New York State Department of Health Advisory Council on Lead Poisoning Prevention Meeting Agendas, Approved Meeting Minutes, and Reports

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New York State Advisory Council on Lead Poisoning Prevention
New York State Department of Health
ESP Meeting Room 1, Concourse Level
Albany, New York
Wednesday, August 21, 2019

AGENDA

10:00 a.m. – 10:30 a.m.	**Registration**
10:30 a.m. – 10:40 a.m.	**Welcome** **Overview of Agenda and Updates** *Michael J. Cambridge, Deputy Director* *Center for Environmental Health* *Advisory Council Chair*
10:40 a.m. – 11:20 a.m.	**Proposed Rulemaking 10 NYCRR Part 67 and Implementation** *Brian Miner, Director* *Bureau of Community Environmental Health and Food Protection*
11:20 a.m. – 12:00 p.m.	**Health Care Provider Outreach Updates and *draft* Guidance Revisions** *Dr. Kristen Navarette, M.D., Medical Director* *Center for Environmental Health*
12:00 p.m. – 12:30 p.m.	**Lunch - On your own**
12:30 p.m. – 1:10 p.m.	**Looking Forward – Additional Amendments to 10 NYCRR Part 67** *Tom Carroll, Chief* *Housing Hygiene Section* *Bureau of Community Environmental Health and Food Protection*
1:10 p.m. – 1:30 p.m.	**USEPA's Lead Renovation, Repair and Painting Rule (RRP Rule) and New York State** *Michael J. Cambridge, Deputy Director* *Center for Environmental Health* *Advisory Council Chair*
1:30 p.m. – 2:00 p.m.	**Council Member Updates and Discussion**
2:00 p.m. – 2:30 p.m.	**Public Comment**
2:30 p.m. – 2:35 p.m.	**Closing**

New York State Advisory Council on Lead Poisoning Prevention
New York State Department of Health
University at Albany School of Public Health
Health Sciences Campus – Café Conference Room
1 University Place, Rensselaer, New York
Tuesday, March 5, 2019

AGENDA

10:00 a.m. – 10:30 a.m.	**Registration**
10:30 a.m. – 10:40 a.m.	**Welcome** **Overview of Agenda and Updates** *Michael J. Cambridge, Deputy Director* *Center for Environmental Health* *Advisory Council Chair*
10:40 a.m. – 12:10 p.m.	**NYS FY 2020 Executive Budget Lead Poisoning Prevention Proposals** *Michael J. Cambridge, Deputy Director* *Center for Environmental Health* *Advisory Council Chair*
12:10 p.m. – 12:40 p.m.	**Lunch – On your own**
12:40 p.m. – 1:10 p.m.	**Health Care Provider Letter for Blood Lead Testing Quality Improvement** *Dr. Kristen Navarette, M.D., M.P.H., Medical Director* *Center for Environmental Health*
1:10 p.m. – 1:40 p.m.	**2019-2020 Kids Quality Agenda Performance Improvement Project for NYS Medicaid Managed Care Organizations** *Dr. Jeanne Alicandro, M.D., M.P.H., Medical Director* *Office of Quality and Patient Safety* *Susan G. McCauley, M.S., R.N., Director* *Bureau of Performance Improvement* *Office of Quality and Patient Safety* *Linda J. Freligh, R.N., Community Health Program Manager* *Bureau of Community Environmental Health and Food Protection*
1:40 p.m. – 2:10 p.m.	**Testing Pregnant Women for Lead** *Dr. Kristen Navarette, M.D., M.P.H., Medical Director* *Center for Environmental Health* *Alicia Fletcher, M.P.H.* *Bureau of Occupational Health and Injury Prevention*
2:10 p.m. – 2:25 p.m.	**Updates on Lead Poisoning Prevention Activities Across the State** *Tom Carroll, Chief Sanitarian* *Bureau of Community Environmental Health and Food Protection*
2:25 p.m. – 2:45 p.m.	**Council Member Updates and Discussion**
2:45 p.m. – 2:55 p.m.	**Public Comment**
2:55 p.m. – 3:00 p.m.	**Closing**

New York State Advisory Council on Lead Poisoning Prevention

New York State Department of Health
ESP Meeting Room 1, Concourse Level
Albany, New York
Thursday, September 28, 2017

AGENDA

10:15 a.m. – 10:30 a.m.	**Registration**
10:30 a.m. – 11:00 a.m.	**Welcome** **Overview of Agenda and Updates** **Review of Minutes from April 26, 2017 meeting** *Michael Cambridge, Deputy Director* *Center for Environmental Health* *Advisory Council Chair*
11:00 a.m. – 11:45 a.m.	**Program Updates** • Data Trends – Overall Screening efforts/updates • Guidance Updates - reaching out within NYSDOH • Primary Prevention Program Update *Tom Carroll, Chief* *Housing Hygiene Section* *Bureau of Community Environmental Health and Food Protection*
11:45 a.m. – 12:15 p.m.	**Update on new IT related activities in the Housing Hygiene Section related to Lead** • Primary Prevention -ColnSpect implementation • Healthy Neighborhoods Program – Tablets in the field • Lead Poisoning Prevention – Leadweb Enhancement *Tom Carroll, Chief* *Housing Hygiene Section* *Bureau of Community Environmental Health and Food Protection*
12:15 p.m. – 1:00 p.m.	**Lunch – On your own**
1:00 p.m. – 1:30 p.m.	**New Drinking Water Program Updates** • Lead in School Drinking Water Regulation 67-4 • Update Free Lead Testing Pilot Program • Update Lead Service Line Replacement Grant Program *Roger Sokol, Ph.D.* *Director, Division of Environmental Health Protection*
1:30 p.m. – 2:15 p.m.	**Council Member Updates and Discussion**
2:15 p.m. – 2:45 p.m.	**Public Comment**
2:45 p.m. – 3:00 p.m.	**Schedule Next Advisory Meeting - Tentative Dates -Spring 2018** **Adjourn**

New York State Advisory Council on Lead Poisoning Prevention
New York State Department of Health
ESP Meeting Room 1, Concourse Level
Albany, New York
Wednesday, April 26, 2017

AGENDA

10:15 a.m. – 10:30 a.m.	**Registration**
10:30 a.m. – 11:00 a.m.	**Welcome** **Overview of Agenda and Updates** **Review of Minutes from September 28, 2016 meeting** *Michael Cambridge, Deputy Director* *Center for Environmental Health* *Advisory Council Chair*
11:00 a.m. – 11:15 a.m.	**Update on NYS Budget** *Andy Ruby, NYSDOH Bureau of Fiscal Management*
11:15 a.m. – 12:00 p.m.	**Program Updates** • CDC Grant – Activities • Primary Prevention Program Update • Guidance Updates • Federal Dust Clearance Standard *Tom Carroll, Chief* *Housing Hygiene Section* *Bureau of Community Environmental Health and Food Protection*
12:00 p.m. – 12:30 p.m.	**Update on RRP Feasibility Discussion** *Eileen Franko, Ph.D., Director of Safety and Health* *New York State Department of Labor*
12:30 p.m. – 1:00 p.m.	**Lunch – On your own**
1:00 p.m. – 1:30 p.m.	**New Drinking Water Program Updates** • Lead in School Drinking Water Regulation 67-4 • Free Lead Testing Pilot Program • Lead Service Line Replacement Grant Program *Roger Sokol, Ph.D.* *Director, Division of Environmental Health Protection* *Teresa M. Boepple-Swider, P.E.* *Assistant Director* *Bureau of Water Supply Protection*
1:30 p.m. – 2:15 p.m.	**Council Member Updates and Discussion**
2:15 p.m. – 2:45 p.m.	**Public Comment**
2:45 p.m. – 3:15 p.m.	**Schedule Next Advisory Meeting - Tentative Dates -Fall 2017** **Adjourn**

NEW YORK STATE ADVISORY COUNCIL ON LEAD POISONING PREVENTION
NYS DEPARTMENT OF HEALTH
SEPTEMBER 28, 2016
ALBANY, NEW YORK
EMPIRE STATE PLAZA, MEETING ROOM 1

Topics	Discussion
Attendees Council Members:	**Council Members:** ➢ Nathan Graber, M.D, M.P.H., Director, Center for Environmental Health, NYSDOH (Council Chair) ➢ Michael Cambridge, R.S., Director, Division of Environmental Health Protection, NYSDOH (Commissioner Designee) ➢ Eileen Franko, Ph.D., Director of Safety and Health, NYS Department of Labor (Commissioner Designee) ➢ Michael Weber, NYS Homes and Community Renewal (Commissioner Designee) ➢ Debra Devine, NYS Homes and Community Renewal (Alternate Commissioner Designee) ➢ Pamela Hadad Hurst, Special Assistant, Commissioner's Policy Office, NYS Department of Environmental Conservation (Commissioner Designee) ➢ Dr. Morri Markowitz, Medical Director, Montefiore Regional Lead Resource Center (Hospital Representative) ➢ Gerard Hathaway, Assistant Director, Codes Division, NYS Department of State (Commissioner Designee) ➢ Thomas Keenan, Temporary Assistance Specialist, NYS Office of Temporary Disability Assistance (OTDA), Bureau of Refugee and Immigrant Assistance (BRIA) (Commissioner Designee) **Western Regional Office Rochester Video Conference Location** ➢ Nancy Heidinger, Lead Program Erie County Department of Health (Educator) ➢ Andrew McLellan, President/Director, Environmental Education Associates Inc. Amherst, NY (Undesignated At Large Public Member) ➢ David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) **Metropolitan Regional Office NYC Video Conference Location** ➢ Matthew J. Chachere, Staff Attorney, Northern Manhattan Improvement Corporation (Environmental Group) ➢ Abby Greenberg, M.D., Member, Nassau County Board of Health and American Academy of Pediatrics – District II (Professional Medical Organization) ➢ Deborah Nagin, M.P.H., Director, NYC Department of Health and Mental Hygiene (NYCDOHMH) – Lead Poisoning Prevention Program (Adjunct Member)

	Absent Council Members: ➢ Susan Duchnycz, Division of Child Care Services, NYS Office of Children and Family Services, (Commissioner Designee) ➢ Patrice Bogan, Deputy Director, Oneida County Health Department (Local Government) ➢ Kallanna Manjunath, M.D, Chief Medical Officer and Pediatrician, Whitney M. Young J. Health Services (Undesignated At Large Public Member) ➢ John Shannon, Administrative Director for the Upstate N.Y. Laborers' Education and Training Fund (Labor Union) **Additional Attendees:** ➢ Megan Mutolo, Senior Attorney, Bureau of House Counsel, NYSDOH ➢ Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection, NYSDOH ➢ Teresa Boepple-Swider, P.E., Assistant Director, Bureau of Water Supply Protection, NYSDOH ➢ Patrick Parsons, Ph.D., Chief, Laboratory of Inorganic and Nuclear Chemistry, Deputy Director, Division of Environmental Health Sciences, Wadsworth Center
Welcome and Introductions	In accordance with Executive Order #3 and the Open Meeting Law, this meeting is available on the internet and the meeting notice and links to the webcast are available at http://www.nyhealth.gov/events and will be archived for 30 days following the meeting. In accordance with Executive Law, section 166, members of the public who appear before the Council and represent any agency regulated by the Department of Health must fill out a Notice of Appearance form provided at the registration table. Dr. Nathan Graber convened the meeting at 11:00 AM and shared opening remarks. The current vacancies on the Advisory Council were shared and include the Child Health Advocate, Parent Advocate, Real Estate, Industry, and Local Housing Authority seats.

NEW YORK STATE ADVISORY COUNCIL ON LEAD POISONING PREVENTION
NYS DEPARTMENT OF HEALTH
SEPTEMBER 28, 2016
ALBANY, NEW YORK
EMPIRE STATE PLAZA, MEETING ROOM 1

Lead Advisory Council Minutes of April 13, 2016 Reviewed	The Council reviewed and discussed the minutes from the April 13, 2016 Council meeting. **Advisory Council Member Comments/Actions Items:** One Council member (Dr. Markowitz) requested a minor revision to the minutes. A second Council member (Matthew Chachere) noted that two discussion items requested at the last meeting were not represented on the current agenda. These discussion items were the preliminary Lead Program Budget and budget process along with the potential for NYS to take over/implement the US EPA Renovation, Repair, and Painting Program (RRP). Dr. Graber proposed that the Lead Program Budget be an agenda item for all future Council meetings and comments on the Lead Program Budget could then be raised during the Council meetings. Dr. Graber also informed the Council that information would be provided regarding the US EPA RRP during the Lead Program Updates portion of the meeting. Dr. Graber made a motion to adopt the minutes with the revision. The motion was seconded by Pam Hadad Hurst and the minutes were accepted by the Council with the one revision included. ➢ DOH will revise the meeting minutes accordingly ➢ The Lead Program Budget will be a standing agenda item for all future Council meetings
Lead Program Updates, Thomas Carroll, Section Chief, Housing Hygiene, Bureau of Community Environmental Health & Food Protection	**Lead Program Updates** (Mr. Thomas Carroll) The DOH provided updates and overviews of various aspects of the NYS Lead Program. Updates included program funding through the state and federal budget, currently available data sets reflecting childhood blood lead levels (BLL) and blood lead testing rates in NYS (Healthy Data NY and the Community Health Indicators Report), and data analysis and surveillance projects anticipated for release in December, 2016. Mr. Carroll also provided overviews of LeadWeb, inspections performed through the Primary Prevention program, the U.S. Environmental Protection Agency's (US EPA) Renovation, Repair, and Painting Program (RRP), and the Program's involvement in regulatory updates.

Discussion on U.S. Environmental Protection Agency Renovation, Repair, and Painting Program	**Advisory Council Member Comments/Actions Items**: The discussion following the presentation was largely focused on the ineffectiveness of the US EPA RRP and respective enforcement activities, as it is being implemented and enforced by the US EPA, and requests for a substantive discussion on how NYS could take over/implement and enforce the US EPA RRP. Council member Mathew Chachere made a motion for NYS to take over the US EPA RRP and impose significant recommendations. Council member Dr. Abby Greenberg identified the need to allow Local Health Departments (LHD) throughout NYS to provide input on this topic. Dr. Graber proposed to table the motion until LHD recommendations could be gathered and an in-person meeting with pertinent state agencies could be convened. Council member Dr. Eileen Franko expressed interest in evaluating the feasibility and components of NYS Department of Labor implementing parts of the US EPA RRP. A motion was made by Dr. Markowitz for state agencies to convene, evaluate the feasibility of implementing the US EPA RRP, and report back to the Council within one year. One Council member (Mathew Chachere) amended the motion for a report back to the Council at the next meeting. Dr. Markowitz accepted the amendment and the motion was seconded by Dr. Franko. The motion was accepted by all members of the Council. ➢ DOH will solicit input from LHDs regarding implementation of the US EPA RRP ➢ Appropriate state agencies will convene to evaluate the feasibility of implementing the US EPA RRP and report back to the Council at the next meeting
Additional Discussion on the Lead Program Update Presentation	The Council also discussed their desire to be involved in the development of proposed regulatory changes to Part 67 of the Public Health Law and their interest in the availability of maps depicting the incidence of BLLs at 5 µg/dL in NYS. Adjunct Council member Deborah Nagin provided an LHD perspective on the challenges of adding multiple service requirements at the same time without additional resources. ➢ DOH will provide an opportunity for the Council to comment on proposed regulatory changes to Part 67 of the Public Health Law ➢ DOH will notify the Council when mapping is publicly available for incidence of BLLs at 5 µg/dL

Blood Lead Standards Update, Dr. Patrick Parsons, Deputy Director, Division of Environmental Health Sciences, Wadsworth Center	**Wadsworth Center for Laboratories Revisions to Blood Lead Standards - Update** (Dr. Patrick Parsons) Dr. Patrick Parsons presented the updated DOH Clinical Laboratory Blood Lead Standards. The update included an overview of the currently available laboratory methods for analyzing lead in blood as well as the need for revising the Blood Lead Laboratory Standards based on the updated CDC definition of elevated BLL of 5 µg/dL and newly released technologies for analyzing blood lead. Dr. Parsons also provided a walkthrough of the updated standards, comments that had been received during the public comment period, and changes to information provided by the lab to the health care practitioner. **Advisory Council Member Comments/Actions Items:** The Council was interested in the ability of health care practitioners to interpret the significance of the analytical method now provided in lab reports for blood lead tests. This resulted in a broader discussion of how health care practitioners interpret blood lead test results. Dr. Greenberg referenced a survey that had been conducted in the late 1990's with doctors to better understand the lead poisoning knowledge and practices within the field and advised the Council that the survey could be repeated. Members of the Council also suggested that the lab reports include recommendations for next-steps that the practitioner should take based on the blood lead results. Additional topics for discussion included standard deviations reported by laboratories and the need for directors of preschools and kindergartens to have access to blood lead results. Dr. Parsons reported that Federal regulations allow for a standard deviation of ± 4 µg/dL, however, most labs can achieve a standard deviation of ± 2 µg/dL. ➢ Dr. Parsons will provide the published papers and presentation to CDC regarding laboratory standard deviations for blood lead tests ➢ DOH will look into what issues surround directors of preschools and kindergartens not being allowed to have access to NYS DOH blood lead data
Lunch Break	1:00 p.m. – 1:30 p.m.

