



STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

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The Honorable Ed McBroom, Vice Chair
Joint Select Committee on the Flint
Water Public Health Emergency
S-1487 House Office Building
Lansing, MI 48933

The Honorable Ed Canfield
Joint Select Committee on the Flint
Water Public Health Emergency
S-1188 House Office Building
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- 1. Prior to July 2015, would you characterize the Department's monitoring of blood lead levels in Michigan children under the Childhood Lead Poisoning Prevention Program (CLPPP) as adequately monitoring for trends in lead exposure?**

Both prior to and after July 2015, CLPPP has fulfilled its program charge as required by the Public Health Code. See MCL 333.5474.

- 2. Is the CLPPP's current blood lead level monitoring done on a real time basis to identify and treat potential public health crises or is it primarily analyzing past data?**

Since the Surveillance System was established based on mandatory laboratory reporting in the late 1990s, CLPPP has provided data to Local Health Departments (LHD) about the number and frequency of elevated blood lead (EBLL) cases in their jurisdictions on a monthly basis, and on some occasions, such as reports of very high blood lead levels, on a daily basis.

- 3. Given the fleeting nature of blood lead levels as they relate to exposure and long term damage, do you believe DHHS has a responsibility to more actively monitor blood lead levels for spikes and address potential causes?**

CLPP has fulfilled its program charge as required by the Public Health Code. See MCL 333.5674. The law does not currently require more active monitoring of blood lead levels. It should also be noted that CLPPP is working with several communities where the percent of

children with EBLL was higher in 2015 than 2014, to identify reasons for these trends, and will continue to be providing data summaries to all LHDs that they can use to investigate unusual trends.

4. What is your policy for sharing blood lead level data with physicians and researchers? Why did Dr. Hanna-Attisha not receive the data she requested on blood lead levels?

DHHS follows the requirements set out in the Public Health Code and its Administrative rules. See MCL 333.5474 and R 325.9086. The second part of this question assumes facts that MDHHS does not believe are true. Data was provided to Dr. Hanna-Attisha in accordance with established requirements under the Public Health Code and Administrative Rules which define when confidential blood lead level information from the surveillance system can be released. Dr. Hanna-Attisha sent her study proposal to MDHHS on September 16, 2015 in which she sought raw data, including people's zip codes, dates of birth, blood level, and date of test. She requested the information from MDHHS program staff but received an auto-reply to her e-mail request stating the person she sent the request to was out of the office. Senator Ananich sent an e-mail to Director Lyon on September 21 asking for his assistance in answering Dr. Hanna-Attisha's request. Senator Ananich's request was forwarded to the MDHHS Institutional Review Board (IRB) on September 21. The MDHHS IRB Administrator determined that MDHHS IRB approval was necessary to release the information Dr. Hanna-Attisha sought. Dr. Hanna-Attisha sent the MDHHS IRB a formal IRB application on September 29, 2015, in which she requested a waiver of the requirement to obtain authorizations from the research subjects to disclose their protected health information for research. Follow-up to the application was needed in order for Dr. Hanna-Attisha to answer MDHHS IRB questions on the data needed for the analysis and the requested waiver of authorizations. After Dr. Hanna-Attisha answered the questions, the MDHHS IRB approved the application on October 1, 2015. MDHHS released information to Dr. Hanna-Attisha on October 2, 2015.

5. Have blood lead level data sharing protocols been modified at all following the interaction with Dr. Hanna-Attisha and Professor Edwards?

The legal requirements and procedures for releasing blood lead data that include confidential identification and health information have not been changed. We have increased the number of staff in the CLPPP program so that data requests can be more quickly processed and we have established a tracking system to monitor the steps of each data request.

6. Was there any indication that DHHS epidemiologists or data employees were planning on analyzing blood lead levels for Flint prior to the outreach from Gov. Snyder's office expressing concerns from Flint residents about water quality?

There are ongoing reviews relating to this question. If information is discovered that is responsive to this question we will share it accordingly.

7. Can you clarify why the conflicting conclusions in July 2015 on Flint blood lead levels of epidemiologist Larder and data manager Scott were not more widely discussed within DHHS and were not elevated to higher levels of authority within the Department to reconcile the different methodologies and conclusions?

There are ongoing reviews relating to this question. Information will be provided when investigation is complete.

