look at

7 what we do, right? Whether that is trying to

8 look at something that's new -- Right? -- a new

9 statute, a new reg, you know, a new policy, a new

10 grant programs. Or does that meet a revision to

11 any one of those that we have. And we're lucky

12 we have a pretty straight line to the folks that

13 we need to talk to in making those changes as a

14 continuum. Some things, of course, are a longer

15 tail, like if there's a statutory or a regulatory

16 change.

17 But the policy work that can be changed

18 pretty quickly, you know, we have tried to do as

19 much as we can on a regular basis. And we have,

20 of course, our past grantees that can tell us

21 that we have a very unique relationship with

22 these communities where it's really important for

23 us to listen to what their needs are and design

24 things around us those needs because, you know,

25 we could say the word "community" all the time,

1 but it really is -- everything is local,
2 everything that we do, everything touches local.
3 Whether it's, you know, a program, a family, a
4 child, I mean, everything is very much local to
5 us. And, you know, all of us have a different
6 piece of how to make that work locally.
7 I think looking at things that we can be
8 doing better and things that are obviously coming
9 to our attention is having programs and funding
10 mechanisms that match what the needs are in the
11 community. You know, is it a competitive
12 program? Is it a different -- is it a
13 formula-based program? What's going to make it
14 easier to apply for our grants?
15 We try every year to make it easy to apply
16 for our grants and somewhere along the line it
17 always gets more complicated. I think we're
18 bound into this templated -- this template that
19 we have for our notices of funding opportunity.
20 And it is complex even though we've tried to make
21 it a lot easier along the way.
22 But even looking at -- across the spectrum
23 and all the work that we're doing and trying
24 to -- trying to align the work, such as -- and I
25 know you've heard me say this before -- not only

1 about linking existing programs and having them
2 work together, like our program, like
3 weatherization, like some the USDA programs that
4 are doing work in homes, but doing things that
5 don't make it harder for communities to do this
6 work, like aligning income requirements --
7 Right -- trying to find a way for us to recognize
8 different programs and how they do things because
9 we have different requirements. But that doesn't
10 mean that we shouldn't fight to make it easier
11 all along the way, to make those requirements
12 easier on communities to do their work.
13 And for us, that has meant looking at what
14 our legacy programs are -- Right? -- lead and
15 other things. And then taking what the community
16 has asked for and building those into our
17 programs or building new ones whether it is
18 flexibility -- Right? -- or whether it is taking
19 a legacy program like lead and adding something
20 else to it so that they can do a whole house
21 approach. But just making it easier to reduce
22 barriers whether you're at the local level or to
23 apply.
24 So in that way, you know, for us, you know,
25 community, local is at the heart of everything

1 that we do. And it shapes everything that we do.
2 This is not an easy thing. Lead is a highly
3 regulated activity in areas around the country.
4 And in that way, you know, we need to be working
5 more to give communities resources, capacity.
6 And there's always some type of stumbling block,
7 and I do see a lot of that now being because of
8 the lack of a contractor base around the country.
9 Because at the end of the day, you need to get --
10 you need to get the work done in units. At the
11 end of day, that's where everything happens. You
12 need to be in the units doing the work.
13 And you could do as much screening as you
14 want, but if you can't go into the units and fix
15 the issues, then it's only fixing half the
16 problem. And for us and in many, many
17 communities, we're faced with that workforce
18 issue. And, again, we've tried to do things
19 within all of our programs to make it more
20 flexible so that monies can be used to help build
21 up that base.
22 But, you know, at the end of the day, making
23 this work for those who are doing the work. And
24 obviously many of you here are doing that work
25 and it's incumbent upon all of us to listen to

1 what those things are, those concerns are because
2 we're all tied in. You know, whether we're at
3 the state level, local level, you know, labs is
4 obviously a huge part of the infrastructure
5 needed to make this happen and make this work and
6 making sure that there isn't a reason for
7 communities or others to say, well, it's just too
8 hard, I'm not going to do it, or this just
9 doesn't make sense. I think we have too much
10 built in and too much at stake to just say, you
11 know, we're going to be doing something else now.
12 And for us, you know, that starts our annual
13 look at what do we need to do better? What do we
14 need to do differently? What do we need to
15 change? And we're constantly asking that -- this
16 feedback loop from philanthropies; from
17 community-based organizations; from our local,
18 state, county grantees. Always trying to improve
19 what we're doing on a regular basis. And
20 obviously that means getting into the
21 community -- Right? -- getting into the community
22 as much as we can and working with them and
23 seeing what their needs are and being able to do
24 things to, again, make sure that we are not the
25 barrier to their success in making it happen.