NYSDOH School Water Testing Regulation 67-4, Teresa Boepple-Swider, Assistant Director, Bureau of Water Supply Protection	**Lead Testing in School Drinking Water** (Ms. Teresa Boepple-Swider) DOH provided an overview of new regulations requiring all school districts and boards of cooperative educational services to test all potable water outlets for lead contamination and to take responsive actions. DOH presented the requirements of the regulation which include: monitoring (sampling, analysis of samples, compliance dates); response (action levels and what schools must do if action levels are exceeded); public notification; reporting; recordkeeping; and, enforcement. **Advisory Council Member Comments/Actions Items:** Several questions were raised following the presentation. The discussion included: The reason for exempting non-public schools; the Senate and Assembly wrote this into the bill. The reason for continuing use of 15 parts-per-billion (ppb) lead as an action level; the Senate and Assembly wrote this into the bill. A council member advised that the action level should be at 5 ppb lead to protect children. The reason for setting an upper limit of 18 hours for the time water sits in the pipes; this comes from the U.S. EPA technical guidance document *3Ts for Reducing Lead in Drinking Water in Schools*. The reason for requiring a sample volume of 250 mL rather than 1 L; need to look at the local water outlet rather than pulling water from the larger plumbing system. A council member requested that NYS conduct a survey of BLLs of children attending schools with exceedances of lead in water. The timeframe for the laboratories to report an exceedance; it was unknown if the Environmental Laboratory Approval Program (ELAP) prescribes when notifications occur. The regulations require the laboratory to notify the school and the school to notify the Local Health Department.

	The timeframe for schools to notify parents of an exceedance; schools must notify parents within 10 days of learning of the exceedance. The school must take immediate action to discontinue potable use of the water outlet. Continued use of water for washing dishes when an exceedance occurs; potable use of the water must be discontinued, however, washing dishes and hands is permitted.
Research of Lead Exposures Associated with Protective Aprons, Dr. Morrie Markowitz, Medical Director, Montifiore Regional Lead Resource Center	**Lead Aprons: A Lead Exposure Hazard** (Dr. Morrie Markowitz) Dr. Markowitz presented data looking at lead dust on the external surfaces of protective aprons and shields worn by physicians, nurses, technicians, and patients during radiographic procedures. Each apron and shield received a visual inspection score, review of storage procedures, radiographic assessment, as well as qualitative and quantitative test for surface lead dust. Results indicated that lead dust was present on shields and aprons and associated with visual scores, storage method and type of shield. It was recommended that care should be taken to minimize damage to shields and aprons as there was less surface lead when more careful storage practices were used. **Advisory Council Member Comments/Actions Items:** One question was raised regarding encapsulating deteriorating aprons to reduce the lead dust escaping through small cracks or holes in the cover. Dr. Markowitz recommended that the aprons should be discarded appropriately when the visual appearance began to deteriorate.
Advisory Council Members Updates on Lead-Related Activities	**Council Members Updates** **Eileen Franko, Ph.D., Director of Safety and Health, NYS Department of Labor (Commissioner Designee)** Nothing new to report. **Dr. Morri Markowitz, Medical Director, Montefiore Regional Lead Resource Center (Hospital Representative)** Discussed work with a community organization in the Bronx who will be looking at the RRP. This will involve a pilot study with walkthroughs of renovations in apartment buildings.

	Thomas Keenan, Temporary Assistance Specialist, NYS Office of Temporary Disability Assistance (OTDA), Bureau of Refugee and Immigrant Assistance (BRIA) (Commissioner Designee) Discussed the resettlement of roughly 600 Syrian refugees over the past year. These have primarily been large families with children. They have been providing cultural lead hazard outreach and education. **Debra Devine, NYS Homes and Community Renewal (Alternate to Commissioner Designee)** The NYS Homes and Community Renewal continues to require testing for lead in buildings. **Pamela Hadad Hurst, Special Assistant, Commissioner's Policy Office, NYS Department of Environmental Conservation** Nothing new to report. **Gerard Hathaway, Assistant Director, Codes Division, NYS Department of State (Commissioner Designee)** Nothing new to report. **Andrew McLellan, President/Director, Environmental Education Associates Inc. Amherst, NY (Undesignated At Large Public Member)** Looks forward to the state agencies reporting back to the Council regarding the feasibility of NYS implementing the US EPA RRP. **David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group)** Announced that Rochester, NY is celebrating the 10th anniversary of the Lead Law and he hopes to be helpful to others wishing to pass similar legislation. **Nancy Heidinger, Lead Program Erie County Department of Health** Currently following-up with 5 – 9 ug/dL BLLs in Erie County as well as conducting inspections. **Deborah Nagin, M.P.H., Director, NYC Department of Health and Mental Hygiene (NYCDOHMH) – Lead Poisoning Prevention Program (Adjunct Member)** NYCDOHMH is currently working to figure how to address the new testing requirements for lead in school water. They have also been working with Hasidic community organizations in Brooklyn and upstate New York. She also added that the U.S. Department of Housing and Urban Development has released proposed regulations.

	Matthew J. Chachere, Staff Attorney, Northern Manhattan Improvement Corporation Announced that the New York City Coalition to End Lead Poisoning joined national advocacy groups in petitioning for writ of mandamus from the United States Court of Appeals for the Ninth Circuit requiring the U.S. EPA to promulgate a rule updating the dust-lead hazard standards and the definition of lead-based paint under the Toxic Substances Control Act. **Abby Greenberg, M.D., Member, Nassau County Board of Health and American Academy of Pediatrics – District II** Requested that an overview of the NYS Lead Budget over the past few years be presented at the next meeting to review trends. **Requests for Next Meeting** ➢ DOH will report on the Lead Program Budget ➢ DOH will report back to the Council about the evaluation of the feasibility of implementing the US EPA RRP ➢ DOH will look into what issues surround directors of preschools and kindergartens not being allowed to have access to NYS DOH blood lead data Meeting Closed Dr. Graber called for any public comments; no public comments were received. The notice for the next meeting will be sent out soon. Dr. Graber adjourned the meeting. **Meeting adjourned at 2:30 pm.**

NEW YORK STATE ADVISORY COUNCIL ON LEAD POISONING PREVENTION
NYS DEPARTMENT OF HEALTH
APRIL 13, 2016
ALBANY, NEW YORK
EMPIRE STATE PLAZA, MEETING ROOM 1

Topics	Discussion
Attendees Council Members:	**Council Members:** ➢ Nathan Graber, M.D, M.P.H., Director, Center for Environmental Health, NYSDOH (Council Chair) ➢ Michael Cambridge, R.S., Director, Division of Environmental Health Protection, NYSDOH (Commissioner Designee) ➢ Eileen Franko, Ph.D., Director of Safety and Health, NYS Department of Labor (Commissioner Designee) ➢ Michael Weber, Representing Darrel Townes, Commissioner, NYS Homes and Community Renewal (Commissioner Designee) ➢ Susan Duchnycz, Division of Child Care Services, NYS Office of Children and Family Services, (Commissioner Designee) ➢ Pamela Hadad Hurst, Special Assistant, Commissioner's Policy Office, NYS Department of Environmental Conservation (Commissioner Designee) ➢ Mary Elizabeth Mokrzycki, Program Manager, City of Syracuse Lead Program (Local Housing Authority) ➢ Dr. Morri Markowitz, Medical Director, Montefiore Regional Lead Resource Center (Hospital Representative) ➢ Gerard Hathaway, Assistant Director, Codes Division, NYS Department of State (Commissioner Designee) ➢ Deborah Nagin, M.P.H., Director, NYC Department of Health and Mental Hygiene (NYCDOHMH) – Lead Poisoning Prevention Program (Adjunct Member) **Western Regional Office Rochester Video Conference Location** ➢ Nancy Heidinger, Lead Program Erie County Department of Health (Educator) ➢ Andrew McLellan, President/Director, Environmental Education Associates Inc. Amherst, NY (Undesignated At Large Public Member) ➢ David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) **Metropolitan Regional Office NYC Video Conference Location** ➢ Matthew J. Chachere, Staff Attorney, Northern Manhattan Improvement Corporation (Environmental Group) ➢ Abby Greenberg, M.D., Member, Nassau County Board of Health and American Academy of Pediatrics – District II (Professional Medical Organization)

	Absent Council Members: ➢ Thomas Keenan, Temporary Assistance Specialist, NYS Office of Temporary Disability Assistance (OTDA), Bureau of Refugee and Immigrant Assistance (BRIA) (Commissioner Designee) ➢ Patrice Bogan, Deputy Director, Oneida County Health Department (Local Government) ➢ Kallanna Manjunath, M.D, Chief Medical Officer and Pediatrician, Whitney M. Young J. Health Services (Undesignated At Large Public Member) ➢ John Shannon, Administrative Director for the Upstate N.Y. Laborers' Education and Training Fund (Labor Union) **Additional Attendees:** ➢ Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection, NYSDOH ➢ Andy Ruby, Bureau of Budget Management, Fiscal Management Group, NYSDOH ➢ Alicia Fletcher, Program Director, Bureau of Occupational Health and Injury Prevention, NYSDOH ➢ Kelly Hughes, Public Health Representative, Bureau of Occupational Health and Injury Prevention, NYSDOH ➢ Roger Sokol, Ph.D., Director, Bureau of Water Supply Protection, NYSDOH
Welcome and Introductions	In accordance with Executive Order #3 and the Open Meeting Law, this meeting is available on the internet and the meeting notice and links to the webcast are available at http://www.nyhealth.gov/events and will be archived for 30 days following the meeting. In accordance with Executive Law, section 166, members of the public who appear before the Council and represent any agency regulated by the Department of Health must fill out a Notice of Appearance form provided at the registration table. Dr. Nathan Graber convened the meeting at 11:00 AM and shared opening remarks. The current vacancies on the Advisory Council were shared and include the Child Health Advocate, Parent Advocate, and Industry seats.

NEW YORK STATE ADVISORY COUNCIL ON LEAD POISONING PREVENTION
NYS DEPARTMENT OF HEALTH
APRIL 13, 2016
ALBANY, NEW YORK
EMPIRE STATE PLAZA, MEETING ROOM 1

NYSDOH Department of Budget, Andy Ruby	**Department of Budget Update** (Mr. Andy Ruby) The 2015-16 budget will maintain current funding for both programs.
Lead Program Updates, Thomas Carroll, Section Chief, Housing Hygiene, Bureau of Community Environmental Health & Food Protection **Discussion on 5 to 9 µg/dL Blood Lead Levels (BLLs)**	**Lead Program Updates** (Mr. Thomas Carroll) The DOH provided an update and overview of the state and federal budget that included CDC grant activities for the remaining two years of the grant. The new Healthy Neighborhood Program (HNP) awards that previously funded 13 counties are now funding a total of 19 counties. **Advisory Council Member Comments/Actions Items**: The discussion following the presentation consisted of how the DOH handles Blood Lead Levels (BLLs) of 5-9ug/dL. The DOH reported it has begun the comprehensive process of updating lead guidance and requested the Council's thoughts on how to integrate the CDC guidance into existing guidance. At this time tracking BLLs 5-9 µg/dL is an option in the 2014-2015 Lead Poisoning Prevention Program (LPPP) work plan. Forty five (45) out of the 56 counties provide some type of follow-up activity for tracking BLLs 5-9 µg/dL. ➢ A discussion of the follow-up activities being conducted by counties for tracking BLLs 5-9 µg/dL will be shared at the next meeting ➢ Draft guidelines will be shared with the Council before publication

Adult Lead Program, Alicia Fletcher, Kelly Hughes, Bureau of Occupational Health and Injury Prevention **Pregnant Women – Current follow-up of Elevated Blood Lead Levels**	**The NYS Heavy Metals Registry and Pregnant Women Follow-up** (Ms. Alicia Fletcher and Ms. Kelly Hughes) The DOH presented information on current activities performed to follow-up on adults with BLLs of 10 ug/dL or above. The activities include telephone interviews for women of childbearing years 16-45 yrs, contact with the reported OB/GYN to discuss the elevated BLL, future retesting the women, and coordination with the pediatrician, if applicable, to arrange blood lead testing on the newborn following the birth. DOH reported regular contact with the local health department (LHD) where the pregnant women reside to alert the LHD of the women with the elevated BLL results and the situation. **Advisory Council Member Comments/Actions Items:** A suggestion was made to include an OB/GYN seat on the Advisory Council. The Council members present were supportive of the action. ➢ DOH and Council members will review to determine whether an OB/GYN physician might fill a Council seat and will consider candidates.
Lunch Break	12:30 p.m. – 1:00 p.m.
Lead Advisory Council Minutes of March 4, 2015 Reviewed	The Council reviewed and discussed the minutes from the March 4, 2015 Council meeting. **Advisory Council Member Comments/Actions Items:** Three Council members (Dr. Greenberg, Pamela Hadad Hurst, and Andrew McClellan) requested revisions to the minutes. Dr. Franko made a motion to adopt the minutes with the changes/revisions. The motion was seconded by several members and the minutes were accepted by the Council with the three revisions included. The minutes, with three revisions, were approved by all with one abstention. ➢ DOH will revise the meeting minutes accordingly

Drinking water Lead and Copper Rule, Roger Sokol, Director, Bureau of Water Supply Protection	**Drinking Water Lead Copper Rule** (Dr. Roger Sokol) DOH provided an overview on the how lead in drinking water is regulated in the State. DOH presented the history of the regulations, background on the sources of lead, and current implementation of the Lead and Copper Rule. The information included – how lead gets into drinking water, clarification of what actions the Lead and Copper Rule requires public water systems take to minimize lead and copper in drinking water, the water sample collection process, and public notification. **Advisory Council Member Comments/Actions Items:** Several clarification questions were raised during and following the presentation. The discussion included: The basis for the lead action level; the basis was described as practical and feasible. The mechanism for public communication. One mode of public communication is the annual water quality report prepared by each public water system. The lead results appear in a table of contaminants tested for; if no exceedances are present, the table will indicate such. The annual report is sent to the person paying the water bill and for multifamily dwellings, the landlords are asked to share/or post the report. Many systems also post the reports on-line. The water sampling location for compliance monitoring. The sampling is a first-draw water sample from a point in the plumbing system that has not been used for a minimum of six hours. The relationship between lead in water and BLLs in children; a Council member suggested since the lead in water is dissolved, it may easier for a child to absorb. The frequency of exceedance of the lead action level in NYS public water systems. Two water systems were described as exceeding the action level for lead out of the 9,000 regulated water systems and 3,000 community water systems. The significance of lead in water compared to lead in dust and the overall effect on BLLs. A Council member indicated – several decades ago, authorities/stakeholders stopped looking at water as the cause of elevated BLLs in children but suggested we may need to consider lead in water as a possible concern for children with BLLs of 5-9ug/dL going forward.

