



State of New Hampshire
Department of Health and Human Services

New Hampshire Annual Meeting

June 11, 2024

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Health Services Advisory Group, Inc. (HSAG), confirms that no one organizing the New Hampshire Quality Meeting activities had a conflict of interest with **AmeriHealth Caritas New Hampshire (ACNH)**, **New Hampshire Healthy Families (NHHF)**, or **WellSense Health Plan (WS)** health plans.

The 2024 Annual Meeting offered 3.75 *AMA PRA Category 1 Credits*™ through the Maine Medical Education Trust. HSAG confirms that none of the planners or presenters for this activity had relevant financial relationships with the Maine Medical Education Trust to disclose.

1. Introduction

On June 11, 2024, the New Hampshire Department of Health and Human Services (DHHS), Office of Medicaid, held the New Hampshire 2024 Roundtable Annual Meeting, Increasing Lead Level Testing Rates of 1- and 2-Year Olds. Representatives from the following organizations attended the meeting: DHHS, managed care organizations (MCOs), community organizations, parent advocates, practitioners, and representatives from provider offices. Health Services Advisory Group, Inc. (HSAG), the external quality review organization for New Hampshire, assisted DHHS by organizing and coordinating the virtual meeting.

The purpose of the meeting was to discuss issues impacting the Lead Testing Rates of 1- and 2-year-olds for New Hampshire Medicaid members. A total of 73 people attended the four-hour virtual meeting. There were 63 participants from DHHS, the three MCOs, parent advocates, practitioners, and representatives from provider offices. Ten additional people participated as speakers, facilitators, and HSAG support personnel.

The main objectives of the meeting on the agenda included:

- Reach consensus on the barriers to blood lead level (BLL) testing of New Hampshire’s 1- and 2-year-olds.
- Brainstorm potential DHHS and MCO collaboration to resolve barriers negatively impacting New Hampshire’s pediatric BLL testing rates.

The meeting began with a brief introduction from an HSAG staff member and the DHHS Chief Medical Officer, Dr. Jonathan Ballard. In addition, three speakers shared information concerning the importance of BLL testing of New Hampshire’s 1- and 2-year-olds and presented the current BLL screening rates for New Hampshire. Appendix A contains the meeting agenda.

This report includes information generated during the meeting through presentations and brainstorming sessions with the attendees. The ideas should not be assumed to be *statistically* representative of the organizations attending. They can be used, however, to identify salient issues relevant to the population, provide contextual information for the larger assessment process, and identify avenues for further investigation.

In this report, the words *member* and *patient* are used generically to denote Medicaid beneficiaries, MCO members, patients, and clients.

DHHS Speaker: Beverly Baer Drouin

The meeting began with Ms. Beverly Baer Drouin, an administrator for the Healthy Homes and Environmental Section of DHHS, Division of Public Health Services, sharing a personal story about lead poisoning that impacted her eldest child as a result of living in a home built before 1978 with deteriorated lead-based paint. Ms. Drouin noted inconsistencies in her son’s developmental milestones early in his childhood and shared examples of observable concern. For example, while her son had the ability to sing, he experienced difficulty stringing words together in a sentence.

Her son’s pediatrician repeatedly dismissed the concerns. After extensive research concerning the effects of high BLLs in children and continuously advocating for lead testing for her son, the pediatrician agreed to test her two young children for elevated BLLs. Ms. Drouin stated that though both her children had elevated BLLs, they were below the New Hampshire “action level” of 20 micrograms per deciliter ($\mu\text{g}/\text{dL}$). Since both children had a BLL under 20 $\mu\text{g}/\text{dL}$, the pediatrician said no further action was necessary.

Her eldest son faced many developmental and cognitive challenges throughout his schooling. Through her display of a series of photographs, she emphasized how easy it was to unknowingly expose her child to lead from deteriorated paint in an older home. Ms. Drouin acknowledged that her son most likely became exposed in the garden dirt from the drip line of the house’s exterior walls with scraped and flaking lead paint, lead in the glass skylight at the front door, and older carpeting that contained dust from wall paint chips and nicks. Throughout her presentation, Ms. Drouin identified the long-term impacts of lead exposure in early childhood on young adults. She confirmed that her child may have looked “normal” from an onlooker’s perspective; however, the long-term ramifications from exposure to lead created many invisible, life-long challenges. She now advocates for BLL testing in all children, education about the effects of a high BLL, and early intervention for children with elevated BLLs.

DHHS Speaker: Erin Metcalf

The second speaker from DHHS was Erin Metcalf, MPH, an administrator for the Medicaid Quality Program of DHHS, Office of Medicaid. Ms. Metcalf opened her portion of the meeting with polling questions for the participants and reviewed the New Hampshire Healthcare Effectiveness Data and Information Set (HEDIS[®])²⁻¹ rates related to BLL testing.

²⁻¹ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

Polling Question

Ms. Metcalf opened with a request for each participant to respond to a series of polling questions to assess the current knowledge of BLL testing and education resources. The questions, designed to test current understanding of lead screening, clarified the expectations of testing parameters in New Hampshire. In addition, question number five highlighted a new resource, a recently released children’s book, *Happy, Healthy, Lead-Free Me!* by Gail C. Gettens and Knatalie Vetter.²⁻²

The participants responded to five polling questions, and the results of the polling questions are displayed in Table 2-1 through Table 2-5. Over 50 participants responded to the polling questions. Most of the nonrespondents included the speakers, facilitators, HSAG support personnel, and DHHS staff.

Question 1: Since April 2018, New Hampshire has been a Universal Testing State—requiring all children, by law, to have their BLL tested at:

Table 2-1—Possible Responses and Results for Question 1

Possible Responses		Percentage of Responses
a.	6 months of age	9.3%
b.	1 year of age	7.4%
c.	2 years of age	5.5%
d.	1 year of age and again at 2 years of age	75.9%

Question 2: Any child enrolled in Medicaid between the ages of 24 and 72 months with no record of a previous blood lead test must receive a test.

Table 2-2—Possible Responses and Results for Question 2

Possible Responses		Percentage of Responses
a.	True	94.2%
b.	False	5.7%

Question 3: Were you aware that a financial incentive program for the pediatric BLL testing quality measure is part of the new Medicaid contract beginning September 1, 2024?

Table 2-3— Possible Responses and Results for Question 3

Possible Responses		Percentage of Responses
a.	Yes	41.5%
b.	No	58.5%

²⁻² Gettens, GC and Vetter, K. (no date). *Happy, Healthy, Lead-Free Me!* Available at: <https://leadfreekidsnh.org/happy-healthy-lead-free-me-resources>. Accessed on: Jul 11, 2024.

Question 4: DHHS encourages continuous quality improvement in health outcomes through its Medicaid contract with the MCO. One of the quality measures in the contract is related to pediatric BLL testing. Based on your expertise, how will this financial incentive impact the pediatric BLL testing rate?

Table 2-4— Possible Responses and Results for Question 4

Possible Responses		Percentage of Responses
a.	The incentive program will increase rates	71.7%
b.	The incentive program will decrease rates	0.0%
c.	The incentive program will neither increase nor decrease rates	5.6%
d.	I am not sure	22.6%

Question 5: Are you aware of the recently released children’s board book *Happy, Healthy, Lead-Free Me!* that engages children with beautiful illustrations and rhyming text while educating the adult reader with messaging on lead exposure prevention and the importance of pediatric BLL testing?