8. What caused DHHS to initially deny the findings and try to discredit the analysis of Dr. Hanna-Attisha and Professor Edwards?

This question assumes facts that MDHHS does not believe are true. MDHHS did not deny the findings of Dr. Hanna-Attisha or Professor Edwards or attempt to discredit their analyses. As to Dr. Hanna-Attisha, MDHHS initially had some questions regarding her specific methodology.

9. Was it methodology or something else that caused DHHS to change course and agree with Dr. Hanna-Attisha and Professor Edwards' conclusions?

My understanding is that we did not regularly analyze our data at zip code level. Dr. Hanna-Attisha's findings that were released at the end of September quickly prompted us to review our data. We contacted Dr. Hanna Attisha and using similar methodology, we were able to confirm an increase in lead levels in those served by the Flint water system, consistent with Dr. Hanna-Attisha's findings.

10. Can you detail DHHS's interactions with other departments on issues affecting public safety?

MDHHS interacts with multiple State of Michigan departments on a variety of issues that affect public health and safety. We conduct these activities under several funding streams including federal grants and cooperative agreements, fees for services, and State of Michigan general fund dollars.

The MDHHS Division of Environmental Health works in cooperation with federal (HUD, EPA, CDC, ATSDR), State of Michigan (MDEQ, MDARD, MDNR, MIOHSHA, MSP) and local government agencies to identify and evaluate chemical and environmental threats.

11. Do you think that DHHS's coordination with other departments, particularly with DEQ, is adequate to prevent public health crises like the Flint water emergency from occurring?

MDHHS is actively engaging with the MDEQ to improve existing avenues of coordination and collaboration. Most recently, MDHHS entered into a memorandum of understanding (MOU) with MDEQ regarding the Toxics Steering Group, which is a coordinated effort to share scientific information among toxicologists working for four state agencies: MDHHS, MDEQ, the Michigan Department of Agriculture and Rural Development, and the Michigan

Department of Natural Resources. MHDDS staff will work with these agencies on issues of common interest to ensure a coordinated response to issues that affect public health.

In accord with the Task Force's recommendations, the MDHHS MO with DEQ provides for a process to ensure that data and public health information is appropriately explained. As part of this process, there will be monthly communications with the departments' respective chief deputy directors as well as the population health and community services administration deputy director, to ensure that combined interests are consistent and to provide the public with consistent recommendations.

12. Please detail the protocol that DHHS utilizes when handling outbreaks such as Legionellosis. Particularly, what caused DHHS to declare the outbreak in Genesee County over in May 2015 when later reports showed that additional cases were still occurring in May 2015?

DHHS follows approved CDC protocols when handling outbreaks such as Legionellosis.

There are standard definitions that the CDC uses to declare when an outbreak over, which is two incubation periods. MDHHS staff began developing its report regarding the 2014 Legionellosis outbreak in Genesee County in April 2015. At that time 2 cases had been reported in January, No cases were reported in February, one case was reported in March, and no cases were reported in April. While the report was being finalized an additional case was reported in May. Between the March and May cases, it appeared to certain DHHS staff that the threshold was met for stating that the outbreak had ended.

13. Can you detail DHHS's analysis of the cause of the Legionellosis outbreak in Genesee County?

MDHHS and GCHD conducted an epidemiologic analysis. It is my understanding that MDHHS staff assisted GCHD with the development of an outbreak specific questionnaire, and interviews were attempted with all identified cases. Survey questions collected information on: demographics, healthcare exposures, residential water source, water exposures in the home, exposure to water outside of the home, work, travel, community exposures, comorbidities, and high-risk behaviors.

The data was compiled in two reports June 2014-March 2015 and May 2015-October 2015. There were no cases reported in April of 2015. These reports can be found on our website at:

https://www.michigan.gov/documents/mdhhs/6-14_to_3-15_Legionellosis_Report_Full_Analysis_Results_511708_7.pdf

14. Were the DHHS staff working on the Legionellosis outbreak aware of water quality concerns while the outbreak was occurring?

While I cannot speak to the specific knowledge of all staff, MDHHS was assured that the water was safe. From a historical and medical perspective, as an airborne communicable

disease, legionella has traditionally been linked to sources where water has collected and pooled, e.g., in the cooling towers, water heaters and air conditioners of larger, multi-story buildings.