	The State's plans for the Lead and Copper Rule in the future. The state is working to update regulations and will continue to focus on compliance with the Lead and Copper Rule. To continue the delivery of quality drinking water, it is important to have open dialogue with providers and consumers, to provide tools for education, and to be highly invested in the oversight of systems. Clarification between the applicable water sampling (Tier 1 or Tier 2) for a single family residence and multifamily unit. The single family residence is generally a Tier 1, and the multifamily is generally a Tier 2. A statement was shared as to how NYC implements the Lead and Copper Rule in single family homes.
Advisory Council Members Updates on Lead-Related Activities	**Council Members Updates** **Dr. Morri Markowitz, Medical Director, Montefiore Regional Lead Resource Center (Hospital Representative)** Discussed research he is involved with looking at lead exposures in the hospital radiology department associated with protective aprons that contain lead. They are currently measuring the dust from the lead apron and noted up to 990 mcg per square foot. BLL testing is underway, and they have written a paper on the findings. **Michael Weber, Representing Darrel Townes, Commissioner, NYS Homes and Community Renewal (Commissioner Designee)** Provided an update indicating last year (2015), the NYS Homes and Community Renewal RFP funding for multifamily housing required building practices that test for lead and remediation if rehabilitation done. **Pamela Hadad Hurst, Special Assistant, Commissioner's Policy Office, NYS Department of Environmental Conservation** Stated the NYS Department of Environmental Conservation (DEC) is consistently testing for heavy metals such as lead in packaging products. When lead is found, DEC notifies the applicable industry parties of the findings. **Gerard Hathaway, Assistant Director, Codes Division, NYS Department of State (Commissioner Designee)** Provided a brief update indicating that during Codes classes – the Codes Division references the 40 CFR 745 Lead Poisoning Code. This is an effort to educate all those taking the Codes class of the requirement that anyone conducting renovations on homes should have proper certification to do lead safe work practices.

	Eileen Franko, Ph.D., Director of Safety and Health, NYS Department of Labor Nothing new to report. **Mary Elizabeth Mokrzycki, Program Manager, City of Syracuse Lead Program** Nothing new to report. **Susan Duchnycz, Division of Child Care Services, NYS Office of Children and Family Services** Described an online training video for providers and the public teaching lead safety. In 2015, 10,530 people completed the training, and since 2010, 50,262 have completed training. **Deborah Nagin, M.P.H., Director, NYC Department of Health and Mental Hygiene (NYCDOHMH) – Lead Poisoning Prevention Program (Adjunct Member)** Stated NYC provides education on water and replacement of fixture, and technical support. The NYCDOHMH is making inroads with the targeted Williamsburg Hasidic community concerning lead poisoning prevention. **Nancy Heidinger, Lead Program Erie County Department of Health** Announced they are waiting for the County Executive to determine whether there will be increased funding for lead activities in Erie County. The County Health Department would like provide more activities for children with BLLs 5ug/dL and above. **Andrew McLellan, President/Director, Environmental Education Associates Inc. Amherst, NY (Undesignated At Large Public Member)** Stated the Buffalo Coalition on Lead and the media have led to positive opportunities working with the Erie County Executive. The group is also excited concerning the work with Niagara County who has applied to HUD for a grant. **David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group)** Thanked everyone for getting on track with the Advisory. Suggested the Advisory Council include an OB/GYN representative to help identify best practices and shape guidance moving forward. Shared that preschool administrators would like access to lead testing levels of children. **Matthew J. Chachere, Staff Attorney, Northern Manhattan Improvement Corporation** Provided an update on litigation in a high court concerning a landlord and a child with an alternate primary residence. Requested that DOH provide significant time at the next meeting to discuss the decrease in clearance dust levels to 10

	secondary to new guidance on BLLs 5ug/dL and above. Suggested that the DOH also discuss the potential for NYS to take over/implement the US EPA Renovation, Repair, and Painting Program (RRP). **Abby Greenberg, M.D., Member, Nassau County Board of Health and American Academy of Pediatrics – District II** Shared an interest in hearing more about the potential lead exposure from lead aprons in radiology settings at the next meeting. **Requests for Next Meeting** ➢ Discuss the potential for a decrease in clearance dust levels to 10 (secondary to new guidance on BLLs 5-9 ug/dL). ➢ Discuss the potential for NYS to take over/implement the US EPA RRP. ➢ Discuss next year's preliminary Lead Program Budget. ➢ An update from Dr. Morri Markowitz concerning the research on lead exposure from protective aprons. Meeting Closed Dr. Graber called for any public comments; no public comments were received. The notice for the next meeting will be sent out soon. Dr. Graber asked for a motion to adjourn, the motion was made by Dr. Franko and seconded by several members. **Meeting adjourned at 2:45 pm.**

NEW YORK STATE ADVISORY COUNCIL ON LEAD POISONING PREVENTION
NYS DEPARTMENT OF HEALTH
MARCH 4, 2015
ALBANY, NEW YORK
EMPIRE STATE PLAZA, MEETING ROOM 1

Topics	Discussion
Attendees Council Members:	**Council Members:** ➢ Nathan Graber, M.D, M.P.H., Director, Center for Environmental Health, NYSDOH (Council Chair) ➢ Michael Cambridge, R.S., Director, Division of Environmental Health Protection, NYSDOH (Commissioner Designee) ➢ Matthew J. Chachere, Staff Attorney, Northern Manhattan Improvement Corporation (Environmental Group) ➢ Abby Greenberg, M.D., Member, Nassau County Board of Health and American Academy of Pediatrics – District II (Professional Medical Organization) ➢ Thomas Keenan, Temporary Assistance Specialist, NYS Office of Temporary Disability Assistance (OTDA), Bureau of Refugee and Immigrant Assistance (BRIA) (Commissioner Designee) ➢ Eileen Franko, Ph.D., Director of Safety and Health, NYS Department of Labor (Commissioner Designee) ➢ Lisa Irizarry, Representing Darrel Townes, Commissioner, NYS Homes and Community Renewal (Commissioner Designee) ➢ Susan Duchnycz, Division of Child Care Services, NYS Office of Children and Family Services, (Commissioner Designee) ➢ Pamela Hadad Hurst, Special Assistant, Commissioner's Policy Office, NYS Department of Environmental Conservation (Commissioner Designee) ➢ Mary Elizabeth Mokrzycki, Program Manager, City of Syracuse Lead Program (Local Housing Authority) ➢ Nancy Heidinger, Lead Program Erie County Department of Health (Educator) ➢ Dr. Morri Markowitz Medical Director, Montefiore Regional Lead Resource Center (Hospital Representative) ➢ Patrice Bogan, Deputy Director, Oneida County Health Department (Local Government) ➢ Gerard Hathaway, Assistant Director, Codes Division, NYS Department of State (Commissioner Designee) **Additional Attendees:** ➢ Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection, NYSDOH ➢ Andy Ruby, Bureau of Budget Management, Fiscal Management Group, NYSDOH **Council Member watching Webcast:** ➢ Andrew McLellan, President/Director, Environmental Education Associates Inc. Amherst, NY (Undesignated At Large Public Member)

	Absent Council Members: ➢ Kallanna Manjunath, M.D, Chief Medical Officer and Pediatrician, Whitney M. Young J. Health Services (Undesignated At Large Public Member) ➢ John Shannon, Administrative Director for the Upstate N.Y. Laborers' Education and Training Fund (Labor Union) ➢ David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) ➢ Deborah Nagin, M.P.H., Director, NYC Department of Health and Mental Hygiene (NYCDOHMH) – Lead Poisoning Prevention Program (Adjunct Member)
Welcome and Introductions	➢ In accordance with Executive Order #3 and the Open Meeting Law, this meeting is available on the internet and the meeting notice and links to the webcast are available at http://www.nyhealth.gov/events and will be archived for 30 days following the meeting. In accordance with Executive Law, section 166, members of the public who appear before the Council and represent any agency regulated by the Department of Health must fill out a Notice of Appearance form provided at the registration table. ➢ The meeting was convened at 11:00 AM. ➢ Dr. Graber, Director, Center for Environmental Health announced he is the newly appointed Chair of the Council and stated he will have the members and DOH staff introduce themselves after a few reminders. ➢ Dr. Graber announced recent changes to the Advisory Council membership. Two Council members departed, Victorie N. Jacques (Parent Advocate) and Clifford Olin, President, EcoSpect, Inc. (Industry) who were thanked for their many years of service to this Council. He welcomed Dr. Morri Markowitz Medical Director, Montefiore Regional Lead Resource Center fulfilling the hospital representative seat; Ms. Patrice Bogan, Deputy Director Oneida County Health Department representing local government; and Mr. Gerard Hathaway, representing Department of State, standing in for Cesar A. Perales. He thanked them all for taking on the new responsibility. ➢ Dr. Graber pointed out there were now vacancies on the Council as it related to Child Health Advocate, Parent Advocate and Industry seats.

	➢ It was stated the renewal notices would be sent to current members whose terms were expiring. ➢ Dr. Graber noted that a quorum of Council members was present so a vote by the Council can be accomplished, but members on the phone could not vote. ➢ Dr. Graber asked the Council members and DOH staff to please introduce themselves. ➢ Dr. Graber asked the Council members to review the minutes from last meeting calling for a motion. Dr. Greenburg made a motion and it was seconded by several others. Minutes were approved without abstentions.
NYSDOH Department of Budget, Andy Ruby	**Department of Budget Update** ➢ Mr. Ruby, Bureau of Budget Management, Fiscal Management Group, NYSDOH stated the 2015-16 budget will maintain current funding for both programs with $4,035,700 for Lead Poisoning Prevention Program and $9,891,200 for Childhood Lead Poisoning Primary Prevention Program. ➢ Dr. Greenberg asked if the distribution of funding to the local health department remained the same. ➢ Mr. Cambridge responded: Basically the funding is unchanged as outlined. ➢ Mr. Chachere stated: Reading the minutes from last meeting we had a fairly long colloquy that this committee never gets budget information until it's a problem. I think it's stated right in the legislation that created the committee that we are supposed to be weighting in and making recommendations on budgeting issues and this is always after the fact. I think the role of this committee is substantially eviscerated. We should be getting budgets long in advance and have an opportunity to comment on them. We can find a way to communicate and every year when this happens I send out emails asking what the budget is and it's a problem. To clarify we should have the information that was presented here in writing included in the materials today. Are there re-appropriations here? Were there funds that were appropriated in the past and just spent or were the funds spent fully? ➢ Mr. Ruby responded: Any funds that were not fully spent in the past have been re-appropriated, but this program is funding at the intended budget amount. ➢ Mr. Chachere asked: Is it all being spent? ➢ Mr. Ruby responded: That is correct. ➢ Mr. Cambridge stated: In the handouts is the presentation that we will be going over and those numbers are in there on page two. An email with these documents was sent prior to the meeting. ➢ Mr. Chachere stated: I don't know why it's a secret process and why the committee is not involved and could be making recommendations. I think it's precisely what is said in the Public Health Law as to what the committee is doing. I think

	the department would want the benefit of our advocacies to push for as much funding as necessary and possible for this very vital issue. ➢ Dr. Graber acknowledged Mr. Chachere's statement and thanked Mr. Ruby for coming before the committee.
Lead Program Updates, Thomas Carroll, Section Chief, Housing Hygiene, Bureau of Community Environmental Health & Food Protection	**Lead Program Updates** (See PowerPoint presentation "Lead Program Updates" for details.) ➢ Mr. Carroll provided an update and overview of state and federal budget that included a $400,000 grant from CDC for three years used to restore central office staff previously cut from the program. ➢ Mr. Carroll stated there was no impact on the Lead Poisoning Prevention Program funding of $4 million and all state money goes directly to the counties. ➢ The Primary Prevention Program remains the same 9.8 million dollars. ➢ Mr. Carroll described how the Primary Prevention Program identifies at risk housing units, inspects for lead hazards and aims to prevent lead poisoning in the future. ➢ Mr. Carroll stated the new Healthy Neighborhood Program awards that previously funded ten counties are now funding 13 counties with a total of 2.7 million dollars. ➢ Dr. Greenberg asked: How many counties get HUD money to do abatement? ➢ Mr. Carroll stated: Three or four counties get HUD. The counties use the Primary Prevention funds they receive to leverage to get the HUD grant. ➢ Mr. Carroll explained the maps in his presentation showing incidence rates in the counties and how testing rates have increased over the years. ➢ Dr. Greenberg asked: How long before new data is available? ➢ Mr. Carroll responded: Hoping sometime during this spring. ➢ Dr. Franko asked: What is the range of error on analytical methods for blood lead levels? ➢ Mr. Carroll explained: Depending on the device, it can range from a plus or minus 2 to 4. ➢ Mr. Carroll gave an update on the Primary Prevention Program: We are currently contracting with 15 counties and serving 23 municipalities. Since its inception in 2007 almost 19,500 children have been directly reached through visits to their home, and over 11,384 referred for blood lead testing. ➢ Mr. Carroll discussed possible reasons for the length of time it takes to correct lead hazards in the home. **5 to 9 µg/dL Blood Lead Levels** ➢ Dr. Graber stated: We are in the process of updating all of our lead guidance and requested the Council's thoughts on how to integrate CDC guidance into our existing guidance.

Dr Graber, Discussion on 5 to 9 µg/dL Blood Lead Levels (BLLs)	➢ Dr. Markowitz stated there shouldn't be a distinction between a pregnant woman's blood level of concern or threshold in order to begin intervention with a child; they should all be 5 µg/dL. ➢ Dr. Franko asked: What are the screening rates for pregnant woman? ➢ Dr. Graber suggested that having the Adult Lead Program speak at the next meeting on efforts to improve communication between obstetricians and pediatricians on kids that are born to moms with (BLLs) 5 µg/dL or greater. ➢ Dr. Greenberg also concurred with Dr. Markowitz. ➢ Dr. Markowitz asked the Council to consider revising the guidelines with the federal level for floor dust sampling stating they will be obsolete when 5 µg/dL is adopted because they are in place to protect against 10 µg/dL. He stated OSHA only has inhalation standards for workers and no standard to protect workers from dust and if it is not on the federal level does it preclude the state from having one? ➢ Dr. Franko stated: We only have authority over NYS public employees with federal OSHA regulating everyone else. ➢ Dr. Graber asked Dr. Franko: Are we pre-empted from carrying out a standard at the state level? ➢ Dr. Franko responded: Yes, the only place we have jurisdiction is for municipal workers. ➢ Mr. Chachere stated that a there has been a petition pending in front of the EPA to push clearance numbers down. That does not mean NYS could not act independently on this issue. He stated he has repeated many times before to the Council that NYS can take over the administration of the Federal Renovation, Repair and Paint Rule (RRP). As long as the state standard is more stringent then the Federal Rule, the state can adopt its own lead laws. He cited several federal standards that needed to be made more stringent justifying the change. He suggested it become a recommendation of the Council. ➢ Dr. Markowitz asked for clarification on how the Council works when a recommendation is made. ➢ Mr. Cambridge explained: In the past, the recommendation would be put on the agenda for the next meeting so staff can research the information and report back to the Council. This recommendation to take over RRP has been made before and the Department chose not to act on it, citing reasons why that decision was made in the past. Mr. Cambridge explained how the recommendations can be made on different levels by the Council and that the Department can opt how it will respond. ➢ Dr. Markowitz requested the Department consider the recommendations of the guidelines he stated. ➢ Mr. Chachere stated: Whatever the issues are, this Council should have a discussion and there should be a report to the Council on the pros and cons of NYS taking over the administration of the Federal RRP Rule. ➢ Mr. Chachere stated that Mr. McLellan was watching the webcast and would be prepared to discuss the current state of RRP as it relates to NYS. Mr. Chachere stated we need to focus on how to improve lead safe work practices.

- Nancy Heidinger reported that Erie County is following up on BLLs 5-9 µg/dL, citing it as a tedious process due to many variables in getting the information. Erie is hoping to do follow-up in a year to see how risk reduction education has effected 5-9 µg/dL
- Mary Elizabeth Mokrzycki stated: The County Health Department refers all elevated BLLs to the City of Syracuse who conducts a full inspection/risk assessment and assists with the remediation.
- Ms. Irizarry asked: Has DOH done a survey to see how prevalent BLL of 5-9 µg/dL are in the local health departments?
- Ms. Freligh stated: Tracking BLL of 5-9 µg/dL is an option in the current LPPP work plan and that 45 out of 56 counties are providing some follow-up activities for tracking BLLs 5-9 µg/dL in the 2014-15 contract year. A report on the activities at the next meeting could be given.
- Mr. Carroll explained: We are asking the local health departments to come up with something on their own that works for them as it relates to 5-9s, so that we may look at and develop best practices from them.
- Dr. Greenberg stated that: Some consideration should be given to the age of the child when looking at the BLLs 5-9s; priority should be given for younger children. Younger children are of greater concern.
- Mr. Cambridge reminded the Council that Mr. Carroll had staffing changes that were going to allow the Department to explore all this new data and come up with more specific guidelines on BLLs 5-9s. We are hoping for more CDC guidance on this issue.
- Dr. Graber said that the suggestions and guidelines being formed will be shared with the Council so they will have a chance to comment on them.