1 You know, it's the federal government, it
2 is -- there's a lot that we have to do but
3 there's also a lot that we can and need to do.
4 And I think it all starts with recognizing that
5 there's always room to try to improve. There's
6 always room to try to make changes. And
7 listening to folks on the ground, it is to me
8 where that all starts. And so that's a huge part
9 of what we do on a regular basis.
10 And even some of the structural issues
11 around statutory, regulatory, we can change. It
12 may take a while, but, you know, fight for a
13 change. We fight for changes all the time, for
14 changes. And, you know, within the continuum of
15 certainly the bigger stuff to get a change, it
16 may take a longer time. But I'm not going to
17 stop fighting for these things because it just
18 makes sense to do continual change for better
19 outcomes.
20 So that was kind of what I was going to talk
21 about during my speech when we had fire drills.
22 But it just -- it kind of encapsulates everything
23 we've kind of talked about where, you know, we
24 are very much in alignment together even though
25 we are doing different things. But we have very,

1 very similar outcomes and I think that's a huge
2 part of why we're all here and why we've been --
3 had so much success in this and what there's
4 still so much that we need to do and continue to
5 do to continue that work here and locally.
6 We're really at noon. We're almost going to
7 be closing out, but I wanted an opportunity just
8 for other reflections before we close out this
9 great meeting. Paul?
10 **DR. ALLWOOD:** Thank you, Matt. I just
11 wanted to just take a moment to just acknowledge
12 and, you know, express my gratitude to, you know,
13 everyone that has contributed to this successful
14 two-day event. You know, first starting with the
15 LEPAC members, you know, they are board members
16 and our liaison members.
17 As all of you know, the LEPAC is a very
18 important part of the administration of our Lead
19 Poisoning Prevention Program at CDC. You know,
20 as evidenced by the adoption of, you know, a, you
21 know, last significant recommendation that came
22 out of this body, which was the updating of the
23 blood lead reference value, which, you know, I
24 was very pleased to hear various reports on how
25 the -- you know, the adoption and implementation

1 of that new policy measure has been progressing.
2 So I thank all of you, especially because,
3 you know, so many of you took the time to come
4 here and join us in person. And I know several
5 others, you know, had the desire to join us in
6 person and weren't able to this time. But we're
7 certainly hoping that next opportunity we'll be
8 able to have, you know, everybody together. It
9 means a whole lot. Not only did we have the
10 opportunity to engage with one another and share
11 information during the sessions, but there was,
12 you know, a lot of ad-hoc interactions which
13 were, you know, in some ways if not, you know,
14 more valuable as -- at least as valuable as the
15 sessions. And, you know, that included things
16 like going out to dinner, several members, it's
17 hearing all.
18 Also want to thank the members of the public
19 that joined and, you know, especially any person
20 who offered their public comments. This is also
21 very important. It's one of the important goals
22 of having a meeting like this, is that it has to
23 be seen as and recognized as and utilized as a
24 forum where the public can also, you know, share
25 their comments and, you know, express their

1 desires or interests in the work that we do.

2 There are some other people that have been

3 really special in making this LEPAC happen, but

4 Alexis and Nick and Perri have been working

5 tirelessly, you know. The FACA rules under which

6 this committee operates is very stringent and

7 literally Nick and Perri and Alexis could have a

8 full-time job just making sure that, you know, we

9 administer the committee in accordance with all

10 of the requirements. But that's not all they do;

11 they do a lot more. So especially grateful for

12 them for their efforts.

13 And then I'd also like to, you know,

14 acknowledge some of the people that we don't hear

15 about a lot even though their contribution to the

16 LEPAC is invaluable. And I'm thinking about our

17 administrative staff which is led by our new

18 deputy branch chief Glykeria Hadjisimos who

19 joined us recently. And there's Sheryl Driskell,

20 Ms. Lena Wynn, and Ms. Arlisha(ph) Gray, all

21 of whom have had to deal with all of the travel

22 paperwork and the meeting logistics and various

23 other things that are really essential, you know,

24 in getting us here. So thank you all for your

25 support.