Table 2-5— Possible Responses and Results for Question 5

Possible Responses		Percentage of Responses
a.	Yes	72.7%
b.	No	27.3%

New Hampshire HEDIS Lead Screening Rates and Measure

Ms. Metcalf continued the presentation with an overview of the New Hampshire MCO performance, trends, and comparative rates concerning the National Committee for Quality Assurance’s (NCQA’s) HEDIS measure—*Lead Screening in Children (LSC)*. Ms. Metcalf noted that when considering a measure for testing and intervention, HEDIS measures are considered the gold standard and used nationally for comparison. The following information includes the description for the HEDIS *LSC* measure:

The percentage of children two years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.²⁻³

The numerator includes members who had at least one lead capillary or venous blood test on or before the child’s second birthday. The denominator includes children who turned 2 years of age during the measurement year and did not have a gap in enrollment longer than 45 days during the 12 months prior to the child’s second birthday.²⁻⁴

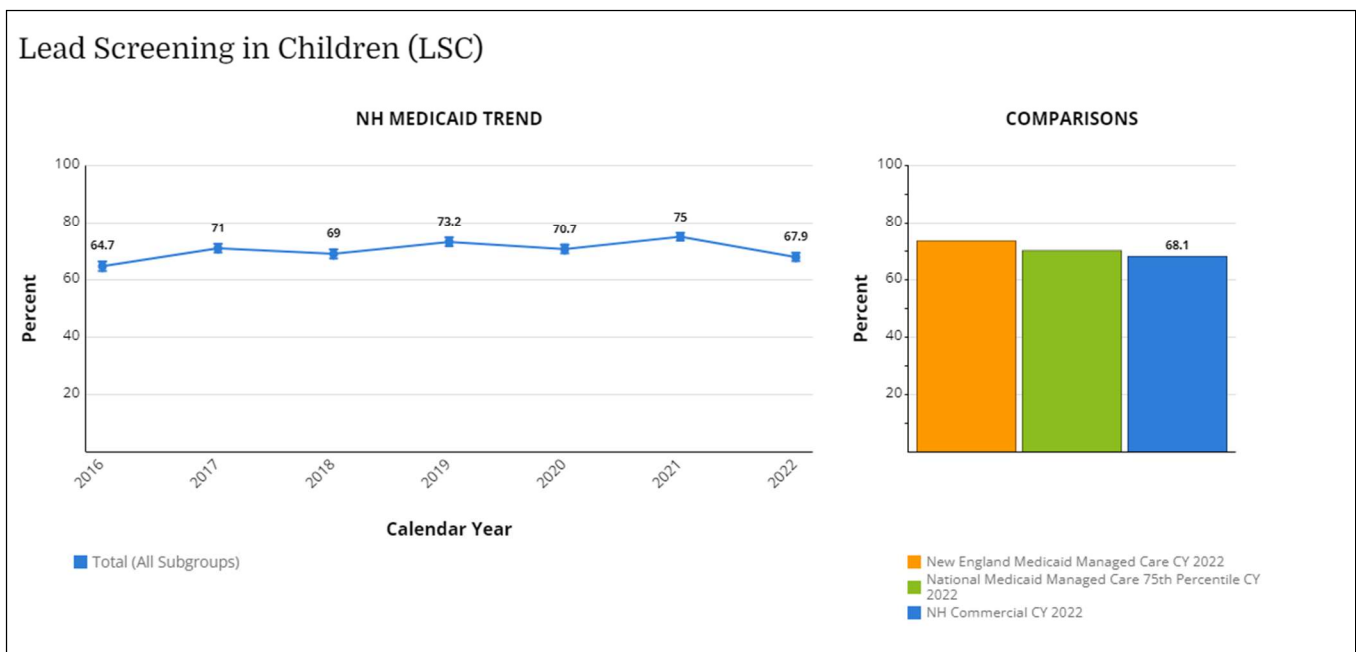
²⁻³ National Committee for Quality Assurance. *HEDIS® Measurement Year 2023 Volume 2: Technical Specifications for Health Plans*. Washington, DC: NCQA; 2022.

²⁻⁴ Ibid.

Ms. Metcalf noted the HEDIS measure only includes evidence of one test by 2 years of age and does not capture additional data points prior to the second birthday. Ms. Metcalf then elaborated about the benefits and opportunities identified within the *LSC* measure and the next steps for improving overall compliance to meet the NCQA Quality Compass® 75th percentile for Medicaid.²⁻⁵

Figure 2-1 notes the yearly percentage of children, 2 years of age, who had at least one BLL test.²⁻⁶ Ms. Metcalf noted the overall managed care trend has been stagnant and declined over the past year. When reviewing the comparison to the NCQA Quality Compass national Medicaid rate, New Hampshire was below the 75th percentile. The New Hampshire Medicaid trend correlated to the New Hampshire commercial comparator; however, Ms. Metcalf emphasized the overall goal for New Hampshire Medicaid children is to remain at or above the NCQA Quality Compass national Medicaid 75th percentile.

Figure 2-1—Lead Screening in Children



As previously noted, the HEDIS rate measured the prevalence of one BLL test prior to a child’s second birthday. In comparison, public health surveillance data further defines the rate with additional data points at 1 year of age and 2 years of age. Figure 2-2 and Figure 2-3 display the New Hampshire Medicaid lead screening rates of 1- and 2-year-olds. It should be noted that children between 23 and 36

²⁻⁵ Quality Compass® is a registered trademark of NCQA.

²⁻⁶ New Hampshire Department of Health and Human Services. Lead Screening in Children (*LSC*). Available at: <https://medicaidquality.nh.gov/reports/lead-screening-in-children-lsc-1>. Accessed on: Jul 15, 2024.

months of age are considered 2-year-olds. The public health surveillance data for 2-year-olds demonstrated lower rates than reported in the HEDIS measure for calendar years (CYs) 2019–2022.