Requests for Next Meeting

- Mr. Cambridge clarified the two requests for next meeting 1. Program putting together numbers based on what we expect the workload to be for an agency. 2. Program handling pregnant women issues and concerns.

"**A Successful Community Effort to Decrease Childhood Lead Poisoning: The Rochester and Monroe County Experience"** (See PowerPoint presentation for details.)

- Dr. Schaffer stated suburban communities in Monroe County have consistently been rated among the best places to live in the nation at the same time they have the 5th highest poverty rate in the US.
- The typical single family house or duplex was built 100+ years ago.
- An article in American Journal of Preventive Medicine showed declines in elevated blood lead levels among children in Monroe County between 1997-2011 where the blood lead levels dropped twice as fast as the rest of the state, excluding NYC, and at 1.8 times as fast as the rest of the nation.

Stanley J. Schaffer, M.D., M.S., Western New York Lead Poisoning Resource Center, Department of Pediatrics, University of Rochester	➢ The Lead Coalition started in 2000 with many stakeholders involved. In 2000 2% of US children had lead poisoning and 7.4 % of the children in Monroe County had lead poisoning. ➢ There are two lead coalition committees that meet each month, Government Relations and Screening and Professional Education. ➢ The 2005 Local Law passed requiring inspection of rental properties every three years including visual for lead paint. ➢ Each year they publish blood lead levels in the County. ➢ The coalition works closely with the school districts to help identify children that may be lead poisoned. ➢ There is a need for primary prevention to prevent lead poisoning in the first place and secondary to prevent additional exposure for those kids and families and pregnant women who already have been exposed. ➢ Dr. Markowitz asked if there is an online registry of houses that have been inspected? ➢ Dr. Schaffer responded that he was not sure if it was active or being worked on. ➢ Mr. Chachere asked if a grant for assessing homes for pregnant women is in effect? ➢ Dr. Schaffer affirmed the program and mentioned several collaborating programs for pregnant women. ➢ Mr. Chachere asked about landlord reception to the program and whether families were discriminated against because of the lead law. ➢ Dr. Schaffer explained it was a learning curve for all involved, but that none of the negative aspects really surfaced. He explained the many health, housing and educational benefits that came from the change and the housing stock appreciated in value. ➢ Ms. Irizarry stated that NYS Homes and Community Renewal has a data base and is interested if the Rochester data base could be linked. ➢ Dr. Graber asked if there is data to back up that property values increased and have the coalitions looked into other housing issues or just lead? ➢ Dr. Schaffer said a student at University of Rochester did a study and a lot of housing component items were changed on the house increasing the value and that the coalition has looked into other funding for housing issues, but concentrates on lead. The different grants that the city receives in many cases removes the financial burden for the repairs by loaning the money that eventually can turn into a grant and be forgiven over time. ➢ Ms. Irizarry asked if outreach to owners, developers, Section 8 and neighborhood groups was conducted while the law was being enacted in order to help individuals to find rental housing. On a second question follow-up to Dr. Markowitz an online data base would be helpful. ➢ Dr. Schaffer stated that extensive outreach was conducted with the help of the stakeholders. ➢ Dr. Franko asked if houses that were closed by the City of Rochester had other violations besides lead paint? ➢ Dr. Shaffer was not sure, but assumed it was more than lead issues.

Advisory Council Members Updates on Lead-Related Activities	➢ Mr. Keenan asked with refugee children there is a lot of cultural considerations so when you speak about the inspection of the home does it include other environmental issues? ➢ Dr. Schaffer stated the outside inspections are visual unless there is an EBLL involved then the County Health Department does a full environmental inspection. **Council Members Updates** Pamela Hadad Hurst, Special Assistant, Commissioner's Policy Office, NYS Department of Environmental Conservation ➢ Nothing to report. Thomas Keenan, Temporary Assistance Specialist, NYS Office of Temporary Disability Assistance, Bureau of Refugee and Immigrant Assistance ➢ Thanked CEH and Ms. Faith Schottenfeld for the brochure "Beware of Lead, Do You Know Where Lead is Hiding" a flyer made for outreach to refugee and immigrant communities across the state. The flyer deals directly with the use of cosmetics and other cultural items that are known to be used, and has been translated into many languages. Mary Elizabeth Mokrzycki, Program Manager, City of Syracuse Lead Program ➢ City of Syracuse is in the process of becoming a "Green and Healthy Homes Place." The City is working with State Attorney General's Office to get a small grant to help get designation. There are 29 points that are looked at when a home is inspected. We are looking at all hazards, code enforcement, structural and environmental, including the air quality and surroundings of the entire structure. The list of stakeholders in the project is extensive. Susan Duchnycz, Division of Child Care Services, NYS Office of Children and Family Services ➢ Mentioned an online video for providers and the public teaching lead safety. In 2015, 2,108 people took the training. Since 2010, 7,319 have taken the training ➢ The office has two forms one for daycare providers and one for parents covering more than lead paint. Requested to review DOH forms with staff and asked for a copy of power point presentations today. Lisa Irizarry, Representing Darrel Townes, Commissioner, NYS Homes and Community Renewal ➢ Is interested in more information on the Rochester certification program. ➢ Lisa mentioned they give preference for lead training to developers when they apply for our programs.

	Nancy Heidinger, Lead Program Erie County Department of Health ➢ Expressed gratitude for having three lead grants that are working in Erie County. Eileen Franko, Ph.D., Director of Safety and Health, NYS Department of Labor ➢ Nothing to report. Matthew J. Chachere, Staff Attorney, Northern Manhattan Improvement Corporation ➢ Mr. Chachere requested a copy of presentations from today. Abby Greenberg, M.D., Member, Nassau County Board of Health and American Academy of Pediatrics – District II ➢ Requested the meetings be held more often and not in the winter. **Meeting Closed** Dr. Graber called for any public comments; no public comments were received. He closed the meeting by thanking everyone for their comments and noted the need for more frequent meetings. He stated the difficulty in scheduling and said we are working on ways to reduce the amount of travel and still have a quorum. The notice for the next meeting will be sent out soon and the agenda will be long. He asked for a motion to adjourn. Meeting adjourned at 2:05 pm.

NEW YORK STATE ADVISORY COUNCIL ON LEAD POISONING PREVENTION
NYS DEPARTMENT OF HEALTH
APRIL 19, 2012
ALBANY, NEW YORK
EMPIRE STATE PLAZA, MEETING ROOM 1

Topics	Discussion
Attendees Council Members	**Council Members:** • Michael Cambridge, R.S., Director, Bureau of Community Environmental Health and Food Protection, NYSDOH (Council Chair) • Matthew J. Chachere, Staff Attorney, Northern Manhattan Improvement Corporation (Environmental Group) • Abby Greenberg, M.D., Member, Nassau County Board of Health and American Academy of Pediatrics – District II (Professional Medical Organization) • Joan Facelle, MD, Commissioner, Rockland County Health Department and Representative, NYS Association of County Health Commissioners, NYSACHO (Local Government) • Thomas Keenan, Temporary Assistance Specialist, NYS Office of Temporary Disability Assistance (OTDA), Bureau of Refugee and Immigrant Assistance (BRIA) (Commissioner Designee) • Ray Andrews, Assistant Director for Code Development, Codes Division, NYS Department of State (Commissioner Designee) • Deborah Nagin, M.P.H., Director, NYC Department of Health and Mental Hygiene (NYCDOHMH) – Lead Poisoning Prevention Program (Adjunct Member) • Maureen Cox, Director, Division of Safety and Health, NYS Department of Labor (Commissioner Designee) • Andrew McLellan, President/Director, Environmental Education Associates Inc, Amherst, NY (Undesignated At Large Public Member) • David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) • Susan Duchnycz, Division of Child Care Services, NYS Office of Children and Family Services, (Commissioner Designee) • Nancy Heidinger, Lead Program Erie County Department of Health (Educator) • Lorraine Collins, New York State Homes and Community Renewal (alternate) **Additional Attendees:** • Rachel de Long, M.D., M.P.H., Director, Division of Family Health, NYSDOH • Robert Chinery, Acting Director, Center for Environmental Health • David Quist, Division of Legal Affairs, NYSDOH • Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection, NYSDOH

	Absent Council Members: • Pamela Hadad Hurst, Special Assistant, Commissioner's Policy Office, NYS Department of Environmental Conservation (Commissioner Designee)/Carlos Montes, DEC (Alternate) • Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY Buffalo (Undesignated At Large Public Member) • Mary Elizabeth Mokrzycki, Program Manager, City of Syracuse Lead Program (Local Housing Authority) • Kallanna Manjunath, M.D, Chief Medical Officer and Pediatrician, Whitney M. Young J. Health Services (Undesignated At Large Public Member) • Mary Binder, Environmental Analyst, Division of Housing and Community Renewal (Commissioner Designee) • Clifford Olin, President, EcoSpect, Inc. (Industry) • Victorie N. Jacques (Parent Advocate) • John Shannon, Administrative Director for the Upstate N.Y. Laborers' Education and Training Fund (Labor Union)
Welcome and Introductions	• The meeting was convened at 10:15 AM. • Michael Cambridge provided opening remarks: ➢ Introduced himself as the newly designated chair of the Council, and thanked Dr. Guthrie Birkhead for his years of leadership as the Council Chair. ➢ Expressed the ongoing commitment of the Department to collaborate on lead issues as exhibited by the presence of Dr. Rachel de Long at the meeting. ➢ Introduced Robert Chinery, Acting Director, Center for Environmental Health, to the Council members. Mr. Chinery replaced Dr. Howard Freed, who recently retired. ➢ Announced the retirement of Clotilde Perez-Bode Dedecker, President/CEO, Community Foundation for Greater Buffalo as the Child Health Advocate for the past three years and thanked her for her service. ➢ Announced the retirement of Thomas P. Mahar, Code Compliance Specialist, Assistant Director, Regional Services, NYS Department of State, and introduced Ray Andrews as the official Commissioner's Designee for the Department of State. ➢ Reminded the Council: In accordance with Executive Order #3 and the Open Meeting Law, this meeting is available on the internet. The meeting notice and links to the webcast are at http://www.nyhealth.gov/events. All webcasts will now

	be archived for 30 days following the meeting. In accordance with Executive Law, section 166, members of the public who appear before the Council and represent any agency regulated by the Department of Health must fill out a Notice of Appearance form provided at the registration table. ➢ Agenda reviewed.
Review and Approval of Minutes	• Mr. Cambridge noted that a few changes had already been incorporated into the copy of the draft minutes distributed in the packets, and asked if there were any further additions or edits to the April 27, 2011 draft meeting minutes. Hearing no objections, the meeting minutes were adopted.
Governmental Affairs Update	• Mr. Cambridge announced James Clancy, Office of Governmental and External Affairs, was not able to attend the meeting but provided the Council Chair with the governmental affairs update that would be shared as part of one of the presentations. **Advisory Council discussion** ➢ Matthew Chachere inquired if an updated list of Council members with the vacant positions was available. He was advised the list was in the packet distributed to members upon arrival. ➢ Dr. Broadbent inquired about the two resumes for potential Council members he submitted and if they were being reviewed, and who was performing the review. Assured by Mr. Cambridge the nominations were sent to the Governor's office, Council Operations, who handles all the appointments. At this time any information that we've received up to date has been shared with the Council.
Updates from Michael Cambridge	• **Updates on budgets for the lead programs:** • **Childhood Lead Poisoning Primary Prevention Program** ➢ Primary prevention efforts in fifteen local health departments. ➢ Funding is approximately $10.1 million which is unchanged from last year. ➢ Mostly State General funds and State Insurance Department funds. ➢ Contract cycle changed to the State fiscal cycle (April 1 to March 31) to allow easier budgetary management of the contracts. .

- **Lead Poisoning Prevention Program**
  - Follow-up of children with elevated blood lead levels in local health departments, and funding for Regional Lead Resource Centers and two Interim Lead Safe House projects (ILSH).
  - Funding is approximately $7.9 million.
  - Funds come from a few different sources including, federal Maternal and Child Health Block Grant funds, State Insurance Department, State General Fund, and hospital-based grant account.

- **Healthy Homes and Lead Poisoning Prevention**
  - Funding for transition to a broader healthy homes initiative. Dr. Mary Jean Brown, Centers for Disease Control and Prevention talked about the program and funding during the last meeting.
  - Funding from the CDC to be eliminated at the end of August 2012.
  - No impact to local health departments, Regional Lead Resource Centers, or ILSHs.
  - Tom Carroll to provide the details of the impacts of the cuts in his presentation.

- **NYSDOH Guidelines for the Identification and Management of Lead Exposure in Children**
  - Printed as a laminated one and two-sided wall chart, and a pocket card (copy provided in packet)
  - Clinical tool for health care providers regarding assessing and managing lead exposure including:
    - Interpretation and management of blood lead levels at different ranges.
    - Timelines for follow up testing.
    - New York State screening regulations.
    - Risk assessment questions.
    - Anticipatory guidance.
  - Input from:
    - Regional Lead Resource Centers.
    - New York City Department of Health and Mental Hygiene.
    - Bureau of Occupational Health.
  - Field tested by healthcare providers across the State.
  - Available to all local health departments and local health providers.

	• **NYSDOH Guidelines for the Prevention, Identification, and Management of Lead Poisoning in Pregnant and Postpartum Women** ➢ Updated clinical tool for prenatal care providers. ➢ Based on public health law and the regulatory requirements for obstetrical care providers. ➢ Recommended actions and timeframes for clinical management of a woman with elevated blood lead levels. ➢ Resource lists to enhance practitioner knowledge regarding sources of lead exposure. ➢ Anticipatory guidance. ➢ American College of Obstetricians and Gynecologists plans to distribute to their members through an article in newsletters and via email, and will be posted on the DOH public website. **Advisory Council discussion** ➢ Dr. Broadbent confirmed the total amount of funding for CLPPP and LPPP was about $10. 1 and $7.9 million respectively. ➢ Dr. Broadbent suggested that a blood lead test should be **"**included in the package of screening tools that obstetricians use" so that every pregnant woman is tested. ➢ Dr. de Long clarified that the recommendation for routine risk assessment with blood lead testing as indicated is already part of the standards for Medicaid Prenatal Care. There is not a specific standardized form that providers are required to use for ordering prenatal lab tests, which likely varies by health plans and contracted laboratories. ➢ Ms. Nagin talked about testing pregnant women in NYC. State recommendations are to test at the first prenatal visit if at risk. One of the significant risks is being an immigrant women – country of birth is a significant thing. A lot of NYC hospitals pretty much routinely test all pregnant women because it's hard to do the risk assessment (they don't always have all of the languages necessary to do the risk assessment), and most of the women are high risk anyways. They've opted to just test all of these women. There are some places where you would test by using the risk assessment as a guide. ➢ Suggestion was made to possibly review the data for Medicaid recipients in the future.
Lead Program Update **Thomas Carroll,** Section Chief,	• See PowerPoint presentation for details. • CDC Cooperative Agreement • Healthy Homes Strategic Plan

