DEPARTMENT OF HEALTH SERVICES

Additional Improvements Are Needed to Ensure Children Are Adequately Protected From Lead Poisoning

REPORT NUMBER 2000-013, MAY 2001

Audit Highlights . . .

Our follow-up audit of the Childhood Lead Poisoning Prevention Program (program) revealed that the Department of Health Services (department) made only limited progress in implementing our recommendations. As a result, the department still:

- ☑ ***Does not ensure California's children identified with lead poisoning receive the proper medical care and are protected from further exposure.***
- ☑ ***Is unable to determine the full extent of lead poisoning in California—having identified only about 10 percent of the estimated 38,000 children needing services.***
- ☑ ***Lacks the enforcement authority needed to reduce or eliminate lead hazards.***

Additionally, the department needs to address staffing shortages and projected funding shortfalls to avoid potential cutbacks in program operations.

As early as 1986, the Legislature charged the Department of Health Services (department) with determining the extent of lead poisoning among children in the State. In 1991 the Legislature set specific goals for protecting children from lead poisoning: it asked the department to evaluate all children for their risk of poisoning; to test those children who were at risk; to provide case management for children who were at risk; and to provide case management for children who were found to suffer from lead poisoning.

Chapter 540, Statutes of 2000, requires the Bureau of State Audits to report on the extent to which the department has addressed the recommendations made in our April 1999 report. Our follow-up audit of the department's Childhood Lead Poisoning Prevention Program (program) concluded that the department still has made only limited progress in fulfilling its most critical missions related to lead poisoning and has not fully implemented all of our previous recommendations. Specifically:

Finding #1: The department does not ensure that local programs follow its case management process.

The department has failed to enforce case management guidelines for local programs that require them to report all their activities for lead-poisoned children. Additionally, when the required reports are submitted, the department does not review them to ensure adequate services are rendered to children. Without obtaining and reviewing case management information, the department cannot be certain that all lead-poisoned children receive proper care, that the levels of lead in their blood are reduced to safe levels, or that the sources of their lead exposure are reduced or eliminated.

We recommended that the department ensures that local programs submit all case management information outlining the services provided to lead-poisoned children, and monitor local programs' activities to ascertain whether lead-poisoned children receive appropriate care.

Department Action: Corrective action taken.

The department stated that it instituted protocols designed to monitor case management by local programs. The protocols include a review of all follow-up forms submitted by local programs as well as a detailed review of a sample of all forms. The reviews are designed to ensure that all follow-up information on lead-poisoned children is submitted promptly and that the information is complete. Further, the branch has conducted site reviews of local health departments. Although some deficiencies have been noted during the reviews and issues requiring additional guidance and training have been identified, the department reports that most local programs are doing an excellent job. Finally, the department reported that it is revising its follow-up forms and tracking database to improve the tracking of case dispositions.

Finding #2: The department has not determined where and to what extent lead poisoning is a problem throughout the State and has not adequately identified children with lead poisoning.

The department has not been successful in its efforts to implement regulations that would require laboratories to report the results of all blood-lead tests. Efficient reporting of all blood-lead tests and their results would provide the department the data it needs to evaluate and report on the nature and extent of lead poisoning among California's children. Implementing these regulations is also critical because current blood-lead reporting requirements do not correspond with the department's more restrictive criteria for providing case management. As a result, the department cannot ensure that all children requiring case management receive these services.

To collect data on where and to what extent lead poisoning is a problem and to ensure that children with elevated blood-lead levels are identified and treated, we recommended that the department adopt regulations requiring laboratories to report all blood-lead test results and complete the testing and installation of software that will allow laboratories to electronically submit their results.

Department Action: Partial corrective action taken.

The department has not adopted regulations requiring labs to report all blood-lead test results. Its proposed regulations to accomplish this are currently being reviewed by the Department of Finance. The department also has not completed the testing and installation of software that will allow laboratories to electronically submit their blood-lead test results. However, the department reported that it continues to recruit labs to voluntarily report all blood-lead test to the State and estimated that it is receiving approximately 50 percent of all tests performed on California children.

Finding #3: The department still needs to design enforcement and evaluation components for statewide screening requirements.

Although the department has substantially complied with state law and the United States Centers for Disease Control and Prevention's guidance in enacting its screening requirements, it has not incorporated measures to ensure these requirements are effective.

To improve the effectiveness of its screening regulations and state plan, we recommended that the department revise its screening regulations to add an enforcement component and to require all providers to document their reasons for not ordering blood-lead tests on children. We also recommended the department develop a plan to monitor and evaluate its screening regulations and statewide targeted screening policy.

Department Action: Corrective action taken.

The department reported that its revised screening regulations became effective November 19, 2001. In its efforts to monitor compliance with these regulations, the department stated that it has produced several pilot reports from the Medi-Cal Managed Care Information System and is in the process of validating the report data. Once complete, the department plans to analyze screening coverage in targeted groups and to identify providers who have poor screening rates. The department also reported that it is conducting an annual evaluation of 300 patient screening charts at each Medi-Cal Managed Care Plan to assess their lead screening performance. Moreover, the department is working with Child Health and Disability Prevention (CHDP) providers to obtain screening data from their information

systems. Once it implements its universal reporting regulations, the department plans to use the data to validate data from Medi-Cal and CHDP.

Finding #4: The department does not identify and educate Medi-Cal or CHDP providers who fail to screen children for lead poisoning.

