

Follow-up of the March 2020 Audit of the Milwaukee Health Department Childhood Lead Poisoning Prevention Program

**Steering and Rules Committee
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Overview

- Lead Poisoning in Milwaukee
- Follow-up Audit Scope and Methodology
- PHF Sample
- Summary and Conclusions

Lead Poisoning in Milwaukee

- ↘ Milwaukee has a high burden of lead poisoning in comparison to other cities and states
- ↘ Lead poisoning is associated with reduced brain development, poor academic achievement, and a range of behavioral issues
- ↘ Lead poisoning disproportionately impacts children of color



Scope and Methodology

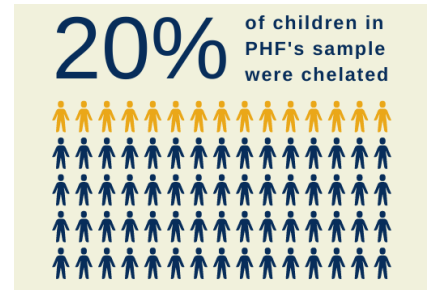
- 7 PHF conducted a case review of a randomized sample of MHD CLPPP cases opened between January 1, 2018 and August 1, 2021
- 7 Reviewed complete cases for 75 children (a 28.6% sample)
- 7 75 cases included:
 - 75 nursing records
 - 105 accompanying property records
 - Child records can be paired with multiple properties and properties can have multiple children
 - Total of 180 records



Example of one environmental health record

PHF's sample

- ↘ Children 1-10 years of age at program enrollment (average age: 2.96; median age: 2.5)
- ↘ Reported race and ethnicity data:
 - 10.5% Asian
 - 65.8% Black/African American
 - 24% Latino/Hispanic
 - Some children may identify as multi-racial
- ↘ 11 of the 75 children had blood lead levels over 40 ug/dL
- ↘ 15 children received chelation upon enrollment or during follow-up



2020 Findings

A finding is a program deficiency based on a statute, policy, code, or funder requirement.

- ↴ *2020 Finding 1: Documentation is not sufficient to assure program compliance.*
- ↴ *2020 Finding 2: Corrective Actions from the 2018 WI DHS Report remain incomplete.*
- ↴ *2020 Finding 3: Not all cases adhered to MHD Policy 300-637 on case management assignment.*
- ↴ *2020 Finding 4: Not all cases adhered to MHD Policy 300-660 on environmental investigation.*



Status of 2020 Finding 1: Documentation is not sufficient to assure program compliance.

- ↵ Program documentation and recordkeeping in PHF's case review were vastly improved
- ↵ Key items that were incomplete in the original audit had complete or nearly complete documentation in the follow-up review

Status of 2020 Finding 2: Corrective Actions from the 2018 WI DHS Report remain incomplete.

- ↵ MHD CLPPP demonstrated corrections to the outstanding items that PHF identified in the 2020 audit, including:
 - Filing and documentation systems
 - Written policies and procedures adopted and implemented
 - Case management of all historic cases
 - Assurance of case follow-up for new cases
- ↵ In Wisconsin, local health departments act as agents of the WI DHS, and carry out the responsibilities required under Wisconsin Statute 254 and Administrative Rule DHS 163

Status of 2020 Finding 3: Not all cases adhered to MHD Policy 300-637 on case management assignment.

- ↴ Significant improvement was documented in compliance with this policy
- ↴ Case management and follow-up occurred on all sampled cases
- ↴ Per MHD Policy 300-637, new cases are to be reviewed and assigned within 1 business day
- ↴ In PHF's sample, the average time from elevated blood lead level to referral was 3.5 days; median was 4 days; range was 0-10 days

Status of 2020 Finding 4: Not all cases adhered to MHD Policy 300-660 on environmental investigation.