Housing Hygiene, Bureau of Community Environmental Health & Food Protection	• Future Issues **Advisory Council Discussion** ➢ Dr. Greenberg asked how the State would provide the infrastructure (staffing) to continue the same activities with the loss of the federal funding ($400, 000), and if it would mean less money for the local health units in the future (to make up for the loss of funding). Mr. Carroll explained the Department is working on how to solve the staffing issue. The Bureau has applied to HUD for a grant that could save the existing staff. Also noted there is a state hiring freeze so no new staff can be hired with state funding. Mr. Cambridge also noted that on the federal level, Congress has directed the CDC to fund the lead poisoning prevention program through the asthma branch in the next fiscal year, but there will be a break in funding that could be restored. One solution may be to possibly reassign staff from other programs. ➢ Dr. Facelle inquired about the functions the current 4.75 FTs were performing. In case prioritization was necessary, what functions were the most critical? What should we as localities be thinking of that we might have to shore up or look elsewhere? Mr. Cambridge explained that all of the functions Mr. Carroll covered in his presentation were critical. Staff is still trying to streamline and develop ways to continue to perform all activities. The Department does not plan to ask the local health departments to take on the functions of state staff. The department will make sure they're all addressed. ➢ Ms. Nagin commented that even though the Department states the loss of federal funding won't directly impact the counties, it will have an important operational impact on the local health department. For example, the length of time it takes to get a contract out the door, which already has been a challenge. She noted other programs in the Department have also lost staff which makes it even more of a challenge. ➢ Mr. Carroll emphasized the point that as far as the funding level to the local health departments, the funding amount will not be diminished in the current contracts. He agreed staffing to perform the critical services is a major concern, and one the Department is working on to resolve ➢ Dr. Greenberg asked a series of questions. Do you have any insight into how the federal government might distribute future monies when it's combined with the asthma or part of the asthma program? Will they do that on competitive applications? Will they do it on incidence of lead poisoning and asthma in various states? ➢ Mr. Carroll replied that we haven't received any early indication as to how the federal government is going to proceed

	but if they do issue any awards, it will probably be competitive, and they will set up the criteria. ➢ Mr. Chachere had a procedural comment about the fact that there was no communication about the funding issue within this committee before today and if members were made aware of these things as they're developing it could only enhance the possibilities that the committee could be working effectively to try to promote the importance of funding for this issue. He also had a substantive concern about the extent to which the Department was looking for other funding streams, such as some states impose a 25 percent, or 5 cent a gallon tax or fee on paint sales to fund programs or NYS taking on the licensing and permitting process under the RRP program. ➢ Mr. McLellan stated he did some rough calculations on how much revenue NYS could collect if the state performed RRP certifications. If 32,000 individuals (about 16,000 upstate and about 16,000 downstate) needed RRP certification and were each charged $20 (what the state health department charges for asbestos initial certifications) you've raised $680,000, annually. The asbestos program in New York State that's run by the Department of Labor licenses contractors to the tune of $300 a year. That would, at 32,000 people contractors generate $10 million annually, and that doesn't include individual certification fees that the asbestos program gets. So, RRP as is, the way the EPA runs it, would generate $10,680,000 annually based on the number of renovators that we think are out there. Mr. Andrews clarified his calculations do not take into consideration the cost of the staff to run that program. ➢ Mr. Cambridge stated the Department would take Mr. Chachere and Mr. McLellan recommendation under advisement as a possibility that would have to be further explored with the Department. In the past, the Department had opted not to take that on because it is a huge program in itself. The cost of delivery of the program would have to be considered. He also acknowledged Mr. Chachere's procedural comment and reported that although the Department had just recently received the notice from the CDC that they were as unable to extend the current cooperative agreement beyond September 1, 2012, a letter could have been shared with members. In the future, for major issues, it could be considered. ➢ Dr. Broadbent inquired if staff is no longer employed, could they come back and work if there were resources available? Mr. Carroll explained that some state funds are appropriated for very particular purposes. They may only be for aid to localities which means they can't be used for state operations or state infrastructure. The grant funds that we currently and previously got from CDC come into the department through an entirely different route, so the staff that is hired on those grants are actually in a different category of employee, without getting too detailed. And we can't simply take other money and pay those same staff. They're entirely different positions. It's complicated and there are many rules that we have to work within.

	➢ Mr. Chachere noted the council is listed as a state partner on the healthy homes logic model but members are not on the strategic planning group. Inquired what the council's role is. Mr. Carroll explained the workgroup isn't strictly about lead; lead is a subset of the much bigger subject of healthy housing. This council provides the Department with advice on lead. ➢ Ms. Nagin recommended considering creating a brochure that lists products that are available through HPD, through neighborhood housing, and through organizations to provide funding to repair lead hazards as well as other home health hazards. Ms. Collins noted that HCR is actively increasing their activities in environmental health issues and noted Ms. Nagin's suggestion. ➢ Ms. Nagin suggested the need to review NYS data to determine what actions are 'do-able" and clearly define everyone's roles (health care providers, state, and local health departments) before acting on the CDC's recommendations. ➢ Mr. McLellan suggested the Medicaid match data be correlated with zip code and housing stock data; possibly GIS mapping to support the primary prevention approach. Mr. Carroll stated a zip code correlation could probably be done but not GIS mapping until the Lead registry has geo coding capabilities.
Primary Prevention Update Cathy Bullwinkle, Quality Improvement Coordinator, Oneida County Health Department	• See PowerPoint presentation for details. **Advisory Council Discussion** ➢ Mr. Andrews requested a program or an outline or something that could be passed on to NYSBOC, which is a state official, the code enforcement organization, because of the commonalities of the two programs. They could play off each other.
LeadWeb and	• Presentation was not given due to lack of time. See PowerPoint presentation for details.

NYSIS Updates Nancy Minch, RN Lead Poisoning Prevention Program	**Advisory Council Discussion** Dr. Broadbent asked if the Department had given thought to allowing daycares, educators, and preschool program staff access to lead data (NYSIIS). Mr. Cambridge replied the Department was aware of their interest and the need to be sure it would be in compliance with the health law or if a change in law would need to be made. Additional research needs to be done.
Advisory Council members provided the following updates on lead-related activities	**Advisory Council Discussion** ➢ Susan Duchnycz, Division of Child Care Services, NYS Office of Children and Family Services, reported they have an online training, Keeping Children Safe, Prevention of Lead Poisoning and other Dangers. Since it began, 10,930 individuals have taken the course. So far in 2012, 2469 individuals have taken the class. ➢ Dr. Greenburg, Member, Nassau County Board of Health and American Academy of Pediatrics – District II, noted that from the perspective of the American Academy of Pediatrics, they agree with what Dr. Broadbent said about the importance of preventive care for children and looking carefully at using the lead level of five as the critical point, because we're about preventing harm to children. The most important thing is primary prevention so they don't even get to a level of five, but we should use that as a trigger point of increased action. ➢ Deborah Nagin, M.P.H., Director, NYC Department of Health and Mental Hygiene (NYCDOHMH) – Lead Poisoning Prevention Program, reported a conference co-sponsored by the city health department and New York State HCR and the city with our housing agency that brought together weatherization, health agencies with 160 people attending for two days. A lot of partners brought together as a jump off point related to primary prevention for lead and other home health hazards. All are beginning to think about better ways to use existing resources. ➢ Ray Andrews, Assistant Director for Code Development, Codes Division, NYS Department of State, reported the organization that works on construction standards for the county, the ICC, is preparing a national code that most states

	and municipalities will follow. It's the closest thing we have in the United States to a national code. The energy code that they work on actually comes out of the Department of Energy. They're starting to meet in May and it's going to go through next year. Last cycle, healthy homes organization tried to put lead prevention into the code. It was unsuccessful. Sometimes it takes a while for some of these things to ripen before they get into codes. It's my expectation they're going to try again, but for your information eventually it may find its way into the code. It has found its way to a little degree into our code, and at the same time we're updating our construction code in New York State, and we'll see how much more we do with that. ➢ Open Discussion : ➢ Mr. Cambridge thanked Kathy Riviello for her years of service to the Lead Poisoning Prevention Program and the Council. Kathy retired on May 5th. ➢ Dr. Broadbent volunteered his services to be a part of any formal strategic planning group for childhood lead poisoning prevention if needed. He also noted he had submitted a few names to consider as council members. In addition, he recommended collaboration with the Department of Education to educate parents about their preschool responsibilities (prevention of lead poisoning and lead testing of children). Mr. Cambridge acknowledged Dr Broadbent's remarks.
Public Comment	There were no public comments.
Adjournment	Meeting was adjourned at 2:20 PM.

NEW YORK STATE ADVISORY COUNCIL ON LEAD POISONING PREVENTION
NYS DEPARTMENT OF HEALTH
APRIL 27, 2011
ALBANY, NEW YORK
EMPIRE STATE PLAZA, MEETING ROOM 7

Topics	Discussion
Attendees Council Members:	**Council Members:** • Guthrie S. Birkhead, M.D., M.P.H., Deputy Commissioner, Office of Public Health (Council Chair) • Matthew J. Chachere, Staff Attorney, Northern Manhattan Improvement Corporation (Environmental Group) • Abby Greenberg, M.D., Member, Nassau County Board of Health and American Academy of Pediatrics – District II (Professional Medical Organization) • Joan Facelle, M.D., Commissioner, Rockland County Health Department and Representative, NYS Association of County Health Officials, NYSACHO (Local Government) • Pamela Hadad Hurst, Special Assistant, Commissioner's Policy Office, NYS Department of Environmental Conservation (Commissioner Designee)/Carlos Montes, DEC (Alternate) • Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY Buffalo (Undesignated At Large Public Member) • Thomas Keenan, Temporary Assistance Specialist, NYS Office of Temporary Disability Assistance (OTDA), Bureau of Refugee and Immigrant Assistance (BRIA) (Commissioner Designee) • Thomas P. Mahar, Code Compliance Specialist, Assistant Director, Regional Services, NYS Department of State, Code Division (Commissioner Designee)-represented by Raymond Andrews-Division of Code Enforcement and Administration • Mary Elizabeth Mokrzycki, Program Manager, City of Syracuse Lead Program (Local Housing Authority) • Deborah Nagin, M.P.H., Director, NYC Department of Health and Mental Hygiene (NYCDOHMH) – Lead Poisoning Prevention Program (Adjunct Member) • Tom Zyra, Assistant Deputy Superintendent for Intergovernmental and Legislative Affairs, NYS Insurance Department (Commissioner Designee) • Robert Perez, Program Manager, Division of Safety and Health, NYS Department of Labor (Commissioner Alternate Designee) • Andrew McLellan, President/Director, Environmental Education Associates Inc, Amherst, NY (Undesignated At Large Public Member) • Kallanna Manjunath, M.D., Chief Medical Officer and Pediatrician, Whitney M. Young J. Health Services (Undesignated At Large Public Member) • Kathleen Pickel, Assistant Director, Division of Child Care Services, NYS Office of Children and Family Services, (Commissioner Designee) • Mary Binder, Environmental Analyst, Division of Housing and Community Renewal (Commissioner Designee) • Clifford Olin, President, EcoSpect, Inc. (Industry)

	• Nancy Heidinger, Lead Program Erie County Department of Health (Educator) • Victoire N. Jacques (Parent Advocate) **Additional Attendees:** • James Clancy, Assistant Commissioner, Office of Governmental and External Affairs, NYSDOH • Michael Cambridge, R.S., Director, Bureau of Community Environmental Health and Food Protection, NYSDOH • Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection, NYSDOH • Rachel de Long, M.D., M.P.H., Director, Bureau of Maternal and Child Health, NYSDOH • Victor Pisani, Acting Director, Division of Environmental Health Protection, NYSDOH • Eileen Franko, Dr.P.H., M.P.H., Director, Bureau of Occupational Health, NYSDOH • Howard Freed, M.D., Director, Center for Environmental Health • David Quist, Division of Legal Affairs, NYSDOH • Susan Slade, RN, M.S., Manager, Child Health Unit, Bureau of Maternal and Child Health **Absent Council Members:** • David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) • Clotilde Perez-Bode Dedecker, President/CEO, Community Foundation for Greater Buffalo (Child Health Advocate) • John Shannon, Administrative Director for the Upstate N.Y. Laborers' Education and Training Fund (Labor Union)
Welcome and Introductions	• The meeting was convened at 10:30 AM. • Dr. Birkhead provided opening remarks: ➢ Welcomed Nancy Heidinger, a public health nurse and health educator at the Erie County Health Department with over 25 years of experience in public health. Ms. Heidinger has been appointed to fill the vacant Educator seat. ➢ Announced the resignation of Dr. Phillip Landrigan, Mt. Sinai School of Medicine, from the Council.
Review and Approval of Minutes	Dr. Birkhead informed members that Ms. Nagin had additional changes that were already incorporated into the minutes, and asked if there were any further additions or edits to the October 5, 2010 draft meeting minutes. Hearing no objections, the meeting minutes were adopted.
Governmental Affairs Update James Clancy,	Dr. Birkhead introduced James Clancy who provided an overview and status of this year's budget and budget items relevant to childhood lead poisoning. ➢ New administration/commissioner has a continued commitment to lead poisoning prevention.

Office of Governmental and External Affairs	➢ The 2011-12 State Budget maintained funding for both primary and secondary prevention programs at current level; Interim Lead Safe Housing (ILSH) program funding reduced by $100,000 as part of larger necessary cost savings measures. **Advisory Council discussion that took place:** ➢ Matthew Chachere inquired about the Executive Order previously in place in the prior administration for the interagency taskforce. Mr. Clancy responded while the Executive Order for a formal taskforce has ended, interagency work will continue. ➢ Matthew Chachere expressed concern that the prior administration really tried to get agencies to work more actively together and that without a formal commitment a "stove piping" approach could occur. Mr. Clancy said he would share those concerns with the Executive Chamber.
Updates from Dr. Birkhead	Dr. Birkhead updated the Council on the status of the proposed 67-2 regulation revisions for which the public comment period ended November 1, 2010. Comments have been received and are being carefully reviewed within the Department with our new commissioner and governor's office. With the new administration, no decisions have been made in terms of the regulations. ➢ Matthew Chachere inquired if the collection of comments is available and if they could be shared between now and the next meeting electronically. Dr. Birkhead responded that he would find out the answer. **Childhood Lead Poisoning Primary Prevention Program (CLPPP)** The CLPPP is currently in 15 counties (neighborhoods with high levels of children with lead poisoning). As of September 2010, over 6,000 units were inspected with almost 5,000 units identified with potential hazards and 1,500 units cleared. As of March 2011, 7,100 homes were identified as free or made free of lead hazards. **Development, Approval and Dissemination of Guidelines for Lead Testing of Refugee Children and Pregnant Women** DOH Refugee Health Program receives a grant from Centers for Disease Control (CDC) to help with the medical reception of new refugees coming into the state and works with the Office of Temporary Disability Assistance (OTDA) to provide services to those populations. Over the last ten years, a shift in refugee resettlement has occurred and more than 90% of refugees are now being settled outside of New York City. The greatest numbers of refugees have come from Myanmar (formerly Burma), followed by Bhutan and Iraq. CDC issued recommendations for testing and follow-up of refugees. DOH formally adopted these recommendations and issued new guidelines to perform lead testing on all refugee children, birth to 16 years of age, and all pregnant women coming into the United States. The guidelines are posted on the DOH's website.

Advisory Council discussion took place on several items including:

- **Lead Testing of Refugee Children and Pregnant Women.**
  - Ms. Nagin pointed out that refugees have a definition that most people don't know. There are a lot of immigrants that come into the State, including New York City, that are not necessarily characterized as formerly refugees. Mr. Keenan asked Ms. Nagin if she was referring to the 'asylee' population(that is, individuals seeking 'asylum' that are unable to return to 'home' country due to fear of persecution), the entrant population which is also given the same benefit status as refugees, but does not come in overseas in the same manner as refugees. The ODTA (BRIA) website includes definitions of the statuses for Cuban/Haitian entrant and asylee American-Asians who also get that status.
  - Dr. Facelle commented should there be a discussion on generalizing some of these recommendations to cover other recent arrivals to the county, i.e., young immigrant children. She suggested promulgating more guidance to medical providers and reinforcing so not only children with official refugee status, but these broader immigrant groups who are not coming through recognized channels might also be able to be more effectively screened. Dr. Greenberg voiced support for this recommendation.
  - Dr. Manjunath inquired if the 3 to 6 months follow-up blood lead tests are being tracked because sometimes children, after getting their initial physical at the refugee health center tend to establish care elsewhere. Dr. de Long responded that we actually enhanced LeadWeb and added a field that can capture refugee status, and are working with local health departments in counties where children are settled to track both the initial & follow-up tests.
  - Dr. Manjunath said another thing to consider is collaboration between CDC and INS, as part of the initial immigration status medical evaluation, to get lead screening to be included. Mention was made that a workgroup between CDC, the Association for State and Territorial Health Officials and the Office of Refugee Resettlement has been convened to revise the domestic and international screening guidelines for lead screening as well as for many other conditions, such has HIV.