Figure 2-2—Medicaid Lead Screening Rates: 1-Year-Olds

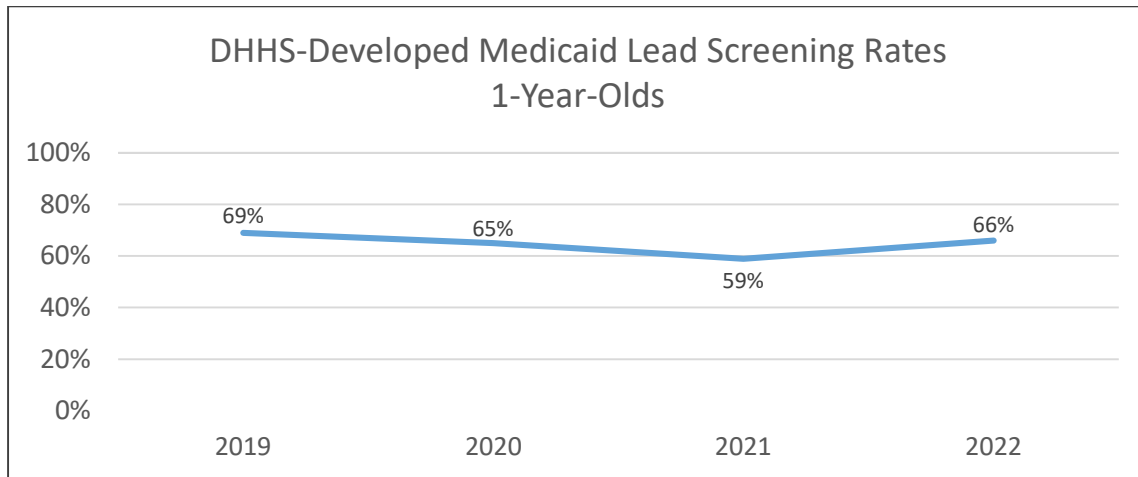
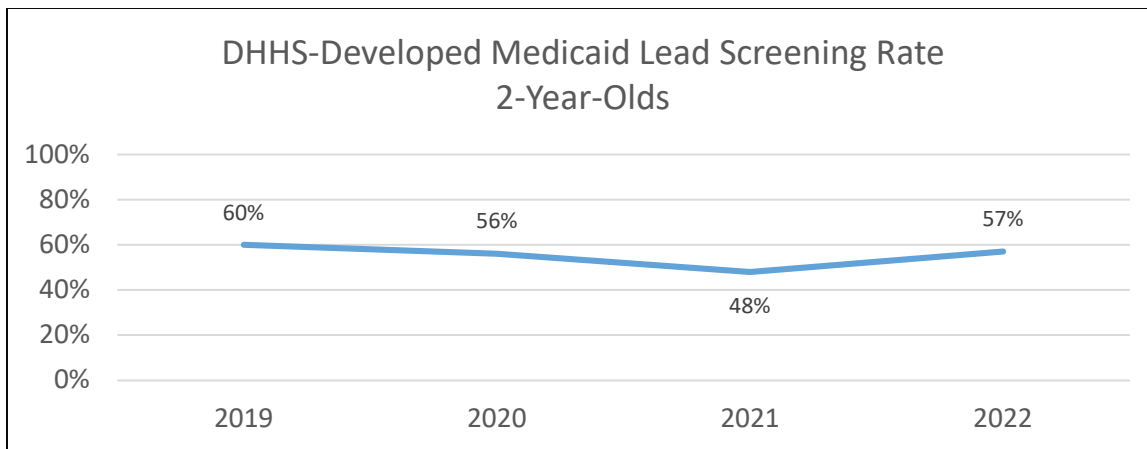


Figure 2-3—Medicaid Lead Screening Rates: 2-Year-Olds



In summary, Ms. Metcalf reiterated the CY 2022 New Hampshire Medicaid rate of 67.9 percent and noted two different data sources (HEDIS and public health surveillance) that New Hampshire intends to use to track BLL testing. The New Hampshire HEDIS *LSC* measure rate declined, falling between the NCQA Quality Compass national Medicaid 50th and 75th percentiles. As New Hampshire DHHS considers its response to the declining rates, Ms. Metcalf shared that the new five-year MCO contract beginning September 2024 will include a withhold or incentive measure related to BLL screenings in children.

DHHS Speaker: Gail C. Gettens

Ms. Gettens, a health educator for DHHS, Division of Public Health Services, Healthy Homes and Lead Poisoning Prevention Program, reiterated the challenges of obtaining current BLL testing rates with conflicting requirements between the New Hampshire State law and the HEDIS measure. Ms. Gettens referenced New Hampshire State law, noting all children enrolled in Medicaid, regardless of whether coverage is funded through Title XIX or XXI, are required to receive a BLL test at ages 12 months and 24 months.²⁻⁷ In addition, the law requires any children between ages 24 months and 72 months with no record of a previous BLL screening to be tested. Ms. Gettens clarified that the completion of a risk assessment without the blood test did not meet the intent of the requirement.

Throughout the presentation, Ms. Gettens discussed the following topics:

- Lead by the Numbers: Exposure and Testing Surveillance Data
- It's Not the Water, It's the Paint: Common Sources of Exposure
- Every Child, Two Tests, by Two: New Hampshire's Universal Testing Law

Ms. Gettens indicated that although the current public media narrative highlights the concern for the presence of lead within the water systems (e.g., drinking fountains), a minimum of 32,350 young children in New Hampshire are living in older homes with lead paint.²⁻⁸ Ms. Gettens stated that lead is not primarily in the water, it is in the paint.²⁻⁹ In addition, Ms. Gettens shared several statistics, demonstrating the impact of testing gaps, but also noted the impact on children who have not received testing. Figure 2-4 illustrates that only 31 percent of children tested were enrolled in Medicaid; however, 58 percent of all children who had a positive BLL were enrolled in Medicaid. The 58 percent of children with a positive BLL highlights the importance of improving overall testing rates, particularly for the Medicaid population.²⁻¹⁰

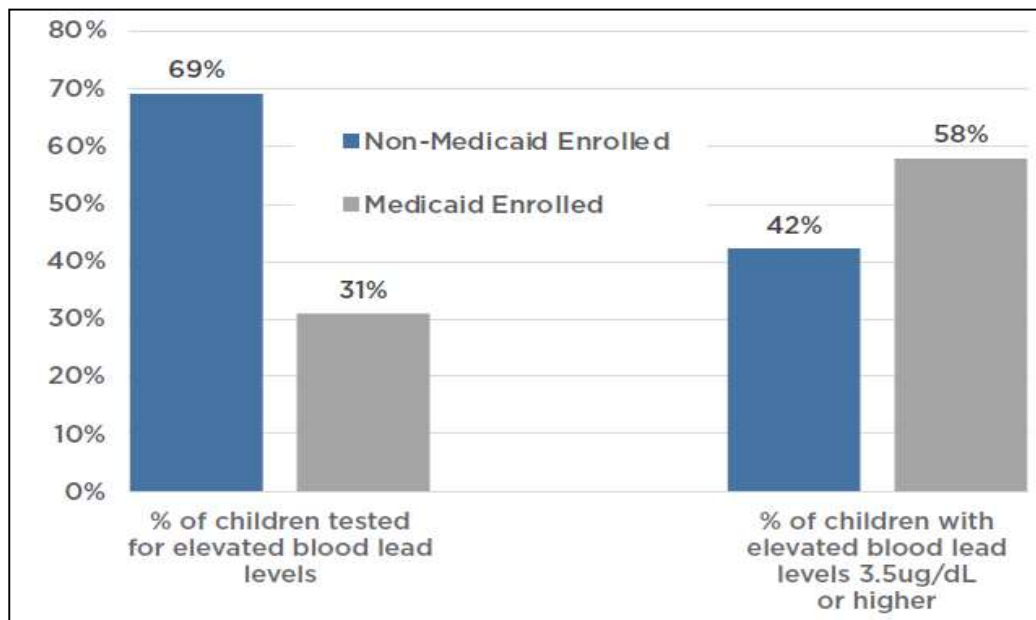
²⁻⁷ New Hampshire Revised Statutes Annotated. (2018). Title X Public Health, Chapter 130-A, Lead Paint Poisoning Prevention and Control. Available at: <https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/inline-documents/sonh/hhlppp-statute-rsa-130-a-mrg.pdf>. Accessed on: Jul 15, 2024.

²⁻⁸ New Hampshire Department of Health and Human Services. Lead Poisoning Prevention Program. Available at: <https://www.dhhs.nh.gov/programs-services/environmental-health-and-you/lead-poisoning-prevention-program>. Accessed on: Jul 15, 2024.

²⁻⁹ Levin R, Brown MJ, Kashtock ME, Jacobs DE, Whelan EA, Rodman J, et al. Lead exposures in U.S. children, 2008: Implications for prevention. *Environmental Health Perspectives*. 2008;116: 1285–93.