- Significant improvement was documented in compliance with this policy

Blood Lead Level (ug/dL)	MHD Policy 300-660	Median timeframe	Average timeframe	Range timeframe
20-44 ug/dL	Within one week	8 days	16.6 days	0-199 days
45-70 ug/dL	Within 48 hours	0 days	0.5 days	0-1 days
70+ ug/dL	Within 24 hours	1.5 days	1.5 days	1-2 days

Blood Lead Level (ug/dL)	MHD Policy 300-660	Median timeframe	Average timeframe	Range timeframe
20+ ug/dL	Within 24 hours (immediately for 40+ ug/dL)	1 day	3.65 days	0-58 days

2020 Observations


An observation is a noted issue or concern that is not based on a regulatory or program requirement.

- ↘ *2020 Observation 1: Documentation and surveillance systems are inefficient and ineffective.*
- ↘ *2020 Observation 2: Children being treated for elevated blood lead levels do not always have access to lead-safe housing.*
- ↘ *2020 Observation 3: There is a lack of clarity for budget oversight and accountability.*
- ↘ *2020 Observation 4: Medicaid is not being fully billed for Medicaid-eligible services.*
- ↘ *2020 Observation 5: There is some uncertainty in the completeness of risk assessments.*



Status of 2020 Observation 1: Documentation and surveillance systems are inefficient and ineffective.

- ↵ Records of each case file are stored in multiple locations (i.e., paper files and various electronic databases)
- ↵ During PHF's case review, compliance information and documentation were stored in different places and piecing together a full case file required looking in multiple places



Status of 2020 Observation 2: Children being treated for elevated blood lead levels do not always have access to lead-safe housing.

- MHD still has limited options and control in supporting and assisting children with elevated blood lead levels in accessing lead-free housing
- The process from the identification of lead poisoning to housing abatement and clearance of lead hazards includes numerous steps and can be lengthy
- In PHF's follow-up case review, the median time from case open to work order completion on a home was 318 days (average of 376 days; range 43-1060 days).



Status of 2020 Observation 3: There is a lack of clarity for budget oversight and accountability.

↵ This observation was out of scope for this follow-up audit



Status of 2020 Observation 4: Medicaid is not being fully billed for Medicaid-eligible services.

- ↵ Documentation was provided by the Wisconsin Medicaid office
- ↵ Provided a total MHD number of approved reimbursements for nursing visits, environmental investigations, and clearances
- ↵ Unclear if all eligible visits are being billed and approved

Status of 2020 Observation 5: There is some uncertainty in the completeness of risk assessments.

- ↘ Noted improvements in documentation of completeness of risk assessments
- ↘ All files contained risk assessments as well as lab results and/or XRF readings
- ↘ In 28 of the 81 risk assessments there was no indication of soil samples
- ↘ In some of these cases, soil samples are not indicated, however, documentation of soil samples being taken or not being necessary should be included



XRF analyzer

Summary and Conclusions

- 7 Case management and follow-up had occurred on each of the sampled cases
- 7 Follow-up response times had decreased for each step of the process
- 7 Program documentation and recordkeeping was vastly improved
- 7 MHD should continue progress on improving documentation, aligning data systems, and better addressing barriers in complex cases



Future Outlook

- ↘ MHD CLPPP continues to improve
- ↘ Some upcoming impacts to the program include:
 - “Catching up” on missed childhood well visits and blood lead screenings will mean “catching” missed children with elevated blood lead levels
 - CDC’s update of the blood lead reference level (BLRV) from 5.0 $\mu\text{g}/\text{dL}$ to 3.5 $\mu\text{g}/\text{dL}$ means many additional children will now be included in the totals who were not previously
- ↘ An increase in children testing positive is not expected to indicate a true increase in children with lead poisoning
- ↘ MHD CLPPP is both aware of these impacts and preparing for them



Thank You

- MHD leadership and CLPPP staff
- Wisconsin Department of Health Services
- Comptroller Sawa and Audit Manager Roedel
- The PHF Lead Poisoning team
- PHF Intern

Questions or Follow-up?

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