- **Childhood Lead Poisoning Primary Prevention Program.** Mr. McLellan asked if there is a standardized set of procedures for evaluations, hazards control, and clearance that all pilot programs are using. Mr. Cambridge explained there are 15 different local health departments and NYC involved. It's standardized, with some flexibility, recognizing the strengths of each program. Each year our report shows the commonalities and how all programs handle the core elements. Mr. McLellan inquired as to consistency for counties that weren't involved in the pilot program and decide to pursue funding. A recommendation was made for standardized procedures (minimum requirements). Mr. Cambridge stated LHDs are EPA

	certified; a requirement for anyone who's going to be assessing lead hazards. If a code enforcement official is doing it, it could be a visual inspection. If there is ever a question it would have to be followed up with the EPA certified person to determine if it's truly a hazard. So, there are the procedures and the program itself that drives the standardization. Mr. McLellan still recommends that some standardization might be in order or at least an investigation of it might be in order. Mr. Cambridge asked to table the discussion on standardization for the next council meeting; however, reinforced information is shared with other counties as far as what's been successful and not desirable.
Changes to Federal Funding Mary Jean Brown, R.N., Sc.D., Chief, Healthy Homes and Lead Poisoning Prevention Branch, Centers for Disease Control and Prevention	Dr. de Long provided an overview of historic and current CDC Lead Poisoning Prevention cooperative agreement funding for New York State, and the recent changes in parameters of funding for states associated with CDC's transition to a broader healthy homes initiative, including a reduction in the maximum funding level to $600,000 annually (which represents nearly a 50% decrease from NYS' current funding level). Dr. Mary Jean Brown joined the meeting via conference call to provide an overview from CDC. • Dr. Mary Jean Brown talked about changes in federal funding and the shift in elimination of lead poisoning from current focused activities to a more global healthy homes approach. Dr. Brown discussed the Funding Opportunity Announcement that was released in early 2011 in which programs could apply for up to $600,000. CDC recognized there are states that may never have had a significant lead problem to qualify for funding. As CDC was directed by Congress to provide funding for healthy homes, it made sense for CDC to limit the amount of monies that went to larger programs, how the money is to be spread out geographically, and the need to fund programs that have the capacity to do the work. The number of children in need of case management traditionally has been delivered to children with high blood lead levels and there are fewer of these children every year. • Dr. Brown also noted that the President's FY12 budget, proposes further combining the Healthy Home and Lead Poisoning Prevention Program with the National Asthma Control program to form the new "Healthy Homes and Community Environments Program" and to further reduce combined funding by 50%. If this happens that cut is going to get passed along to our funded programs. CDC has specifically discontinued funding to large city programs to absorb the reduction. • Dr. Brown noted that there is also a new *Green and Healthy Housing* initiative coming out as a way for private foundations to get into this game and provide another funding stream for healthy homes activities and for lead poisoning prevention too.

	Advisory Council discussions that took place: ➢ Dr. Birkhead inquired about the healthy homes approach and asked if congress actually directed CDC to do that. Dr. Brown noted that they actually changed the name of the appropriation line to healthy homes and lead poisoning prevention. ➢ Dr. de Long asked Dr. Brown to provide further information about the Green and Healthy Housing initiative. Dr. Brown noted that the Green and Healthy Housing initiative is actually the brainchild of a woman in Baltimore named, Ruth Ann Norton. The Department of Energy (DOE) received some stimulus funding. Ruth Ann and others brought to the attention of DOE that the last time people started doing energy efficiency in housing in the 1970s people got sick. So the first push for DOE was "do no harm." Fourteen cities received some funding from the Council on Foundations and Support trying to get people excited about this issue of green and healthy housing within their communities. Some communities have been really successful and there is a certain competition to get a healthy housing designation. ➢ Ms. Nagin expressed concern about getting rid of "big city funding." She asked for a better understanding on how this actually works and if the CDC was open to hearing and recognizing the need to try to reserve some kind of resources and monitoring rather than just eliminating this funding and pushing it through the state. Dr. Brown explained that every award sent out depends on availability of funds. By September and/or October, CDC should have some idea if this is actually going to take place. We'd have to figure out something that's fair, and welcome in-depth discussion about how to approach that if there is an enormous cut in our funding. ➢ Mr. Chachere asked to identify the decision makers or players. Dr. Brown explained budgets were put together in October or November of 2010 for FY12 federal budget. The Department of Health and Human Services CDC Director puts together the CDC budget that goes to Office of Management Budget and to the Secretary of Human Services (may stop at Deputy Assistant Secretary), and then goes to the White House for incorporation into the President's budget. Introduced to Congress (similar process in the Senate) and the Senate and House come together and tries to negotiate a budget before October 1st.
Lead Testing Improvement Strategies Susan Slade, R.N., M.C.H.E.S.,	Information was co-presented by Ms. Slade and Ms. Minch on DOH multipronged efforts to increase lead testing rates in collaboration with local health departments (LHDs), Regional Lead Resource Centers (RLRCs) and other internal and external partners through public and professional education, use of portable lead testing devices and linking of New York State Immunization Information System (NYSIIS), the state's immunization registry. • Ms. Slade described the long and short term goals for lead testing of children. The long term goal is the implementation of Public Health Law that 100% of children in NYS are tested at one and two. The short term 2010 objectives are 75%

and Nancy Minch, R.N., Bureau of Maternal and Child Health	of one year olds will be tested for lead and 67% of two year olds will be tested. The objectives for 2014 are 80% of one and 80% two year olds will be tested; and 60% of children will have two tests by age three. Ms. Slade also updated the Council on some recent educational activities this year, which included: ➢ Collaboration with HANYS to develop a fall 2010 edition of a newsletter focused on New York State Lead Poisoning Prevention efforts, i.e., lead poisoning testing requirements for children, EPA certification requirements, healthy neighborhood programs and coalition groups who really increased lead testing and lead poisoning prevention in the community. ➢ Posting of timely health alert information to providers and local health departments, i.e., calabash chalk clay alert. ➢ Finalization of professional pregnancy guidelines and their submission through the executive approval process. ➢ Development of updated health care provider reference cards with revised risk-assessment questions, developed in collaboration with Regional Lead Resource Centers. ➢ Development of a questions and answers document, in conjunction with Wadsworth Laboratories and Division of Nutrition, about the use of portable lead care testing devices. This document is posted on the Department's web site. ➢ Completion of a comprehensive guidance document that can assist all types of laboratories understand the requirements for lead testing and reporting. This document is currently under development. • Ms. Slade discussed the linkage of the NYSIIS and LeadWeb systems as a mechanism that supports improvements in lead testing rates. The Lead Poisoning Prevention Program (LPPP) has been able to build on the success of NYSIIS through the high acceptance among health care providers and high utilization on the immunization side. The LPPP has support from LHDs and health plans that are looking forward to the capability of assessing lead testing practices of providers and to target education and quality improvement activities to specific providers. A daily data exchange between LeadWeb and NYSIIS provides the opportunity for the physicians to view their patients, determine whether each patient had a lead test, and print the report of the test. On a monthly basis, about 400 of these reports are being printed by providers for their own use. The LPPP is in the process of developing prompts and important reminders for the providers about lead testing requirements and risk assessment. • Ms. Minch provided an overview of how adding prompts to NYSIIS application will help to increase blood lead testing rates and improve follow-up services. She defined prompts as brief messages placed on a frequently used screen without the user having to do anything. The LPPP developed a series of desired provider messages regarding risk assessment, testing children at ages one and two years, and reminders regarding follow up. The reminders prompt providers when a child is due or overdue for a one or two-year old lead test, and when a confirmatory, retest, or follow up test is required. A retest is required a sample has clotted or its amount is insufficient for testing. We also wanted to provide easy access to contact

information and provide the ability to see the child's complete blood lead testing history.

- In January 2011, the LPPP, working with a vendor, started developing business rules for the technical implementation of the prompt messages. All users who managed patient, immunization or lead screens will be able to view child-specific passive prompts because there is no confidential information displayed about the child's lead test results. Ms. Minch also discussed active lead prompts that are available to providers, and state and LHDs, when they actively look at a child's record and lead test history. Lead educational forms and links to resources will also be available in NYSIIS for all providers to use.

- Currently, NYSIIS has links to immunization information locally and national links. Lead educational forms and links to resources will also be available in NYSIIS for all providers to use. These will include links to Department of Health LPPP home page, local LPPPs, Regional Lead Resource Centers, and other state and national resources for lead poisoning prevention. The LPPP is working towards release of prompts in September 2011.

Advisory Council Discussion that took place:

- Ms. Jacques asked if there is a place for physician comments. It was affirmed that within NYSIIS there is a general comment section and a comment section specific to the lead test.
- Dr. Manjunath commented about the challenges posed by a busy office work flow to going to a site and looking for prompts. He indicated anything that could automatically come to the physician system would be easier rather going to the site and looking for the prompts, especially since not all practices have the staff to do this. Dr. Birkhead explained the Department is working on developing an electronic two-way exchange that NYSIIS can feed in and every practice would have an integrated electronic child health record. However, it is probably another couple of years before data could be fed directly.
- Dr. Greenberg noted that to have physicians utilize the system more requires that they have confidence in the system. She indicated she's heard a fair amount of dissatisfaction because the interfaces between their ability for immunization and what comes up in NYSIIS is not always accurate. She explained providers are not getting all the information by the system about immunizations they provided and this creates a lack of confidence in the system. Dr. Birkhead responded he would ask someone from the Immunization Program to give her a call. There are ongoing quality improvement issues in terms of getting records to properly match when they come in from different roots. If there's a specific practice that is having a specific problem, we need to know about that.
- Dr. Manjunath reported on having had major issues with the interface and having to re upload 2-3 years of data and not getting data back. He also asked if these prompts and reports could be generated for WIC certification to try and get more testing done. Dr. Birkhead answered WIC medical forms include a space for lead test results and the WIC

	data system has a field for lead too. They may actually have prompts built in to the WIC system, but the data currently doesn't feed back and forth between the two systems. Dr. de Long explained the WIC providers have access to lead information in NYSIIS.
Medicaid Redesign Guthrie Birkhead, M.D., M.P.H., Office of Public Health	Dr. Birkhead described a major effort of this administration is to reform the Medicaid program. • A Medicaid Reform Taskforce was formed in February 2011, and part of the process was to seek comments and suggestions from the public. Another round of Medicaid reform taskforce ideas are scheduled to be completed by November 2011 that will feed into next year's budget process. Dr. Birkhead explained he was bringing the concept of Medicaid redesign to the Council to generate ideas that result in savings within the Medicaid program or an improved quality of care within the Medicaid program. The department is collecting these ideas to put forward to the Medicaid redesign team, which is an external committee that receives and discuss these reports. The website can be accessed for more information but basically it's looking for a general title (theme), description, and any impact on cost savings. A discussion was held with Jason Helgerson, the Medicaid Director, about whether some of the activities/services provided to lead poisoned kids enrolled in Medicaid could be covered under the Medicaid program as medically necessary services. Any input on that idea is welcomed. **Advisory Council Discussion that took place:** ➢ Dr. Facelle stated many of the functions performed for the community, i.e. maternal child home visiting to high risk families with young children, are not reimbursable. She asked if there was a way to link Medicaid reimbursement to the types of services performed by public health departments and to allow them to bill Medicaid directly. Dr. Facelle explained that currently a contract with a certified agency is needed in order to bill Medicaid. Dr. Birkhead replied the concept of allowing licensed home agencies to bill Medicaid directly could be checked into and discussed. ➢ Dr. Hunter reinforced getting information out to health professional schools and getting students involved in the issues before they graduate. Dr. Birkhead noted that there will be a series of regional meetings around the State in the next couple of months hitting places that were not hit in the first round of meetings and they will be open to the public. We'll get the dates and location. ➢ Ms. Nagin mentioned Rhode Island has provided Medicaid reimbursement for window replacements for lead poisoned children. She also suggested integrated pest management, asthmatic child or family member, refer them to a program for Medicaid reimbursement. Maine and New Jersey had taxed the paint industry to support public health. ➢ Dr. Franko cited the healthy homes concept as a way to garner Medicaid reimbursement. CDC has already set the

	Healthy Homes initiative as the way to go and this helps substantiate it as the model for the Department to use. In some states, environmental home visits for asthma have already been established for Medicaid reimbursement. So now this has been established for asthma, it may be easier to roll lead in to get Medicaid reimbursement. ➢ Ms. Bullwinkle from Oneida County Health Department, attending the Council meeting as a member of the public, was invited to discuss her recent opportunity to give testimony to the Medicaid redesign team. She described three specific ideas: o One of the things proposed was to change the formula that doesn't allow billing Medicaid for certified agencies but does allow it for licensed home care agencies (LHCA). While counties were looking at this for maternal and child health, she had noted that there's a potential for lead program activities as well. In Oneida County there are Medicaid visits that we cannot bill for, and we have to pick up that cost. However a number of counties because of the formula changes would open as a LHCA and they could fund their maternal and child health. Potentially a lot of home care nurses with public health skills who know the resources in the community could be repurposed to lead if those nurses could bill those visits under Medicaid. o Another window of opportunity is weatherization. Unfortunately for many outside of NYC or large cities, the savings to investment ratio (SIR) formula does not pay for window replacements in buildings with less than four units. If the saving to investment formula could be changed, it would permit us to replace those windows, and could be a very good opportunity to protect children's health. o Another area potentially relatively easy to change is to modify language in the managed care boilerplate that would allow a child with an elevated blood lead levels (BLLs) not to have to go to that managed care company (it would be pre-approved). This can save a tremendous amount of time and allow LHDs to do their work and get reimbursed. ➢ Ms. Nagin suggested including both the nursing and the environmental intervention/risk assessment for children with lower BLLs for Medicaid reimbursement. She also suggested the same kind of service be considered for reimbursement for pregnant women. ➢ Dr. de Long asked those present who were sending in a Medicaid Redesign proposal to please send the LPPP a copy and we can help review or comment on it. A template for proposals and information on the Web site link were provided.
Advisory Council members provided the following	**Advisory Council Discussion:** ➢ Mr. Chachere inquired about Dr. Landrigan's resignation and the process to become a council member. Dr. Birkhead responded the Council members are appointed by the Governor and the two currently vacant seats are hospital and real estate. Dr. Birkhead requested CVs for any potential candidates be sent to Rachel de Long.

updates on lead-related activities	➢ Mr. Chachere brought up the topic of Renovation, Repair and Painting (RRP) Rule. He stated New York should consider taking on administering the RRP program as many other states have done as this state has the largest number of old housing stock containing lead based paint in the country. He explained we can reduce the number of children lead poisoned by having strong, safe work practices that are enforced and reduce Medicaid costs. ➢ Ms. Binder reported that their agency is now New York Homes and Community Renewal and has a new commissioner. She also commented the Advisory Council webpage was outdated as the most recent posted council report was 2005. ➢ Mr. Andrews noted that the Energy Law has now changed, which has changed the Energy Code. He said the new Energy Code will require the replacement of a window will require the window to meet current standards. These windows will not contain lead, thus the new code will be helpful for lead poisoning prevention. ➢ Ms. Nagin commented that while the costs associated with window replacement may be high, the impact of changing those windows in terms of health impact for children, is very significant.
Public Comment	There were no public comments.
Adjournment	Meeting was adjourned at 2:35 PM.