²⁻¹⁰ New Hampshire Department of Health and Human Services. 2020 Lead Exposure in New Hampshire Data Brief. Available at: <https://wisdom.dhhs.nh.gov/wisdom/assets/resources/lead-exposures/2020-lead-data-briefs/NH-Report-2020.pdf>. Accessed on: Jul 15, 2024.

Figure 2-4—Lead Screening Rates



Ms. Gettens identified several mitigating factors over the past five years that contributed to the decrease in testing. The impact of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) and a testing supply recall through 2021 contributed to a 25 percent decrease in testing rates from 2019 to 2021. For CY 2022, Ms. Gettens noted:

- 39 percent of 1-year-olds were not tested versus 40 percent in 2019.
- 49 percent of 2-year-olds were not tested versus 52 percent in 2019.
- The number of children ages 72 months and younger with a BLL of 3.5 $\mu\text{g}/\text{dL}$ increased from 797 in 2019 to 1,005 in 2022.²⁻¹¹

Ms. Gettens summarized her presentation with three points. First, she stated that testing rates are recovering, but continue to need improvement. Second, she encouraged collaborative attention, effort, and focus to improve the rates of BLL testing. Later in the meeting, Ms. Gettens reminded participants of the importance of ensuring that a child's skin does not contain lead residue when obtaining a blood sample to test BLLs. Soap and water should be used to clean the skin since hand sanitizer will not remove the lead particles. Finally, Ms. Gettens stressed that without efforts to prioritize testing, education, and collaboration, too many children remain exposed to lead.

²⁻¹¹ Ibid.

3. Keynote Speaker: Alan Woolf, MD

The keynote speaker, Alan Woolf, MD, MPH, FAAP, FACMT, FAACT, introduced the topic of his presentation: *Old Adversary, New Challenges: Update on Childhood Lead Exposure and the Importance of Blood Lead Level Testing*. Dr. Woolf is the Director of the Pediatric Environmental Health Specialty Unit at Boston Children’s Hospital, a member of the New Hampshire Statewide Clinical Lead Advisory Committee, and Director of the Region 1 New England Pediatric Environmental Health Specialty Unit (PEHSU).

Dr. Woolf shared appreciation for the opportunity to collaborate with the other speakers and particularly noted a word of appreciation to Beverly Drouin for her courage in relating a painful account of parenting a child with lead exposure. In addition, he offered an encouraging word to all participants regarding future medical residents who are being encouraged and educated to respond to the concerns of parents, particularly in the child’s younger years. He emphasized a parent’s instinct is invaluable to a practitioner’s success.

The outline of the presentation included four significant topics:

- Identify novel non-paint sources of exposure
- Cite children who are especially vulnerable
- Recognize lead’s clinical effects, methods of testing
- Identify roles for health care providers (HCPs)

Dr. Woolf challenged the participants to consider why lead testing remains an important topic, citing that homes built before 1978 are more likely to have lead-based paint.³⁻¹ In addition, childhood lead toxicity has potential lifetime health effects and substantial population-level effects on children’s intellectual abilities, academics, and problem-solving behaviors. At the highest levels, it can cause coma, seizures, and death. Dr. Woolf noted that lead is one of the easiest environmental hazards to mitigate; however, it can also be found in non-housing sources such as cosmetics, imported spices, cookware, children’s toys (i.e., pewter models of animals, etc.), dust, and pottery. Additionally, some occupations (i.e., demolition, construction, remodeling, etc.) can cause parents to bring traces of lead home from construction sites. Finally, exposure to lead often impacts the most vulnerable populations such as foster children, immigrants, migrants, and refugees.

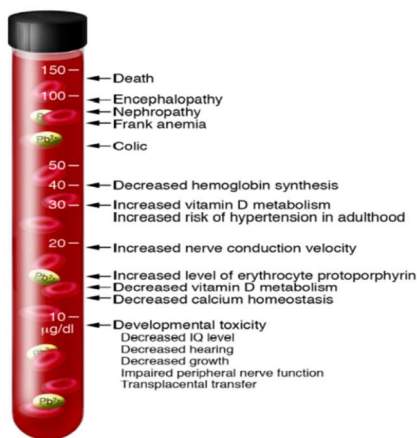
Dr. Woolf reviewed the related pathogenesis for lead and shared that lead tricks the body into thinking it is iron or calcium, creating a deficit in the body for those two minerals. Dr. Woolf continued to explain

³⁻¹ United States Environmental Protection Agency. Protect Your Family from Sources of Lead. Available at: <https://www.epa.gov/lead/protect-your-family-sources-lead>. Accessed on: Jul 15, 2024.

the biochemical challenges and highlight the impact of lead poisoning and its long-term effects with a video titled *The Poisoned Water: The Health Impacts of Lead Exposure*.³⁻²

Dr. Woolf described symptoms associated with clinical toxicity and the related outcomes. Common symptoms included irritability, distraction, constipation, complaints of stomach pain, poor appetite, and trouble sleeping. He emphasized that there is no signature symptom. This means that HCPs must utilize critical thinking and listening skills when completing their assessments since the lack of intervention/treatment could lead to unacceptable outcomes. Figure 3-1 visually represents the potential outcome related to the observed effect levels ($\mu\text{g}/\text{dl}$).³⁻³

Figure 3-1–Potential Outcomes and Observed Effect Levels



J. Clin. Invest. 116:853-857 (2006)

Dr. Woolf challenged participants to consider the role of the HCP. He identified the following ways to comply with lead testing requirements:

- Order BLL testing at the well-child checkup for all 1- and 2-year-olds.
- Confirm a fingerstick BLL with a timely venous BLL test.
- Ensure all BLL results are shared with New Hampshire DHHS.
- Follow-up with physical exams to interpret BLL findings.
- Counsel families regarding what the findings mean and the next steps.
- Provide education on prevention, mitigation, and diet (e.g., iron, magnesium, calcium, and vitamin D).
- Ensure timely follow-up management.
- Complete a referral to an early intervention program (EIP), HeadStart, and/or other resources.

³⁻² WGBH Educational Foundation. (2024). PBS Learning Media. Poisoned Water: The Health Impacts of Lead Exposure. Available at: <https://wosu.pbslearningmedia.org/resource/nvpw-sci-leadexposure/wgbh-nova-poisoned-water-the-health-impacts-of-lead-exposure>. Accessed on: Jul 15, 2024.

³⁻³ Bellinger, DC and Bellinger, AM. Childhood lead poisoning: The torturous path from science to policy. *The Journal of Clinical Investigation*. 2006;116(4):853-857. <https://doi.org/10.1172/JCI28232>.

Dr. Woolf also discussed the challenges and advantages of testing preschool-age children with a capillary or venous approach. The advantage of a capillary BLL sample included the ability to complete the test at the point of care (POC). A POC instrument allows office staff to easily be trained, requires a small amount of fingerstick blood, and provides an immediate result. Conversely, the capillary BLL test has a higher risk for skin contamination, false positives, and a limited range of results; and the provider may not consistently report the findings to DHHS. Dr. Woolf then compared the advantages of a venous BLL test, considered the gold standard, including the ability to mitigate false positives with a cleaner environment and an expanded range of accuracy. Drawbacks included the geographical location of a lab, requiring trained staff, and a longer wait time for a result.