15. Did DHHS consider the switch of drinking water sources in Flint as a possible cause for the Legionellosis outbreak? If so, what prevented the department from discussing this with DEQ and conducting further testing to either confirm or rule out the Flint River as a cause?

While I cannot speak as to the specific considerations of all MDHHS staff, I am aware that an epidemiologic analysis was performed and a link to the switch in Flint's water source was considered. This analysis can be found in the reports identified in the answer to question #13.

16. In your opinion, were there any other departments or levels of government (city, county, federal) that were uncooperative or obstructionist in DHHS's investigation into the Legionellosis outbreak cause?

With the ongoing investigations I do not wish to speculate on the intent of other agencies. While I believe there are things MDHHS could have done better, I believe MDHHS sought to work cooperatively with all involved agencies as it assisted the GCHD in its efforts to address the Legionellosis outbreak.

17. What actions did DHHS take to educate and notify the public of the Legionellosis outbreak in Genesee County? Do you feel this was adequate? Why was public notification delayed until January? Is this in line with DHHS protocol?

Epidemiological analysis of disease outbreaks are often times very complicated, and not surprisingly this Legionellosis outbreak defied, a simple conclusion. As MDHHS continued to examine the data, it recommended that GCHD notify health care providers in the county of the increase in cases, so they would be aware as they treated patients. As time went on, and even without any conclusion as to the source of the outbreak, MDHHS decided to provide public notification. MDHHS's actions were consistent with its protocols relative to working with local health departments in addressing outbreaks.

18. What was DHHS's interaction with the federal Center for Disease Control in investigating the Legionellosis outbreak? Please detail CDC suggestions as well as why or why not DHHS did not follow those recommendations.

MDHHS has six CDC staff embedded within its public health staff who are in active communication with their agency, while functioning in support of public health activities in Michigan. These staff include a doctoral-level microbiologist Epidemic Intelligence Service Officer, a medical doctor/epidemiologist Career Epidemiology Field Officer and two post graduate Fellows. All of these staff were involved in this investigation since the fall of 2014 and were in frequent communications with Atlanta-based CDC program staff, in support of their efforts. MDHHS is not aware of any suggestions or recommendations from the CDC that were not followed.

19. Do you believe overall that DHHS fulfilled its mission of protecting the health of Flint residents?

Yes.

20. What do you believe were DHHS's primary shortcomings in detecting and remedying the public health implications of the Flint water emergency?

Without accepting the question's assumptions, which are the subject of current investigations, MDHHS has recently undertaken significant steps to strengthen and improve on overall communication and collaboration internally and with external partners. The previously discussed MOU is one example; another is the recent reorganization of staff who have direct interaction with local health departments (see response to question 24). As additional areas for improvement are identified by internal or external reviews, those will be addressed in turn.

21. Should the ODWMA be returned to DHHS supervision as it was before being transferred to the DEQ? Is it possible for the DEQ to focus on public health without the input of DHHS?

DHHS is not aware of any recommendations at this time but will review any as they are received.

22. Is it true that county health departments cannot act on lead issues- that it is out of their jurisdiction? If so, what changes does DHHS recommend?

No, local health departments have authority under the Public Health Code to conduct investigations, lead testing, case management, and abatement work.

23. What have been the consequences to the employees/divisions that so spitefully treated the public and professionals that brought information contrary to the department positions?

This question appears to assume facts which MDHHS does not believe are true.

24. What internal changes have been made to better interact with the public and to show equal standing to differing opinions from other health professionals?

This question is unclear and appears to assume facts which are not true. That said, MDHHS recognizes that there are areas where communication could be improved.

MDHHS has completed a reorganization to improve collaboration between program areas and to strengthen communication throughout the Population Health and Community Services Administration. The reorganization aligns essential program functions and service delivery of environmental health and communicable disease programs and elevates our

staff with responsibility to communicate with the LHD's. This will ensure that our local health entities are better connected with MDHHS senior leadership.

25. Does the county health department have the right to contact the CDC or are they prevented by law or rule from DHHS?

Yes, the local health departments have the right to contact the CDC.

26. Has any employee at DHHS been fired or removed from their position in response to the Flint water crisis?

There are investigations ongoing and if the results of those investigations suggest a need for disciplinary action against any MDHHS employees, the Department will consider those, in accord with Civil Service Rules.