NEW YORK STATE ADVISORY COUNCIL ON LEAD POISONING PREVENTION
NYS DEPARTMENT OF HEALTH
OCTOBER 19, 2009
ALBANY, NEW YORK
EMPIRE STATE PLAZA, MEETING ROOM 4

Topics	**Discussion**
Attendees	**Council Members:** • Guthrie S. Birkhead, M.D., M.P.H., Deputy Commissioner, Office of Public Health (Council Chair) • Mary Binder, Environmental Analyst, Division of Housing and Community Renewal (Commissioner Designee) • David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) • Matthew J. Chachere, Staff Attorney, Northern Manhattan Improvement Corporation (Environmental Group) • Maureen Cox, Director, Division of Safety and Health, NYS Department of Labor (Commissioner Designee) • Joan Facelle, MD, Commissioner, Rockland County Health Department and Representative, NYS Association of County Health Commissioners, NYSACHO (Local Government) • Abby Greenberg, M.D., former Director, Center for Public Health, Nassau County Health Department; Representative, American Academy of Pediatrics – Division II (Professional Medical Organization) • Pamela Hadad Hurst, Special Assistant, Commissioner's Policy Office, NYS Department of Environmental Conservation (Commissioner Designee) • Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY Buffalo (Undesignated At Large Public Member) • Thomas Keenan, Temporary Assistance Specialist, NYS Office of Temporary Disability Assistance (OTDA), Bureau of Refugee and Immigrant Assistance (BRIA) (Commissioner Designee) • Thomas P. Mahar, Code Compliance Specialist, Assistant Director, Regional Services, NYS Department of State, Code Division (Commissioner Designee) • Mary Elizabeth Mokrzycki, Program Manager, City of Syracuse Lead Program (Local Housing Authority) • Lindsay Lake Morgan, R.N., Ph.D., A.N.P., Assistant Professor, Decker School of Nursing, SUNY Binghamton (Educator) • Deborah Nagin, M.P.H., Director, NYC Department of Health and Mental Hygiene (NYCDOHMH) – Lead Poisoning Prevention Program (Adjunct Member) • Clifford Olin, President, EcoSpect, Inc. (Industry) • Andrew McLellan, President/Director, Environmental Education Associates Inc, Amherst, NY (Undesignated At Large Public Member) • Kathleen Pickel, representing William Dorr, Assistant Director, Division of Child Care Services, NYS Office of Children and Family Services (Commissioner Designee) **Additional Attendees:** • Howard Freed, MD, Director, Center for Environmental Health • Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health, NYSDOH • Dick Svenson, Director, Division of Environmental Health Protection, Center for Environmental Health, NYSDOH • Michael Cambridge, R.S., Director, Bureau of Community Environmental Health and Food Protection, NYSDOH

	• Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection, NYSDOH • Eileen Franko, Dr.P.H., M.P.H., Director, Bureau of Occupational Health, NYSDOH • Bruce Phillips, Counsel, Division of Legal Affairs, NYSDOH • Susan Slade, RN, MS, Manager, Child Health Unit, BCAH • Larry Franklin, NYS Lead Poisoning Prevention Program Project Officer, CDC • Dr. Ginger Chu, Epidemiologist, CDC **Absent Council Members:** • Alison Cordero, Deputy Director for Community Preservation, St. Nicholas Preservation Council, Williamsburg (Real Estate) • Susan Duchnycz, Child and Family Services Specialist 2, Division of Child Care Services, NYS Office of Children and Family Services, (Commissioner Designee) • Kallanna Manjunath, M.D, Chief Medical Officer and Pediatrician, Whitney M. Young J. Health Services (Undesignated At Large Public Member) • John Shannon, Administrative Director for the Upstate N.Y. Laborers' Education and Training Fund (Labor Union) • Clotilde Perez-Bode Dedecker, President/CEO, Community Foundation for Greater Buffalo (Child Health Advocate) • Philip J. Landrigan, M.D., M.Sc., FAAP, Director and Professor of Pediatrics, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital)
Welcome and Introductions	• The meeting was convened at 10:13 a.m. • Dr. Birkhead provided opening remarks regarding compliance with relevant executive orders: ➢ In accordance with Executive Order #3 and the Open Meeting Law, this meeting is available on the internet. The meeting notice and links to the webcast are at http://www.nyhealth.gov/events. (Note: this webcast is archived until November 19, 2009. All future webcasts are anticipated to be announced at this website and will be archived for one month following the meeting). ➢ In accordance with Executive Law, section 166, members of the public who appear before the Council and represent any agency regulated by the Department of Health must fill out a Notice of Appearance form provided at the registration table. ➢ Dr. Birkhead provided an overview of the meeting agenda.
Review and Approval of Minutes	Dr. Birkhead asked members if there were additions or edits to the June 26, 2009 meeting minutes. No additional revisions to minutes were requested. A motion to accept the minutes was made by Dr. Greenberg, seconded by Ms. Mokrzycki. The motion carried.
Update on Office-Based Lead Testing, Rachel de Long, M.D., M.P.H., Director, Bureau of Child	Dr. de Long provided a brief update on office-based ("point-of-care") lead testing. • DOH has been distributing information to health care providers and labs on new regulations pertaining to lead testing within physician offices and clinics, which went into effect June 2009. The DOH web site (www.nyhealth.gov/environmental/lead) contains all the documents DOH has distributed to providers and labs. • Effective September 1, 2009, Medicaid began reimbursing 'point-of-care' in-office blood lead testing. The July 2009 special edition of the Medicaid Update describes the expanded coverage. (A copy was included in the meeting folders.)

and Adolescent Health	• Systems development for electronic reporting of blood lead tests performed by Physician Office Laboratories (POLs) is underway. Through enhancements to the New York State Immunization Information System (NYSIIS), POLs will be able to report blood lead test results performed in their offices to DOH. Doctors will have access to lead test information for their patients and prompt functions that will help doctors and local health departments identify children due for lead tests. DOH is working closely with NYC Dept. Health and Mental Hygiene (NYCDHMH), which has its own blood lead test reporting system, to coordinate reporting and data exchange, so providers don't have to report to both NYC and DOH. Implementation of data entry screens and data exchange to display lead test information within NYSIIS is targeted for early 2010, with additional reports and prompts to follow.
Council Discussion	**Advisory Council discussion took place on several issues, including:** • Timeframes for transitioning provider offices from current paper reporting to the new electronic reporting through NYSIIS, once the new system is in place. • Availability of summary materials regarding LeadCare®II for use at an upcoming AAP chapter meeting. It was noted that materials are available on the DOH and manufacturer's Web sites. • How screenings in health fairs and other public settings should be handled. It was noted that this depends on the type of lab and the approvals they have from Wadsworth, and will be addressed in a forthcoming question and answer document. • Ongoing work with local health departments (LHDs) to use their local data, and the additional benefits that the linkage with the immunization data system will provide. It was noted that LHDs use a number of existing standard reports and that additional customized reporting functionality will be implemented shortly. **Follow-up Items:** • DOH staff will provide updates on the NYSIIS-LeadWeb linkage and LeadWeb dynamic reporting functions at future meetings. • Dr. Broadbent will access summary materials on office-based testing on the DOH Web site for use with his AAP colleagues, and reach out to DOH staff regarding any outstanding questions
Governor's Task Force on the Prevention of Childhood Lead Poisoning: Wendy Saunders, **Vice-Chair of Task Force, Deputy Secretary for Health, Medicaid & Oversight; Lola**	Ms. Saunders explained that Governor Paterson issued Executive Order 21 establishing the Task Force in June 2009, and introduced staff from the Governor's Office who are chairing the Task Force committees. Valerie Grey, Director of State Operations, is the chair of the Task Force. The Governor has noted that lead poisoning deserves our highest priority. He created the Task Force to work with the Advisory Council and wants to convey his thanks to the Advisory Council for their efforts. Ms. Saunders asked the Task Force committee chairs to share a summary of work to date and future plans with the Advisory Council. A copy of Executive Order 21 and Task Force membership were included in the meeting folder handouts. Ms. Brabham-Harder explained the Task Force is charged with implementing a coordinated strategy for lead poisoning prevention. It is organized into three subcommittees. The first Task Force report is due November 30, 2009. • **The Awareness and Education Committee** is chaired by Ms. Brabham-Harder with representatives from DOH, Dept. of State (DOS), Dept. of Labor, Office of Children and Family Services (OCFS), the Council of Children and Families (CCF), Division of

Brabham-Harder, Assistant Secretary for Health, Medicaid & Oversight; Tony Giardina, Assistant Secretary for Economic Development; Peter Iwanowicz, Assistant Secretary for the Environment	Housing and Community Renewal (DHCR), Office of Temporary Disability Assistance (OTDA), and Division of Budget (DOB). Its focus is to increase the awareness of state and local government and other agency staff, homeowners, parents, and other parties about dangers of lead and availability of lead testing. The committee is working with programs that serve children in foster care, victims of domestic violence, children released from custody, and other higher-risk populations to ensure providers are educated and have materials on hand for families, and is exploring the development of a short PSA on lead poisoning prevention. • **The Lead-Safe Housing Compliance Committee** is chaired by Mr. Giardina with representatives from DOS, DHCR, OTDA, NYS Housing Finance Agency (HFA), Empire State Development Corporation (ESDC), DOH, and the NYS Energy Research and Development Authority (NYSERDA). The committee currently has four major focus areas: 1) Protecting rights of tenants; 2) Enhancing disclosure laws related to lead; 3) Incentives for funding for abatement; and 4) Lead-safe work practices training. • **The Partnerships Committee is chaired** by Mr. Iwanowicz. The committee is assessing how to strengthen existing partnerships and forge new ones, and how to coordinate local and state efforts, including: 1) Collaborating with social service agencies (e.g., child care providers, foster parenting, and domestic violence service agencies) that place families in homes to help staff identify risks in potential housing and make referrals. 2) Leveraging stimulus funds, the Green Jobs/Green NY Act, the weatherization program, and other programs that go into homes.
Council Discussion	**Advisory Council discussion took place on several questions and issues, including:** • How the State Education Department (SED) could be involved in promoting lead testing. It was noted that there has been discussion about requiring lead testing information at school entry, as is done with licensed child care providers through OCFS, but that would not happen until older ages. • Whether the state has any leverage or influence with unlicensed child care providers. It was clarified that there is no specific oversight of unlicensed, providers; for licensed providers, the state can access and inspect the premises. Mr. Chachere further noted that there are restrictions in some social services laws that limit government enforcement ability in family day care centers, and offered to provide details later. • The availability of any grant programs developed to help people who need money up front to make home improvements, rather than rely on tax abatements, which may be less helpful for people with less means. Ms. Nagin specifically noted that window replacement is not cost-effective within the calculations of the weatherization program, and asked if there is other money that can be matched to replace windows in high risk areas. Mr. Giardina and Mr. Iwanowicz responded the Task Force is looking at all options, while recognizing current fiscal limitations It was noted that the new Green NY Program is flexible and can pilot new approaches using a whole building perspective. • The benefits of developing an inclusive process that takes advantage of the expertise from Advisory Council members and other external stakeholders. • New federal regulations on renovation, remodeling and repair that are effective April 2010. Mr Chachere specifically recommended that the state take over licensing and enforcement of this program, noting that this could generate revenue for the state and strengthen enforcement of the regulations. He also commented that enforcement of disclosure laws is an issue that the Task Force could discuss

	with the state Attorney General's Office.
	• A question was raised by Dr. Broadbent about whether someone seeking homeowners insurance has to waive rights regarding lead hazards. Mr. Giardina indicated that the Task Force would look into this issue.
	
	Follow-up items:
	• The Task Force will:
	  • continue to explore a variety of options for financial supports and incentives related to lead remediation, including the new Green NY Program;
	  • consider additional processes for incorporating input from external stakeholders; and
	  • explore issues related to enforcement of federal disclosure laws and homeowners insurance.
	• Mr. Chachere will provide further details regarding potential changes to state law to ameliorate restrictions in existing social services laws that may limit government enforcement ability in family day care centers.
	• A more in-depth discussion of the EPA regulations on renovation, remodeling and repair, including consideration for state takeover of the program, will be scheduled for the next Council meeting.
	• DOH staff will continue to share feedback and input from Advisory Council members on relevant topics with the Governor's Task Force.

Proposed Changes to State Regulations: Part 67-2, **Michael Cambridge, RS, Director, and Tom Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection, NYSDOH**	Dr. Birkhead commented that DOH has been working on changes to Part 67-2 for several years and is seeking input to complete this process. DOH made changes based on comments received from Advisory Council members and other stakeholders. DOH will share with members the comments that have been received and would like additional input from the Council prior to the next Council meeting. The proposed regulations were presented and a discussion followed with the Council. Mr. Carroll reviewed the history of the regulations, current proposed revisions, the process of adoption, and comments on the proposed revisions received from local health departments. The revisions to the regulations were included in the folder. In 2005 and 2006 the Advisory Council formally commented on the revisions and changes were made in response. In September, 2009, a requirement for abatement of all dwellings associated with an EBL child was added to the proposal. The proposed change that received the most comments was to 67-2.6(a) which added a requirement that LHD require abatement of lead-based paint hazards for all dwellings associated with EBL children. A temporary exception would be granted for economic hardship. Numerous LHDs commented that the cost of abatement might cause property abandonment, family avoidance of the health department to avoid costs of repairs, or avoidance of landlords' renting to parents of young children or other forms of housing discrimination. Some also cited published and experience-based evidence concerning the effectiveness of less costly interim controls. Concerns also included lack of flexibility; lack of an EPA certified workforce; creation of delays; method for determining economic hardship; and timeframes. Mr. Carroll stated that in response to these concerns, DOH is re-evaluating this requirement and requested input from the Advisory Council.

Council Discussion	**Advisory Council discussion took place on several issues. Key comments included the following:** • There is a LHD staff shortage due to reduced staffing and positions that cannot be filled that could impact the work. • Concern was expressed about the economic impact, the workload, and the lack of capacity to work flexibly with people in the community, especially around less severe hazards. • Lack of certified workers is a real concern in rural areas. The revision will also lead to delays. • Landlords will take legal action to avoid or delay expense. A mechanism is needed to handle this delay while protecting tenants. • Mr. Chachere stated that current State law, read in conjunction with current federal law, already mandates abatement, with certified workers, when a child is lead poisoned. DOH discussed that the federal definition could not be combined with a state law without a regulatory change. • There needs to be a clear way to define 'economic hardship.' LHDs remember the experience of implementing the Clean Indoor Air Act, and how difficult it was for LHDs to define 'economic hardship.' • The reason there aren't enough abatement workers is because no one requires abatement. Demand will drive supply. If a law is enforced, it creates the demand for people with training. • Discussed the differences in terms of work practices for abatement versus interim control, the work is often the same. • LHDs are directly involved in deciding what needs to be corrected and determine if work is abatement or interim control. • One of the big challenges in NYC is money. More financing would make a big difference. For court-ordered work, NYC's housing dept. does the work and then bills the landlord so there is little delay. It would be helpful if NYS could make resources available for this work. • It would be one thing if this regulation came with a guarantee of staffing and money to do it, but it must be coupled with pragmatic interventions that won't fail. The costs seem unclear. DOH can look into and provide cost estimates. • People thought interim control lasted 5 years. Now it is believed to last 12-13 years, if maintained. • In Syracuse the cost to get rid of every lead hazard averaged $15,000 for one to two family residential and $20-$25,000 for 2-4 unit homes. The homeowner has to add in $1-2,000. • Ms. Nagin stated NYC used to issue modified orders for one/two family homes, where a homeowner's child was poisoned. NYC allowed remediation, not abatement, and then returned to see if they were maintaining it. They weren't maintaining it. NYC changed the regulations to require abatement and works with the homeowner to find financing. • Dr. Birkhead stated that DOH wants to complete public comment, but if there are other groups, we can include them. **Follow-up items:** • Next meeting will provide a discussion concerning 67-2 and the comments received. • DOH will review costs associated with abatement and interim control measures.
Primary Prevention of Childhood Lead Poisoning Update: State Update,	**Note**: Following lunch, Dr. Howard Freed, Director, Center for Environmental Health, chaired for Dr. Birkhead in his absence. **State Update** The Childhood Lead Poisoning Primary Prevention Program (CLPPPP) started as a pilot project in 2007 with $3 million in eight

Ken Boxley, Bureau of Community Environmental Health and Food Protection	cities/counties: Albany; Erie; Oneida; Onondaga; Orange; Westchester; Monroe; and New York City. In Year 2 (08-09), the funding increased to $4.9 million to include four more counties: Broome; Chautauqua; Dutchess; Schenectady. In year three (09-10) funding increased another $2.5 million to $7.4 million total, to include five additional counties: Niagara; Rensselaer; Ulster; Fulton; Montgomery. The program is no longer a pilot, but is a permanent program. The year one final report, and preliminary report results for year two are on the DOH web site: (www.nyhealth.gov/environmental/lead/exposure/childhood/primary_prevention/pilot_program/)
Panel, New York City Department of Health and Mental Hygiene Lead Program – Deborah Nagin, Director; Orange County Lead Program – Bob Dietrich, Director; Oneida County Lead Program - Cathe Bullwinkle, Quality Improvement Coordinator	**Panel Discussion of Local Projects** **New York City Department of Health and Mental Hygiene Lead Program** Ms. Nagin reviewed progress of the NYC Department of Health and Mental Hygiene. NYC released its 2008 data report (on-line at: http://www.nyc.gov/html/doh/html/lead/research.shtml). From 1995 to 2008 there has been an over-90% decline in childhood lead poisoning. NYC has strong laws that require building owners to regularly inspect older homes with young children and make repairs. The NYC Health Code forbids dry sanding and scraping. **Orange County Lead Program** Mr. Dietrich described Orange County's primary prevention program. The Lead Safe Orange (LSO) initiative combined four programs to create the primary prevention program. Education activities include giving people cleaning supplies. LSO works with the Healthy Neighborhoods program. The program also visits all medical offices. Outreach includes letters to property owners explaining the primary prevention program; Workers go door to door, and leave door hangers to let residents know they'll come back. They also set up a stationary post in the neighborhood. Community health workers conduct visual inspections. They can then refer to a sanitarian for testing if hazards are identified. For property owners, the program has paint kits worth $300 for anyone who takes lead safe training. **Oneida County Lead Program -** Ms. Bullwinkle described Oneida's primary prevention program. The program used GIS to map the locations of high-risk housing using 20 years of historical lead data. The map showed that lead poisoning was concentrated in the center of the City of Utica. The program used the birth registry to contact parents of substandard housing. Three programs are collaborating – the Childhood Lead Poisoning Prevention Program (CLPPP), Primary Prevention, and Healthy Neighborhoods. The program is also working with property owners. It offers a training and free HEPA vacuums. Program takes digital photos and then uses the XRF. Program has held legal seminars to education judges and lawyers. A task force has formed to look at housing and court issues. In Utica, code officers have been deputized so they can cite for conditions conducive to lead poisoning.
Evaluation of Year 2 Progress, Carol Kawecki, Program	**Evaluation of Year 2 Progress,** The National Center for Healthy Housing (NCHH) conducts research, training, provides technical assistance to the CDC and others, and manages the Healthy Homes Training Center. For the NYS Primary Prevention Project, NCHH is managing data and evaluating progress

