MEMORANDUM

LEGISLATIVE REFERENCE BUREAU

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To: Honorable Members of the Steering and Rules Committee

From: Aaron Cadle – Legislative Fiscal Analyst

Date: July 3, 2018

Subject: Executive Summary – Review of Childhood Lead Poisoning Prevention Program

I. Scope

This executive summary sets forth the preliminary findings and recommendations of the Legislative Reference Bureau's (LRB) management review of the Milwaukee Health Department's (MHD) Childhood Lead Poisoning Prevention Program (CLPPP). A full presentation of the LRB's findings will be forthcoming.

During the course of this management review the LRB:

- Conducted 44 interviews with 26 people.
- Analyzed data on CLPPP operations.
- Analyzed "raw data" on MHD operations.
- Analyzed data provided by the Municipal Court.
- Reviewed relevant State statutes and municipal code.

II. Findings

1. Reliable data to analyze CLPPP operations was unavailable.

2. Due to the unreliability of the data, it was not possible to verify if there were service-delivery failures in the MHD's elevated blood-lead level program.

3. The MHD consistently failed to use its enforcement powers to ensure abatement of properties linked to lead-poisoned children.

4. The number of abatement orders issued in recent years declined as follows:

   A. 2015 – 77
   B. 2016 – 51

C. 2017 – 34

5. The number of citations issued for failure to comply with abatement orders declined as follows:

   A. 2015 – 46
   B. 2016 – 19
   C. 2017 -- 1

6. The number of direct-administered abatements (third-party abatements overseen by the MHD) declined as follows:

   A. 2013 – 12
   B. 2014 – 3
   C. 2015 -- 3
   D. 2016 -- 0
   E. 2017 -- 0

7. The review indicated disregard for state-mandated service obligations, misguided policy decisions, and the following management deficiencies:

   A. No management reporting requirements.
   B. Meeting agendas set by those supervised rather than supervisors.
   C. Excessive reliance on the state of Wisconsin's STELLAR database as a management tool.
   D. Failure to verify preliminary Elevated Blood Lead Level (EBLL) test results.
   E. Failure to locate EBLL children for services.

III. Recommendations

1. Direct managers to require specific monthly and year-to-date reports from subordinates.

2. Use an investigator to locate difficult-to-find children. Staff may need to work occasional evenings and weekends to help realize this goal.

3. Create a procedure to verify the domicile of a lead-poisoned child who vacates that domicile before contact by the MHD to ensure inspection and abatement of any lead hazards found.

4. Increase the number of children retested to verify reported preliminary EBLL test results.

5. Develop protocols and procedures to quickly identify when the MHD's enforcement powers should be initiated.

6. Implement door-to-door campaigns in evenings and on weekends to encourage households in areas where the incidence of lead-poisoned children is high to have the blood-lead level of children in the household tested.

7. Conduct an educational campaign for landlords in areas where the incidence of lead-poisoned children is high to promote blood-lead level testing of tenant children.

8. Hire a grant administrator to oversee all the MHD grant applications and compliance with grants awarded.

9. Consider using non-nursing personnel to make site visits to lead-poisoned children and to monitor these children until their blood-lead levels decline to state-mandated thresholds.

10. Install more window liners rather than window replacements to increase the number of properties abated.