OLR Bill Analysis

sHB 6727

AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS FOR IMPLEMENTING THE RECOMMENDATIONS OF THE LEAD POISONING PREVENTION WORKING GROUP.

SUMMARY

This bill makes various changes related to lead poisoning prevention and treatment. Principally, it:

1. reduces, from 72 to 24 hours, the timeframe within which a health care provider must notify the parent or guardian of a child under age three whose test results show a blood lead level of at least 3.5 micrograms per deciliter (µg/dL) (§ 2);

2. requires the state's two regional lead poisoning treatment centers to report quarterly to the Department of Public Health (DPH) on the number of people treated for lead poisoning and related demographic information (§ 3);

3. removes the requirement that children's blood lead levels that exceed specified thresholds must be confirmed in two tests taken at least three months apart before local health directors conduct on-site inspections and remediation (§ 4);

4. requires DPH's lead poisoning educational and publicity program to direct information to owners of residential property constructed prior to 1978, instead of 1950, as under current law (§ 6);

5. specifies that owners of dwellings with toxic lead levels occupied by children under age six must remediate the lead through testing, abating, or managing the dangerous materials (§ 7);

6. requires pediatric primary care providers to complete (a) an annual medical lead risk assessment for all children from birth to age six and annually screen those with elevated risk, (b) a lead screening test for all children at ages 12 months and 24 months, and (c) follow-up testing for children with a blood lead level of at least 3.5 µg/dL (§ 8);

7. requires prenatal health care providers to (a) provide pregnant patients guidance on lead poisoning prevention during pregnancy and postpartum, (b) assess patients using a risk assessment tool and screen those at high risk, and (c) notify the local health director of patients with a blood lead level of at least 3.5 µg/dL (§ 8);

8. modifies the blood lead level thresholds at which local health department lead poisoning prevention and control programs must provide children case management services and distribute educational materials to the children's parents or guardians (§ 10); and

9. requires children, before enrolling in public school, to have a lead poisoning medical risk assessment and, if the assessment indicates risk, a test of their blood lead levels (§ 12).

Lastly, the bill makes technical and conforming changes (§§ 1, 4, 5, 9, 11 & 13-16), including eliminating obsolete provisions on a (1) plan to phase out DPH's program on environmentally safe housing for children and families (§ 1) and (2) DPH review of lead poisoning data it collects (§ 16).

EFFECTIVE DATE: October 1, 2023, except that the provision on primary care provider testing and prenatal care (§ 8) takes effect January 1, 2024, and the technical changes to DPH's annual lead report (§ 9) take effect upon passage.

§ 2 — REPORTING BLOOD LEAD LEVELS

The bill reduces the timeframe, from 72 to 24 hours, within which a health care provider must make a reasonable effort to notify the parent

or guardian of a child under age three whose test results indicate a blood lead level of at least 3.5 µg/dL.

By law, licensed health care institutions and clinical laboratories must report a person with blood lead levels of at least 3.5 µg/dL to DPH, local health departments, and the health care provider who ordered the testing. The report must include specified information on the person, the provider who ordered the testing, the sample collection and analysis, and any other information the DPH commissioner requires. For the latter, the bill specifies that the information must be reported in a manner the commissioner prescribes.

It also removes the requirement under current law that the DPH commissioner consult with the administrative services commissioner to determine how data in individual and monthly lead testing reports, which health care institutions and clinical laboratories submit to DPH, is transmitted.

§ 3 — REGIONAL LEAD POISONING TREATMENT CENTERS

The bill requires each lead poisoning treatment center to report to the DPH commissioner on the number of people treated for lead poisoning; each person's town of residence, race and ethnicity; and any other information the commissioner requires. The centers must report this information quarterly and as the commissioner prescribes.

Existing law allows the DPH commissioner, within available appropriations, to establish two regional lead poisoning treatment centers in different areas of the state by providing grants to two participating hospitals. The bill requires these two hospitals to have demonstrated expertise in lead poisoning treatment, in addition to prevention, as under current law.

The bill also specifies that the (1) DPH commissioner must determine the designated area of the state that each hospital serves and (2) centers must, at a minimum, provide consultation services to pediatricians and other primary care practitioners, instead of all physicians, on proper lead poisoning treatment.

§ 4 — ON-SITE INSPECTIONS AND REMEDIATION

As under current law, the bill requires local health directors to conduct on-site inspections and order remediation for children with lead poisoning if a child has a confirmed blood lead level between (1) 10 and 15 µg/dL before January 1, 2024, and (2) 5 and 10 µg/dL from January 1, 2024, to December 31, 2024. However, the bill removes the requirement under current law that these blood lead levels must be confirmed in two tests taken at least three months apart.

§ 6 — EDUCATION AND PUBLICITY PROGRAM

By law, DPH's Lead Poisoning Prevention Program must include an education and publicity program that informs the general public and specified individuals of the danger, frequency, and sources of lead poisoning and ways to prevent it.