In summary, Dr. Woolf noted:

- Lead contamination of water, housing, and other sources is a public health concern in New Hampshire.
- Especially vulnerable groups include children living in disadvantaged communities, refugees/immigrants, and children with autism.
- There are important differences between fingerstick (capillary) and venous BLL tests.
- HCPs have an important role in testing, reporting, managing patients with elevated BLLs, and counseling families.

This powerful presentation set the stage for the ensuing discussions about the barriers and strategies to overcome to increase BLL testing in New Hampshire.

4. Barrier Evaluation

After the presentations by the speakers, a brainstorming session, led by facilitator Tanya Lord, PhD, provided a visual and real-time collaboration of ideas utilizing the MURAL application. Carrie McFadden, MPH, assisted Dr. Lord in facilitating the session. Prior to the meeting, Dr. Lord and Ms. McFadden offered two training sessions for participants to learn about the MURAL application on the afternoon of June 5, 2024, and the morning of June 6, 2024. A total of 23 participants attended the two MURAL training sessions.

Dr. Lord utilized several methods to engage participants in brainstorming, creating affinity clustering, developing “How Might We” (HMW) questions, and voting. Through the virtual brainstorming session conducted using the MURAL application, Dr. Lord encouraged participants to share their ideas concerning barriers to lead testing. The MURAL application allowed participants to write their ideas on virtual “sticky notes” and “post” them to a community whiteboard. In addition, the participants had the option of choosing the color of the sticky note to connect the comment to the group of stakeholders to which they belonged (i.e., community organizations, DHHS, parents, providers, MCOs, or other stakeholders).

Dr. Lord also encouraged open dialogue so participants could further elaborate on their ideas. Several participants openly shared concerns regarding education for parents and providers, limitations with testing supplies and access, staffing issues, and overall support for the parent(s) who may not know why timely lead testing should be completed. Dr. Lord facilitated the dialogue as participants continued to develop and post sticky notes using the MURAL application. Overall, the activity generated 151 identified barriers to lead testing, and the facilitators grouped the responses into eight categories. The list below includes the eight categories and the number of responses for each category:

- Staffing Issues (37)
- Lack of Public/Parent Education (37)
- Lack of Provider Education (31)
- Testing Issues (28)
- Financial (6)
- Transportation (6)
- Data/Reporting (4)
- Language Barriers (2)

The facilitator then briefly discussed the eight categories with the participants during an open dialogue. Dr. Lord prompted the participants to consider which category or group of barriers should be prioritized. As the discussion concluded, the participants utilized the voting function within the MURAL application to select three barriers. Each participant, excluding the facilitators and HSAG employees, submitted three votes, identifying the barriers that required immediate attention. The voting process identified the following top three barriers:

- Lack of Public/Parent Education
- Lack of Provider Education
- Testing Issues

The next sections of the report provide additional information concerning the top three barriers.

Lack of Public/Parent Education

Participants recognized a lack of comprehensive education concerning the importance of BLL testing. Specifically, parents and the general public lack sufficient knowledge regarding the potential prevalence of lead in their community, the testing process, and long-term consequences of undetected lead poisoning. Participants felt many parents may be unaware of the need for early detection, often resulting in reluctance or refusal to have their children tested. In addition, parents of children required to be lead tested may not know about previous educational efforts. Participants encouraged stakeholders (i.e., MCOs, HCPs, DHHS, etc.) to update or try new types of communication methods, such as text reminders and other social media platforms.

The participants generated 37 comments about barriers to public/parent education, and those comments generated four general categories of response:

- Parent concerns about their child's safety and pain during testing
- Lack of time for appointment process and lab draw
- Lack of knowledge regarding the risks and benefits of testing
- Lack of knowledge regarding the prevalence of lead in their community

Lack of Provider Education

Dr. Lord encouraged the participants to discuss the challenges facing providers to complete a BLL test for 1- and 2-year-olds. The participants described issues with the lack of standardized protocols and workflows within healthcare organizations regarding testing parameters, treatments, and interventions. In addition, some participants noted a lack of POC testing within the office setting, limited access to supplies, missing connectivity/collaboration within the medical record system, and a potential unintended bias for children who are meeting milestones and/or do not have assessment triggers in their medical records. One provider noted the challenge of remaining current with federal testing expectations and state-to-state variances regarding intervention for positivity.

The participants generated 31 comments about barriers to provider education, and those comments generated three general categories of response:

- Concerns about misinformation regarding testing requirements

- Lack of knowledge regarding positive results and related interventions
- Prejudgment regarding the lack of risk for a member or a member's current living conditions

Testing Issues

Dr. Lord requested participants to share their experiences and describe the barriers to testing. One participant described inconvenient access to testing, limited availability of POC testing equipment, and challenges confirming whether a test had been completed. In addition, several participants noted a lack of supplies during a recall, causing a period of time in which POC testing could not be completed. Providers shared concerns about false positive results and a lack of knowledge to correlate a positive test with the appropriate intervention. As a follow up, several participants shared their knowledge regarding the testing process and noted unclear instructions, such as utilizing handwashing with soap and water versus alcohol or hand sanitizer, to ensure an accurate test. During an open dialogue, one participant noted a concern with tracking the history of testing, making it a challenge to confirm whether the child should receive another test.

The participants generated 28 comments about barriers to testing, and those comments generated four broad categories of response:

- Lack of POC testing or lab access within the physician's office
- POC false positive results requiring additional testing
- Frustration with recall of testing supplies and short expiration windows
- Inability to track or confirm testing history

5. Strategies to Address Barriers

Following the identification of the top three barrier categories, the participants developed HMW questions to frame the challenges in a solution-oriented manner. Once again, the facilitator led the group through the activity using the MURAL application. Participants used the sticky notes to suggest over 100 solutions for the following questions. The full list of suggestions is included in Appendix C.

The HMW questions included the following:

- HMW improve patient education and awareness of lead testing and screening?
- HMW increase and sustain provider education and awareness of the importance of lead screening?
- HMW streamline testing to accommodate office and community needs?

As in the previous session, each participant voted for one to three strategies to address the HMW questions. The facilitator counted the votes, identified the top categories of strategies to address the barriers, and shared the following:

HMW improve patient education and awareness of lead testing and screening?

- Increase social media campaigns: Utilize targeted social media campaigns to educate young parents about lead testing.
- Develop educational materials: Create educational materials for local daycares and other community organizations to share with families.
- Partner with schools: Implement educational programs in schools for families with young children.
- Public service announcements: Launch public service announcements to raise awareness about lead poisoning and testing.
- Text message reminders: Develop text message campaigns to remind parents about lead screening for their children.

HMW increase and sustain provider education and awareness of the importance of lead screening?

- Mandatory education: Require lead poisoning education for healthcare providers as part of license renewal.
- Offer Continuing Medical Education (CME)/Continuing Nursing Education (CNE) courses: Provide free or low-cost CME/CNE courses concerning lead poisoning for HCPs.
- Develop educational resources: Create a centralized platform with educational resources concerning lead poisoning for providers.
- Electronic medical record (EMR) prompts: Integrate EMR prompts to remind providers about lead testing during well-child visits.

- Mentorship programs: Facilitate mentorship programs to connect experienced providers with those who are new to lead screening.

HMW streamline testing to accommodate office and community needs?

- Increase POC testing availability: Equip more provider offices with POC testing instruments.
- Mobile testing events: Organize mobile lead screening events in convenient locations for families.
- Alternative testing sites: Explore alternative testing locations such as community centers or Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinics.
- Simplify data reporting: Develop solutions to streamline data collection and reporting for community-based testing.
- Extend testing hours: Offer lead testing outside of regular office hours to accommodate busy families.