Although the department has taken steps to educate providers of the need to screen high-risk children for lead poisoning, it has been unable to target its educational efforts to those providers who are not ordering blood-lead tests. Both the State and federal government require that all children receiving Medi-Cal and CHDP services receive a blood-lead test; however, less than 25 percent are tested.

To improve the effectiveness of its outreach efforts, we recommended that the department target those providers who fail to comply with the screening requirements.

Department Action: None.

The department reported that it has taken no action to improve the effectiveness of its outreach efforts by identifying and educating Medi-Cal and CHDP providers who fail to screen children for lead poisoning. However, it reports that it has increased the reimbursement to all Medi-Cal and CHDP providers for blood tests and counseling as an incentive to increase screening rates.

Finding #5: Ongoing staffing shortages and lawsuits as well as projected funding shortfalls threaten the department's current level of program operations and its ability to make needed improvements.

The department's progress in protecting California's children from lead poisoning has been hindered by the lack of adequate staff and by lawsuits that divert the attention of the staff it does have away from its primary mission. Of equal concern, without an infusion of funding, the department is projecting a funding shortfall for the program in fiscal year 2003–04 that would likely result in cutbacks in activities, which are already insufficient.

To ensure that the program is able to adequately protect California's children from lead poisoning, we recommended that the department take the steps necessary to ensure that the program has adequate funding and staffing to achieve its mandates and goals.

Department Action: Pending.

The department reported that it is looking at possible options that will ensure adequate funding for the lead poisoning program.

Finding #6: The lack of explicit enforcement authority limits state and local efforts to reduce or eliminate sources of childhood lead exposure.

Although the department has conducted numerous training sessions to educate local officials about ways to use existing laws to order and enforce the reduction or elimination of lead hazards, it has been unsuccessful in its efforts to have legislation enacted to strengthen statewide authority in these areas. As a result, local officials and the department may be unable to adequately protect children from lead hazards.

We recommended that the department seek legislation granting the department, cities, and counties the authority to investigate properties with suspected lead hazards and to order and enforce the abatement of lead hazards against property owners. In the absence of this authority, the department should continue its efforts to assist local authorities with issuing and enforcing abatement orders by continuing its training and education efforts.

Department Action: Partial corrective action taken.

The department states that if AB 422, 2001–02 Session, is enacted, it will make explicit the authority of both state and local agencies to order and enforce abatement of lead hazards. In the interim, the department reported that it has developed a draft enforcement guidance manual for local agencies and will continue conducting training classes for local programs.

Finding #7: The department remains at risk of losing federal funding for lead hazard reduction and elimination activities.

The department has been unsuccessful in enacting regulations granting it the authority to impose administrative, civil, and criminal sanctions against those who violate state requirements related to lead-safe work practices. As a result, the department has failed

to comply with the requirements of the Federal Environmental Protection Agency. Until the department addresses these issues, it places the State and local agencies at risk of losing federal funding to support lead reduction or elimination activities.

We recommended that the department seek legislation granting enforcement authority to impose administrative, civil, and criminal sanctions against those violating lead-safe work requirements.

Department Action: Pending.

The department reported that it is working on options that will allow it to impose sanctions for noncompliance with lead-safe work practices and certification requirements.

Finding #8: The department has yet to complete a statewide plan for its health care provider outreach efforts.

In 1996 the department began developing a statewide provider outreach plan to educate providers on the importance of evaluating and testing children for lead poisoning. Although the department has begun to implement some of its provisions, the plan is still in draft and lacks timelines and implementation strategies the department will need to evaluate whether its activities are on target and effective in reaching and educating providers.

We recommended that the department continue its efforts in finalizing and implementing a comprehensive statewide provider outreach plan complete with timelines and implementation strategies.

Department Action: Corrective action taken.

The department stated that the plan is completed and that implementation efforts are underway. Its outreach activities include new outreach materials, Web site accessible information, a media campaign, and provider notification.

Finding #9: It is too soon to tell whether the department's requirement for local programs to monitor their outreach and education efforts is successful.

The department now requires local programs to evaluate the effectiveness of their outreach and education efforts in identifying more lead-poisoned children, and it also provides assistance to local programs in developing the proper tools to complete these efforts. However, full implementation and evaluation of these efforts are to occur over a two-year period ending June 30, 2002. These

efforts will allow the department to determine which outreach strategies achieve the best results and to share the knowledge with local programs.

We recommended that the department continue its efforts to assist in refining the tools that are currently in place for evaluating the effectiveness of the local programs' outreach and education efforts.

Department Action: Partial corrective action taken.

The department has received and reviewed the first and second biannual progress reports from local lead poisoning programs. The department states that it created a database to track and analyze the information in the progress reports.

Finding #10: The department developed a comprehensive lead-safe schools program; however, it may not have the funding to fully implement the program.

In response to a department study that found many schools and day care facilities have lead-based paint or lead in their water, the department developed a curriculum to educate schools and day care staff on the appropriate steps for reducing or eliminating lead hazards. Although it has conducted training at slightly more than half of the school districts targeted for having elementary schools, it will be unable to complete its training efforts before its funding expires.

We recommended that the department pursue the funding needed to complete its lead-safe schools training program in all targeted school districts and to provide follow-up training to these schools as necessary.

Department Action: Corrective action taken.

The department states that it is continuing to fund the lead-safe schools program and is renewing its contract to create instructional materials and train school district representatives about lead hazards. The department is also working on finalizing an evaluation report on the program.