The bill requires the program to specifically direct the information to residential property owners who own housing constructed prior to 1978, instead of 1950, as under current law.

§§ 1 & 7 — LEAD REMEDIATION

Current law requires owners of dwellings with toxic lead levels occupied by children under age six to abate, remediate, or manage the dangerous materials and follow DPH regulations for doing so. The bill instead requires the owners to remediate the lead through testing, abatement, or management of the materials and correspondingly redefines these activities.

Under the bill, "remediation" means the process of remedying a lead hazard condition, including investigation, abatement and, if appropriate, ongoing management measures.

"Abatement" means any set of measures designed to reduce or eliminate lead hazards, including encapsulation, replacement, removal, enclosure, or covering of paint, plaster, soil, or other material containing toxic lead levels and all preparation, clean-up, disposal, and reoccupancy clearance testing.

The bill makes related technical and conforming changes.

§ 8 — PRIMARY CARE PROVIDER TESTING

Pediatric Care Providers

Current law requires primary care providers who provide pediatric care, other than emergency departments, to conduct annual lead testing on children:

1. ages 36 to 72 months whom DPH determines to be at higher risk of lead exposure based on their enrollment in HUSKY or residence in a municipality with an elevated lead exposure risk;

2. all children ages nine to 35 months, in accordance with the Advisory Committee on Childhood Lead Poisoning Prevention recommendations;

3. all children ages 36 to 72 months who have never been screened; and

4. any child under 72 months if the provider determines it is clinically indicated under the advisory committee's recommendations

The bill instead requires providers to conduct lead risk assessments and testing that include the following:

1. a complete annual medical risk assessment based on guidelines the DPH commissioner prescribes for all children from birth to age six,

2. an annual lead screening test for all children with elevated risk of lead exposure based on the medical assessment findings,

3. a lead screening test for all children at ages 12 months and 24 months, and

4. follow-up testing according to schedule the DPH commissioner sets for all children with a confirmed blood lead level of at least 3.5 µg/dL.

Similar to current law, the bill also requires providers to provide

educational materials and guidance information on lead poisoning prevention to each child's parent or guardian in keeping with the DPH commissioner's childhood lead screening recommendations.

Prenatal Care Providers

The bill requires prenatal health care providers to do the following:

1. provide each pregnant patient anticipatory guidance on lead poisoning prevention during pregnancy,

2. assess each pregnant patient at the initial prenatal visit for lead exposure using a risk assessment tool the DPH commissioner recommends,

3. screen or refer for blood lead screening each pregnant patient found to be at high risk for lead exposure,

4. notify the local health director in the jurisdiction where the pregnant patient lives if the patient has a blood lead level of at least 3.5 µg/dL, and

5. provide anticipatory guidance on preventing childhood lead poisoning to each patient at the patient's postpartum visit.

The bill also requires a local health director, when notified by a provider of a pregnant patient's elevated blood lead level, to conduct an epidemiological investigation and take other actions required under existing law (e.g., provide educational information and, in some cases, relocate the family).

§ 10 — LOCAL HEALTH DEPARTMENT LEAD PREVENTION AND CONTROL PROGRAMS

Existing law requires DPH, within available appropriations, to establish a financial assistance program to help local health departments pay for their expenses related to lead prevention and control. In order for a local health department's lead poisoning prevention and control program to be eligible for DPH funding, the program must meet specific requirements for case management and education services.

Under current law, local health departments must provide case management services, including medical, behavioral, epidemiological, and environmental intervention, for children who meet either of the following criteria for blood lead levels:

1. one confirmed level of at least 20 µg/dL or

2. two confirmed levels, taken at least three months apart, of at least 15 µg/dL, but less than 20 µg/dL.

The bill eliminates these criteria and instead requires local health departments to provide case management services to children with a blood level of at least 3.5 µg/dL.

Additionally, the bill lowers, from 10 to 3.5 µg/dL, the threshold for blood lead levels in children at which local health departments must give educational materials on lead poisoning prevention to the children's parents, legal guardians, and appropriate health care providers.

The bill also requires these educational materials to be provided in English, Spanish, and any other language common to people in the local health department's jurisdiction.

§ 12 — SCHOOL HEALTH ASSESSMENTS

The bill requires all children, before enrolling in public school, to have a lead poisoning medical risk assessment and, if the assessment indicates risk, a test of their blood lead levels. The assessment must be conducted as part of the child's school health assessment required under existing law. By law, the school health assessment must be completed by a licensed physician, advanced practice registered nurse (APRN), physician assistant (PA), or school medical advisor in the presence of the child's parent or guardian or a school employee.

Under current law, a child's blood lead levels must be tested as part of the school health assessment only if (1) the local or regional school board determines it is necessary, after consulting with the school medical advisor and the local health department and (2) a physician,

PA, or APRN orders the test.

COMMITTEE ACTION

Public Health Committee

Joint Favorable
Yea 37 Nay 0 (03/20/2023)