As summarized by Dr. Lord, the solutions suggested by all types of stakeholders (DHHS, MCOs, providers, and other stakeholders) offered a comprehensive approach to making a difference.

6. Conclusions

At the conclusion of the team collaboration, Erin Metcalf offered closing remarks and thanked the presenters and participants for attending the meeting. She also reminded participants to complete the annual quality meeting evaluation that would be available to all participants at the close of the meeting.

After the meeting, 54 participants completed the annual quality meeting evaluation. Eight items required a *Strongly Agree, Agree, Disagree, or Strongly Disagree* response. In addition, four responses required a *Yes or No* response. Appendix D contains the annual quality meeting evaluation questions. The Main Medical Education Trust approved 3.75 contact hours for *AMA PRA Category 1 Credit™*. Four physicians received the Category 1 Credit. Additionally, DHHS offered 3.50 nursing contact hours, and 29 nurses received the contact hours for this activity.

The number of participants attending the meeting, the number of participants who attended the MURAL training sessions prior to the meeting, the diversity of organizations represented, the information presented by the speakers, the guidance provided by the facilitators, and the feedback generated during the meeting attested to the success of the virtual New Hampshire Annual Quality Meeting concerning improving the rates of BLL testing in New Hampshire.

Appendix A. Agenda

**DHHS Roundtable
Increasing Lead Level Testing Rate in 1- and 2-year-olds Agenda
Tuesday, June 11, 2024**

Objectives

- Objective #1— Reach consensus on the barriers to blood lead level testing of New Hampshire’s 1- and 2-year-olds.
- Objective #2— Brainstorm potential DHHS and MCO collaboration to resolve barriers negatively impacting New Hampshire’s pediatric blood lead level testing rates.

Time	Agenda Item	Speaker/Presenter
8:30 am	Welcome and Logistics	HSAG
8:35 am	Introduction – Outline of the Day	Jonathan Ballard, MD <i>DHHS Chief Medical Officer</i>
8:40 am	Living in a Pre-1978 Home: The Personal Story of Lead Poisoning	Beverly Baer Drouin, <i>Administrator, Healthy Homes & Environment Section, DPHS</i>
8:55 am	Polling on Existing New Hampshire Lead Testing	Erin Metcalf, MPH, <i>Administrator, Medicaid Quality Program DHHS Bureau of Program Quality</i>
9:00 am	New Hampshire HEDIS Lead Screening Rates and Measures	
9:10 am	The Secret Epidemic: Understanding Childhood Lead Exposure in New Hampshire <ul style="list-style-type: none"> • Lead by the Numbers: Exposure and Testing Surveillance Data • It’s Not the Water, It’s the Paint: Common Sources of Exposure • Every Child, Two Tests, by Two: New Hampshire’s Universal Testing Law 	Gail Gettens, MS, ECMP <i>Health Educator, Healthy Homes & Lead Poisoning Prevention Program, DPHS</i>

Time	Agenda Item	Speaker/Presenter
9:30 am	<p>Key Note Speaker</p> <p>Old Adversary, New Challenges: Update on Childhood Lead Exposure and the Importance of Blood Lead Level Testing</p>	<p>Alan Woolf, MD, MPH, FAAP, FACMT, FAACT</p> <p><i>Director, Pediatric Environmental Health Specialty Unit, Boston Children's Hospital</i></p>
9:50 am	<p>Facilitated Discussion on Brainstorming Barriers to Lead Testing</p> <ul style="list-style-type: none"> • Working together: What can be done? How do we do it? • Potential Barriers – group voting 	<p>Tanya Lord, PhD ATW Health Solutions</p>
10:45 am	Break	
11:00 am	Facilitated Discussion on Brainstorming Solutions	Tanya Lord, PhD
11:50 am	Facilitator Discussion – Summary of Brainstorm Exercise	Tanya Lord, PhD
12:15 pm	Closing Remarks	<p>Erin Metcalf, MPH, <i>Administrator, Medicaid Quality Program DHHS Bureau of Program Quality</i></p>

Appendix B. Barriers

Lack of Public/Parent Education
Parents not wanting to "hurt" their child
Parent doesn't have time
Lack of parental follow through
Parents not bringing children in for appt
Parents don't understand why lead testing is important
Parents are not bringing kids to lab for ordered BLL
Parental reluctance
Parent shame/guilt
Parents not wanting to do it in the moment "we will come back"
Parents may be in a rush and not able to bring child to the lab that day then forget
Parent education/resistance
Uninformed parents and people who support parents - e.g., grandparents, childcare, neighbors?
Parents don't want to wait after physical is done to complete
Parental bias to testing: Anti-Vaxxer sentiment pre- or post- pandemic and overall distrust with the medical/scientific community. Parent/Guardian refusing to seek care
Parent education or resistance
Parent lack of knowledge on effects of lead poisoning
Do not understand they may be at risk
Understanding the dangers
Parents fear of having child tested "hurt" by POC or lab draw
Parents don't want to go to lab
Parent hesitancy about need for lab work
Parents do not want to get venipuncture done
Do not like their kids getting painful procedures.
Lack of understanding that it is truly dangerous
Parent unaware of testing recommendations

Lack of Provider Education
Disinformation
Providers are not doing them
Provider Knowledge
Lack of provider knowledge
Lack of concern when lead levels are below 5-10
Don't understand the problem with elevated lead if the child appears healthy
CME for pediatricians and family medicine providers on importance of testing
Might not be concerned if child appears healthy and is meeting milestones
Providers telling parent levels over 5 mcg/dl are fine and
Medical Providers/ Staff not understanding Lead Poisoning
Misunderstanding that lead is poisonous
Pre-judgment of living situation
Lack of provider knowledge
PCP assigned inconsistencies as a barrier and allowed for the update based on historical claim data.
Provider thinks child is not at risk if living in a house built after 1997
Misunderstanding of why testing is done - think child is not exposed
Are 2 year old well child visits happening
Lack of clinical education
Clinical training
Provider/clinical staff education
Providers not following CDC guidance
Providers not being UTD on lead level guidelines
Lack of provider buy-in
Not all medical providers understand testing law and guidelines
Providers not testing
Provider unaware of recs
Lack of EMR connectivity with Provider community to MCOs to partner with bi-directional data exchange.