1 And then before I turn it back to you, Matt
2 -- Matt, I'd like to just remind everybody a
3 couple important things that are happening fairly
4 soon. First is that there is a call for papers
5 that has been issued by the program. The due
6 date for the submission is October 30th. This
7 is -- we're hoping to publish a supplement of
8 Pediatrics that's going to be focused on
9 childhood lead exposures in children and
10 adolescents. And we are really hoping to get a
11 very strong response to that call paper. And
12 there's a wide range of topics that we are
13 looking to attract.
14 And so if you have any interest in
15 publishing in that supplement and if you're doing
16 any work on lead exposures in children or
17 adolescents, you know, it's a wide range of
18 topics. So I would encourage you to submit. If
19 it's -- you know, we're looking for, you know,
20 original research, commentaries, you know,
21 reports, case reports, or notes from the field.
22 You know, any of those would be eligible for the
23 supplement. So please, you know, submit before
24 October 30th if you have an interest to do so.
25 And then we mentioned earlier that our

1 Annual Recipients Meeting is going to be
2 happening in December, December 4th to
3 December 7th. So that's where we're going to be
4 bringing together, in person, all of the 62
5 programs that we fund through corporate
6 agreements for lead poison prevention at the
7 state and local level.
8 In addition to that, we're also bringing our
9 newly funded community-based organizations and
10 also planning to bring partners from the U.S.
11 territories. You know, we're trying to engage to
12 ensure that we -- you know, we're not -- not
13 because of your geographic location, you know,
14 we're -- we're not thinking that you should be
15 receiving the same services, same amount of
16 attention for, you know, this pernicious problem
17 of childhood lead poisoning.
18 So we're going to be, you know, hoping to
19 have partners at the meeting, like HUD, Matt, and
20 others from your agency. EPA are hoping to have
21 presentations from colleagues from EPA, HRSA.
22 And we're looking to find speakers from the
23 Department of Education. So Tammy if this is
24 something that you would be able to provide any
25 assistance with or make some recommendations.

1 And we are also hoping to have WIC and CMS
2 present at that event. So the dates are
3 December 4th to December 7th and we're going to
4 be right here in the Roybal Campus and we're
5 really hoping that you'll help us get the word
6 out. And whomever in your network you think
7 would really benefit from knowing about this,
8 please help us spread the word.
9 Anything else?
10 **DR. RUCKART:** This is Perri. I wanted to
11 just add that I think most people aren't aware
12 that next week is National Lead Poisoning
13 Prevention Week, and we also have a webinar on
14 Thursday, October 26th. And you can find out
15 more information to register on our website.
16 **MR. AMMON:** Exactly what I was going to say.
17 I was asked -- I think it was a couple minutes
18 before the meeting last Friday and I was asked in
19 front of the senior team, oh, can you talk about
20 that? And I'm like, well, I'll just talk about
21 it next week, how's that?
22 So I'm talking to all of the senior staff at
23 HUD this Friday on that. But it's great work
24 from all of the agencies and all of the different
25 participants. Great.

1 Just to echo what Paul was talking about, I
2 really appreciate Perri and Paul and everyone's
3 help who makes this happen. I know I get a lot
4 of e-mails from CDC, and I'm like, I better
5 answer, better -- sometimes I don't answer right
6 away. Sometimes, right? You've got to remind me
7 a couple of times because I get a flood of
8 e-mails, but I -- I really appreciate the working
9 partnership that we've had all these years and
10 making it work.
11 And really everyone here and all of the
12 LEPAC members and liaisons, I very much appreciate
13 everybody's input and everybody's work in this,
14 and really all the work that you do locally in
15 your everyday work. And I can't thank you enough
16 for continuing to work and giving us a little bit
17 of your insight and updates through these
18 meetings. So I very much appreciate it.
19 With that, looking at -- and we've -- as
20 you noticed, as part of our topic list, you know,
21 we've kind of expanded our topic list from the
22 blood lead reference value and the adult lead. I
23 know that there has been interest in other
24 topics. I know lead and climate change is
25 certainly a topic that is very much front and

1 center. I know all the agencies have climate
2 action plans. We do as well. And that seems to
3 be a next relevant topic for us to discuss at our
4 next meeting. And if there are other topics, we
5 certainly will work into those and consider those
6 as we plan for the next meeting.
7 Any final thoughts from anybody other than
8 that? Thank you all again. Safe travels back
9 and I look forward to meeting with you soon.
10 Take care.
11 **DR. RUCKART:** I just want to say thank you
12 to Matt for being the chair of this committee and
13 keeping us running smoothly and getting a lot
14 accomplished and sparking some really interesting
15 discussions. So I'm thanking you.
16 (Concluded at 12:06 p.m.)
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3 I, Mary K. McMahan, Certified Court Reporter

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