Staffing
Time constraints to follow up (providers and parents) everyone has too much to do and not enough time
Limited provider time with patient
Too many competing priorities
Busy office schedule
Limited time
Other priorities, especially for low income families
Not completing Lead Risk questionnaires with parents
Not enough provider offices have POC. Parents don't follow up on venous lab slip
Working into practice process flows
Follow up needed can't be done by providers if unable to reach the family
Missed appointments
Office visit time
Staffing for case management
Staffing issues
Provider shortages/turnover/loss of trained staff
Not a lot of time given by my hospital for preventive visits, we get the same amount of time for a simple ear infection as these in depth visits.
Limited staff
Staffing issues with time & resources
Appointment access concerns for rescheduling when apt was missed
Inconsistent staffing
Lack of confidence by team due to low volume
Appointment delays
Access to providers in a timely way
Workflow barriers - when to perform, before provider or after
Office staffing so some things can be missed or deferred during visits
Visits are too short for Dr to do everything necessary

Testing Issues
Need for testing in a way that prevents child fear of vaccines and labs
Phlebotomy not in the office
Labs ordered but parents not following through to get labs
False Positive due to the unknown barriers outlined in this presentation. So helpful to hear the details about keys, alcohol wipes versus Hand washing etc. We need more knowledge community wide, all levels (office staff, parents, schools, etc.)
Keep BLL test results, pediatric blood lead level test results, in a child's health record
Debating the diagnosis
Lack of trust in product due to multiple recalls
Testing done elsewhere, i.e. WIC visit but results not being shared with provider
Testing availability outside of standard treatment options
Lack of standard work for collection
Providers not being UTD on lead level guidelines
Not using point of care testing
Parents trusting next steps
Lack of confidence in testing supplies due to recent recall
More POC testing
Inconsistent POC testing readings
Issues with Lead Care Testing supplies
Distrust of tests after recall
Clotted samples, and then they are not returning back for redraw
Concern about waste of product due to 90 day expiring
Practices not using POC
HEDIS measurement changed! for BLL testing
Some are not able to obtain or order BLL if capillary is elevated
Lack of testing outside of age 1 & 2 if risk factors are present
Lack of tests in office- parents unlikely to come back again to test
Recalls on lead care kits (POC)
Collection at time of visit
Difficulty tracking whether testing has already been done
Not being required for school/ seen as important as vaccines
Practices assuming patients will have lab work performed and in turn have lead testing during this time which is not always the case

Transportation
Lack of transportation
Transportation Issues
Parents unable to get to appts

Data and Reporting
Lack of data from non-provider sites for MCOs
Member attribution and appointment setting
Requiring BLL testing results be documented on children's health forms
Lack of alignment across programs/payers/stakeholders on barrier removal/solutions
State registry mandatory use and access to MCOs.
Engaging providers in care gap list when MCO PCP assigned attribution is questioned and can't be altered without member input.
Consistent reporting into state so that kids that fall through gaps are found
Child care facility alignment with screenings

Financial
Financial implications
Not enough financial reimbursement for capillary POC. No incentive to use it

Language Barrier
Non-English speaking population

Appendix C. Strategies to Address Barriers

Strategies to Address: HMW Improve Patient Education and Awareness of Lead Testing and Screening?
Strategies for DHHS
Standard work for lead education for parents at 9 month visit in prep for 12 month visit
Increase social media campaigns that target young parents to educate them on testing their children
Utilize Dept of Transportation road signs to advertise lead testing for children
Texting program for anyone enrolled in Maternal/child health programs reminding of lead screening due
Provide education and resources/materials to local day cares to share with families
To help with resources create an education platform that can be utilized in provider practices vs having DHHS go out to all of our medical group practices
Require provider education on Lead poisoning and study results. Proper testing (not only at 1&2)
Work with home visiting agencies /programs to help parents understand the dangers of lead and the ease of testing in a way they can understand
Penalize MCOs significantly for poor outcomes
Education through schools for families with younger than school-age and school age children
Implement a text for babies campaign for all new mothers that prompt them to test their one and 2-year old children
Work with low income access points to support education of parents and guardians (after school programs, shelters, food pantries, other low income resources)
Legislate more stringent requirements for buying pre 1978 housing and disclosing or testing for hazards
Public Health public service announcement/campaign
Leveraging DCYF visits & engagement with parents as an opportunity to encourage PCP visits and understanding of medical needs
Tailor education to learning styles of parents today. Phone accessible, bite size information. Prompt parents through cell phones for screenings
Stateside educational campaign including –billboards—radio ads—social media ads—TV commercials
Public awareness campaigns
Money to fund street corner banners asking parents to test at age 1 & 2
Collaborate with ECE/daycare programs to encourage parents to test
Ongoing pointed education to providers and parents about the importance of lead testing
Offer lead testing clinics at community events
Create videos taking a tour of Pb 'hot spots' in a home for TikTok and UTube

Strategies to Address: HMW Improve Patient Education and Awareness of Lead Testing and Screening?
Strategies for MCO's
Make incentives immediate at doctor's office
Lead free me books provided to parents at 9 month visit to que the provider to have the discussion to prepare parents for the 12 month visit
Pay providers directly instead of through their hospital/employer for doing these steps
Offer incentive to parents and providers to have testing done
Financial incentives for parents
Send electronic alerts with PSAs about the importance of lead screening to the insured members
Continue member incentives
Get more visible education and effects of lead to local libraries, recycling centers, grocery stores etc.
MCO care gaps
Financial incentives for parents
Align lead screening and follow up across ALL health plans - public and private
Have birthing centers include important lead prevention and testing education in their packets they give to new parents
Gift cards for providers who screen patients best
Make incentives immediate at doctor's office
Lead free me books provided to parents at 9 month visit to que the provider to have the discussion to prepare parents for the 12 month visit
Offer incentive to parents and providers to have testing done.
Pay providers directly instead of through their hospital/employer for doing these steps
Send electronic alerts with PSAs about the importance of lead screening to the insured members
Continue member incentives
Strategies for Providers
Include lead testing competency in onboarding of staff
Invite DHHS into offices for lunch & learn or similar
Build reminders into EMR systems
Have nursing staff contact parents prior to WC visits to discuss testing and put in POC orders
Have parents complete electronic or paper risk assessment questionnaire while in waiting room or prior to office visit Make sure it is simple and in multiple languages
More education to be done at the 9th well check to prepare for the upcoming 12 month visit

Strategies to Address: HMW Improve Patient Education and Awareness of Lead Testing and Screening?
Work with Public Affairs in our organizations to launch a Lead Campaign on lead paint awareness and testing ages and testing to expect (POC) at Well Child Visits
Have OB offices provide lead testing and lead hazard education to all women of child bearing age
Develop standard process flow for testing in your/provider's clinic
Include discussion of risks of lead poisoning beginning at first visit
Have better nurse follow up for patients who don't go to lab to get drawn
Greater awareness given to all levels of staff. reduction of misinformation
Scheduling of appointments outside of annual visit timeframe (appointments after 12 months, after 24 months etc.)
Offer testing at urgent cares with PCP notification
Include lead testing competency in onboarding of staff
Invite DHHS into offices for lunch & learn or similar
Have nursing staff contact parents prior to WC visits to discuss testing and put in POC orders
Have parents complete electronic or paper risk assessment questionnaire while in waiting room or prior to office visit Make sure it is simple and in multiple languages
More education to be done at the 9th well check to prepare for the upcoming 12 month visit
Work with Public Affairs in our organizations to launch a Lead Campaign on lead paint awareness and testing ages and testing to expect (POC) at Well Child Visits
Medical offices to send out notification to parents that kids are due for lead screening prior to the visit to give them a heads up
Strategies for Other Stakeholders
Offer space at public forums for education, for example space on the wall at a sporting event
Make standard practice to put info on lead testing and importance into after visit summaries for child visits birth-2 years so parents know to ask (in case providers don't have time to bring it up)
CMS QI TA for to share best practices across Medicaid program participation
Develop user friendly home testing. Can this be done via dried blood spots
Work with state legislators to include lead test results on daycare and school entrance forms
Use of media stories & other major communications
Utilize lead-free book in library hours to educate and share the message

Strategies to Address: HMW Increase and Sustain Provider Education and Awareness?
Strategies for DHHS
Identify providers seeing pediatric patients and require lead education for license renewal
Recognition of top MCO and or provider group for lead testing one State website in public facing offices with press event
Road shows, provider bulletins
Offer CME/CNE hours on this topic
Increase lead testing reimbursement rate
Develop podcasts for health care professionals
Offer free annual CME/CNE on this topic and notify licensed providers thru OPLC
Make it a rule that providers need annual lead training and provide them the time in their day to do it
Audit provider offices on their compliance with Universal Testing
Public health detailers visit offices and have one person in office lead the staff education and provide updates to providers
Have annual in-services for providers and nurses onsite (where the staff work)
Greater awareness and educational opportunities through schools with high lead in water test results
Work with board for license level educational requirements and continuing ed requirements on this topic
Strategies for MCO's
Financial incentives for providers to do BOTH tests
Sponsor ECHO education that include Quality Improvement Project
DHHS alerts and required CME for license renewal
Provider Incentives
Mandate provider offices comply with Universal Testing for reimbursement
Engage nurses in your program to perform outreach to patients like they do with other wellness needs
Pay me as the parent with a gift card for testing
Have Child Care centers post lead poisoning education for parents and remind them to get their children tested
Advocate for state subsidies for phlebotomists in the peds offices
Partner with DHHS to provide more ECHO educational series for Providers
Strategies for Providers
Start education with OB practices around lead testing vs waiting for well child pedi visits. Share happy, healthy, lead-free me book with OB practices and family place (OB in-patient) floors
Need for Medicaid to increase reimbursement of longer WCC's for providers/staff to educate the parents of the importance and need for lead testing

Strategies to Address: HMW Increase and Sustain Provider Education and Awareness?
Offer lunch and learn sessions geared toward providers
Require more lead poisoning training in medical school
Gift cards to be given out at office visits for screening
Add prompts in EMRs that are able to be implemented as a standard to remind providers of screening needs.
Participate in ECHO projects with QA projects to train staff
Other Stakeholders
Need better transportation for families who can not get to appointments
Find a way to put HEDIS measure incentive in front of providers/program managers
Home visiting to do follow up

Strategies to address: HMW Streamline Testing to Accommodate Office and Community Needs?
Strategies for DHHS
Have events for testing i.e., feed them and test them
Install POC instruments in all provider offices
Connect EMR to HHLPPP for reporting
Mobile lead screening events
Solve for POC test results reporting in community based testing environments - data collection resolution is needed
Have EMR prompt medical providers to test children at one and 2-yo. If they haven't been tested prompt should continue for 3, 4
Facilitate mentorship on workflow between practices with high POCT testing rates and those who want to implement POCT
Dramatic social media education that grabs parents attention
Provide community screening where parents and patients are (local trampoline parks, ski areas, parks) after hours and weekends
Mobile testing and reporting like dental clinics at schools
Work on community engagement opportunities that allow for POC testing and reporting solutions
Offer community testing at various events in the state that attract pedi population - Wild NH at NH F&G, Fairs, etc.

Strategies to address: HMW Streamline Testing to Accommodate Office and Community Needs?
Strategies for MCO's
Lead mobiles in neighborhoods, county fairs; reward to child - tickets for a ride!
Build best practice alerts in EMR
Better reimbursement for POC in the office
Formal training of clinical staff in capillary collection
Pay the parents gift cards at the office visit
Pay the child with college savings bonds for testing
Strategies for Providers
Provide POC testing prior to child seeing provider
Review charts of patients needing testing and establish a reminder process
Offer lead testing clinics similar to flu clinics
Better POCT testing options in PCP office
Have lead test orders automatically populate for all children in their EMR to remind provider to ask about risk factors and prompt them to order the test.
Offer offsite options for testing to better accommodate pts
Standardize or encourage testing of pregnant women, offer testing as part of any visits for pregnant patients
Establish a team approach to completing testing during patient visits
Offer point of care testing if you don't already
Embrace POC as parents don't want to do Venous tests
Strategies for Other Stakeholders
Develop relationship between clinics and state for there to be an easy way to order more tests in a timely fashion- so clinics are never out of tests or worried about holding expired tests
Outreach from DHHS for overdue tests (not just for completed tests with results over 5mc/dl). A unified approach to looking at registries and closing gaps for overdue 1&2 year old
This is not related to provider education- but at an insurer level, improving reimbursement rates would incentivize clinics to test. I believe they're losing money on tests right now but I may be wrong
CMS QI TA for to share best practices across Medicaid program participation



Appendix D. Annual Quality Meeting Evaluation

Annual Quality Meeting Evaluation Increasing Lead Level Testing Rate in 1- and 2-year-olds Evaluation Form

Tuesday, June 11, 2024

Please check the response that most accurately describes your evaluation of the following statements.

A. Objectives

The following objectives were met during the meeting:	Strongly Agree	Agree	Disagree	Strongly Disagree
1. Reach consensus on the barriers to blood lead level testing of New Hampshire’s 1- and 2-year-olds.				
2. Brainstorm potential DHHS and MCO collaboration to resolve barriers negatively impacting New Hampshire’s pediatric blood level testing rates.				

B. Increasing Lead Level Testing Rates

Living in a Pre-1978 Home: The Personal Story of Lead Poisoning

Speaker: Beverly Drouin,
Administrator, Healthy Homes and Environment Section, DPHS

The speaker was knowledgeable about the topic of the meeting, an effective speaker, and presented valuable information regarding the long-term impacts of lead exposure and recognizing pre-1978 housing as the most common source of lead exposure for young children.	Strongly Agree	Agree	Disagree	Strongly Disagree

C. HEDIS Lead Screening Rates and Measure

Speaker: Erin Metcalf, MPH
Administrator, Medicaid Quality Program, DHHS Bureau of Program Quality

The speaker was knowledgeable about the topic of the meeting, an effective speaker, and presented valuable information regarding HEDIS lead screen metric limitations and New Hampshire data and areas for improvement.	Strongly Agree	Agree	Disagree	Strongly Disagree

D. Childhood Lead Exposure in New Hampshire

<p>Speaker: Gail Gettens, MS, ECMP <i>Health Educator, Healthy Homes and Lead Poisoning Prevention Program, DPHS</i></p>	Strongly Agree	Agree	Disagree	Strongly Disagree
<p>The speaker was knowledgeable about the topic of the meeting, an effective speaker, and presented valuable information regarding identifying childhood lead exposure as a significant pediatric environmental health issue in New Hampshire, recognizing low pediatric blood lead level testing rates of NH children enrolled in Medicaid, and identifying common sources of lead exposure for children living in New Hampshire.</p>				

E. Old Adversary, New Challenges: Childhood Lead Exposure and Importance of Pediatric Blood Lead Level Testing

<p>Keynote Speaker: Alan Woolf, MD, MPH, FAAP, FACMT, FAACT <i>Medical Director, Pediatric Environmental Health Specialty Unit, Boston Children’s Hospital</i></p>	Strongly Agree	Agree	Disagree	Strongly Disagree
<p>The speaker was knowledgeable about the topic of the meeting, an effective speaker, and presented valuable information regarding the identifying of novel sources of lead and children who are especially vulnerable to exposure, recognizing the methods of screening and testing children for lead exposure, and identifying roles for HCPs in managing children with Pb poisoning and counseling their families.</p>				

F. Meeting Facilitator

<p>Tanya Lord, PhD <i>Chief Innovation Officer ATW Health Solutions</i></p>	Strongly Agree	Agree	Disagree	Strongly Disagree
<p>The facilitator effectively and efficiently managed the discussions during the meeting.</p>				