Manager, National Center for Healthy Housing	of the grantees. NCHH does problem-solving with each of the twelve grantees, and brings lessons from other sites. Ms. Kawecki provided an overview of the statewide progress of the grantees. As of June, 2009, 787 units were cleared of lead hazards. There has been a great deal of marketing and outreach, which has generated the majority of investigations. Key Points: • Gaining entry to a unit. The vast majority were entered on first try. Only 16% needed two or more attempts. • Inspection. Most investigations were interior or exterior visual. Most potential hazards were confirmed. The majority of units inspected are rentals. Rental apartments of 1-2 units seem to be the most stubborn, difficult to address, versus bigger units or owner-occupied. Only 4% of units had a prior history of EBLLs investigation. • Enforcement. About 1/3 require no further enforcement after initial notice. Fifty-six percent needed additional actions – most just needed conferences with staff in offices to get work started. • Incentives. Very few people who took Lead Safe Work Practices Training received any incentives. • Funding: Very few people are able to get dollars from stimulus funding or foundations to remediate units. Recommendations: • Using Section 1370 to get in the door is working - deputize code enforcers. • Get partnerships moving as quickly as possible. It takes time. • Grantees show that visual inspections are not enough, consider requiring dust samples. • Grantees say they need help to publicize new EPA Renovation, Repair, and Painting Rule.
Council Discussion	**Advisory Council discussion took place on several issues, including:** • The availability of federal funds through NOFA for capacity building that may be of interest to CLPPPP grantees. It was noted that the timeframe may be an issue. • Identification and education regarding non-paint sources of lead during home inspections. It was noted that all three primary prevention grantees represented at this meeting use a comprehensive approach to inspections that involved non-paint hazards. • Enforcement of New York City's dry scraping ban. Ms. Nagin noted that investigation and enforcement is largely complaint-driven. The availability of NYC statistics on HPD follow-up audits of buildings in which a child with an EBLL is identified and referred to HPD. Ms. Nagin noted that these data are available. • The effectiveness of abatement vs. other lead hazard remediation methods. Mr. Chachere specifically stated that data presented by NCHH, which found that 56% of units with a prior history of children with EBLLs were found to have current lead hazards provides empirical support for the need for permanent abatement, and that current laws are not working. Ms. Kawecki responded that until recently, there was no dust clearance testing required at the end of an EBLL investigation, so we don't know if it was the abatement, or if the clearance was not done. The critical question is getting the data at different phases, so you know where you are in terms of your hazard.

	Follow-up Items: DOH staff will provide continued updates on the implementation of this core initiative at future meetings.
Lead Surveillance and Testing Update, Susan Slade, RN, MS, Manager, Child Health Unit, BCAH	In response to a recent change in CDC national recommendations concerning lead testing of children in Medicaid, DOH conducted an analysis of childhood lead poisoning and testing within the NYS Medicaid population. Ms. Slade reviewed the recent statements from CDC and presented the results of the DOH analysis. • In the August, 2009 MMWR, the CDC updated its recommendations regarding blood lead testing of children enrolled in Medicaid, based on analysis of 1999-2004 National Health and Nutrition Examination Survey data. This analysis found that the national prevalence of elevated blood leads (≥ 10mcg/dL) in children aged 1 to 5 years was 1.9% for children in Medicaid and 1.1% for children not enrolled in Medicaid, which is not a statistically significant difference. Based on this finding, the CDC no longer recommends a single national policy for blood lead testing for Medicaid-eligible children. Instead, it encourages states to develop local policies based on local data. • In response, NYSDOH conducted an analysis of lead testing and lead poisoning rates, using a matched dataset of Medicaid eligibility and lead registry files. Results from the NYS DOH analysis (not including NYC) indicate that lead testing rates are higher among Medicaid-eligible children at age 1 and 2 years compared to non-Medicaid eligible children. It also found that there are significant disparities in the incidence of lead poisoning by Medicaid status. Although Medicaid-eligible children account for 39% of those tested for lead, they constitute 77% of those with elevated blood lead levels. The rate of incidence of lead poisoning in NYS children is over five times as high among Medicaid-eligible children compared to non-Medicaid-eligible children who have been tested for lead. Disparities exist for BLLs 5-9 mcg/dL; 10-14 mcg/dL; 15-19 mcg/dL; and 20+ mcg/dL. Among children tested at both ages 1 and 2 years, BLLs of Medicaid-eligible children are more likely to persist or rise compared to non-Medicaid children. • Next steps include issuing a Medicaid Update article statewide to present findings and to reinforce New York's universal testing policy, and updating the analysis to incorporate NYC data.
Council Discussion	**Advisory Council discussion took place on several issues, including:** • The challenge of balancing universal and targeted testing promotion efforts to improve lead testing rates among all children, while assuring that health care providers understand the higher risk and continued critical importance of testing Medicaid-eligible children. Dr. Broadbent expressed concern that messages related to testing of Medicaid-eligible children may reinforce the idea that suburban providers do not need to test their patients. DOH staff clarified that this specific focus on Medicaid data is in response to CDC's MMWR recommendations, and the associated concern that doctors may incorrectly think they no longer need to test Medicaid children. • How the planned linkage of lead and immunization data systems is expected to increase lead testing practices by community health care providers. Both state Council members and the CDC representative emphasized this project as a key strategy for increasing lead testing.

	• Ms. Nagin summarized additional data analysis for New York City that shows similar disparities in the incidence of EBLLs among Medicaid-enrolled children. • A concern was raised that the CDC recommendations may negatively impact state and local testing promotion efforts. It was clarified by the CDC representative that the recommendations are not intended to be detrimental, and that there are differences regionally that may not be addressed by a single national recommendation, so that states should identify their populations at risk, and to establish their own strategies. **Follow-up Items:** • DOH lead program staff will develop a Medicaid Update that incorporates the data presented and reinforces New York's universal lead testing requirements while accurately conveying the risk to Medicaid children to specifically promote lead testing of this group. • DOH staff will provide updates on additional lead testing improvement activities and lead testing rates at future Council meetings.
Council Member Updates	**Advisory Council members provided the following updates on lead-related activities:** • Mr. Chachere expressed concern that there is not enough time for discussion at Council meetings. He suggested either more meetings, longer meetings, or fewer agenda items. He specifically requested that the EPA regulations coming into effect in April be put on the agenda for the next council meeting. He also asked that budget-related items be discussed regularly, noting that reductions were proposed to five different lead appropriations in the Governor's budget. • Mr. Chachere stated there is a call for comments from EPA on reducing lead clearance standards for lead dust to 10 mcg/sq.ft. for floors and 100 mcg/sq.ft. for windows. The call for comments closes October 21. Those interested should submit their comments. He recommended this issue be put on a Council agenda • Mr. Mahar reported that he was approved to go to Baltimore on Nov. 2-4 to support a code change at the national level to include lead based paint. • Mr. Franklin noted that two weeks had been designated National Lead Poisoning Prevention Week in October, and localities could focus on either or both weeks for their awareness activities. • Ms. Nagin reported that NYC Mayor Bloomberg has signed a proclamation for Lead Poisoning Prevention Week. • Dr. Broadbent voiced concern about, "letting finances drive our dreams for primary and secondary prevention." He indicated it's clear a BLL 10 mcg/dL is hazardous, and the state should lower the follow-up level from 15 to 10 mcg/dL. He acknowledged local health commissioners are struggling with budget problems. He is hopeful that LeadCare II will take hold to improve testing practices. He noted that providers may follow CDC guidelines over state guidelines and laws, and asked that the CDC be mindful of local challenges in creating national recommendations. Dr. Broadbent also expressed thanks to those who developed the new state guidelines for BLLs < 10 mcg/dL and said he found the Task Force creation very positive.
Public Comment	No comments were received.
Adjournment	Dr. Freed thanked everyone for coming, noting that DOH values their advice. Meeting was adjourned at 3:07 p.m.

NEW YORK STATE ADVISORY COUNCIL ON LEAD POISONING PREVENTION
NYS DEPARTMENT OF HEALTH
JUNE 26, 2009
ALBANY, NEW YORK
EMPIRE STATE PLAZA, MEETING ROOM 4

Topics	Discussion	Follow-Up Action
Attendees	**Council Members:** • Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health, NYSDOH (Commissioner Designee Meeting Co-Chair Representing Dr. Birkhead) • Dick Svenson, Director, Division of Environmental Health Protection, Center for Environmental Health, NYSDOH (Commissioner Designee Meeting Co-Chair Representing Dr. Birkhead) • David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) • Matthew J. Chachere, Staff Attorney, Northern Manhattan Improvement Corporation (Environmental Group) • Alison Cordero, Deputy Director for Community Preservation, St. Nicholas Preservation Council, Williamsburg (Real Estate) • Maureen Cox, Director, Division of Safety and Health, NYS Department of Labor (Commissioner Designee) • Susan Duchnycz, Child and Family Services Specialist 2, Division of Child Care Services, NYS Office of Children and Family Services, (Commissioner Designee) • Joan Facelle, MD, Commissioner, Rockland County Health Department (Local Government) • Abby Greenberg, M.D., Director, Center for Public Health, Nassau County Health Department; Representative, American Academy of Pediatrics – Division II (Professional Medical Organization) • Pamela Hadad Hurst, Special Assistant, Commissioner's Policy Office, NYS Department of Environmental Conservation (Commissioner Designee) • Thomas P. Mahar, Code Compliance Specialist, Assistant Director, Regional Services, NYS Department of State, Code Division (Commissioner Designee) • Dr. Kallanna Manjunath, Chief Medical Officer and Pediatrician, Whitney M. Young J. Health Services (Undesignated At Large Public Member) • Andrew McLellan, President/Director, Environmental Education Associates Inc, Amherst, NY (Undesignated At Large Public Member) • Mary Elizabeth Mokrzycki, Program Manager, City of Syracuse Lead Program (Local Housing Authority) • John Shannon, Administrative Director for the Upstate New York Laborers' Education and Training Fund (Labor Union) **Additional Attendees:** • Michael Cambridge, R.S., Director, Bureau of Community Environmental Health and Food Protection, NYSDOH • Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection, NYSDOH • Eileen Franko, Dr.P.H., M.P.H., Director, Bureau of Occupational Health, NYSDOH • Howard Freed, MD, Director, Center for Environmental Health • Bruce Phillips, Counsel, Division of Legal Affairs, NYSDOH • Susan Slade, RN, MS, Manager, Child Health Unit, BCAH	

	Absent Council Members: • Guthrie S. Birkhead, M.D., M.P.H., Deputy Commissioner, Office of Public Health (Council Chair) • Mary Binder, Environmental Analyst, Division of Housing and Community Renewal (Commissioner Designee) • Clotilde Perez-Bode Dedecker, President/CEO, Community Foundation for Greater Buffalo (Child Health Advocate) (watched via web casting) • Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY Buffalo (Undesignated At Large Public Member) • Thomas Keenan, Temporary Assistance Specialist, NYS Office of Temporary Disability Assistance (OTDA), Bureau of Refugee and Immigrant Assistance (BRIA) (Adjunct Member) • Philip J. Landrigan, M.D., M.Sc., FAAP, Director and Professor of Pediatrics, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital) • Lindsay Lake Morgan, R.N., Ph.D., A.N.P., Assistant Professor, Decker School of Nursing, SUNY Binghamton (Educator) • Deborah Nagin, M.P.H., Director, NYC Department of Health and Mental Hygiene (NYCDOHMH) – Lead Poisoning Prevention Program (Adjunct Member) • Clifford Olin, President, EcoSpect, Inc. (Industry)	
Welcome and Introductions **Council Discussion**	• The meeting was convened at 10:17 a.m. • Dr. Rachel de Long and Richard Svenson co-chaired the meeting in Dr. Birkhead's absence. • Mr. Svenson welcomed and introduced a new member of the Advisory Council, Dr. Joan Facelle, Commissioner of the Rockland County Health Department and past president of the New York State Association of County Health Officials (NYSACHO). Mr. Svenson also welcomed new Council members Andy McLellan and Alison Cordero to their first Advisory Council meeting. • Mr. Svenson provided opening remarks regarding compliance with relevant executive orders: ▪ In accordance with Executive Order #3 and the Open Meeting Law, this meeting is being made available on the internet. The meeting notice and links to the webcast are at http://www.nyhealth.gov/events. (Note: this webcast is archived until July 26, 2009. All future webcasts are anticipated to be announced at this website and will be archived for one month following the meeting.) ▪ In accordance with Executive Law, section 166, members of the public who appear before the Council and represent any agency regulated by the Department of Health must fill out a Notice of Appearance form located at the registration table. ▪ Mr. Svenson provided an overview of the meeting agenda. • Mr. Chachere asked if Council webcasts could be archived for more than 30 days. Dr. de Long will find out and report back to the Council.	All webcasts are available on-demand for a minimum of 30 days, and retained for

	• Mr. Chachere asked if there is a way for members of the public who cannot attend the meeting to provide public comment. Dr. de Long will find out and report back to the Council. • Prior to the meeting, and at the meeting, Mr. Chachere asked about the process for introducing agenda items. Dr. de Long replied that input is welcome and solicited at each meeting. An email will be sent to Council members prior to the next meeting to solicit items. • Dr. de Long responded to the question raised by Mr. Chachere prior to and again at the meeting how the Council formally develops and adopts recommendations. Dr. de Long replied that any Advisory Council member can introduce a proposal for a formal recommendation. The Council will follow general rules of order, in which a motion is made, seconded, discussed, and then voted upon if there is a quorum (majority) present. The outcome will be recorded in the minutes and in the annual report to the Legislature. Mr. Svenson added that decision-makers at the Department of Health (DOH) attend these meetings, and listen and consider the discussion, even if no formal recommendations are produced.	a minimum of 4 months. Lead Advisory Council has a 30-day archive period after which the links are removed, and a DVD is maintained. All meeting participants, including Council members or members of the public, must be physically present at the meeting or visibly present via videoconferencing from another officially designated public meeting site. All members of the public must fill out a Notice of Appearance form.
Review and Approval of Minutes	• Mr. Svenson asked members if there were additions or edits to the minutes from the last Council meeting. • Mr. Chachere requested that a statement regarding county participation in primary prevention activities be clarified, and also suggested identifying speakers by name in the minutes. • A motion to accept the minutes with the above revision was made by Mr. Mahar, seconded by Dr. Greenberg. The motion carried, and the minutes were adopted.	The transcript from the March meeting was reviewed and the 3/31/09 minutes revised accordingly. Final minutes were sent out to members, with other material requested.
Governmental Affairs Update, Jim Clancy, Office of Governmental and External Affairs, DOH	In early June, the Governor announced the creation of the Governor's Task Force on the Prevention of Childhood Lead Poisoning. Eradicating lead poisoning is one of the Governor's top priorities, as reflected in the creation of the task force, expansion of the primary prevention program, and the legislation linking the lead and immunization registries. This is an interagency task force, whose goal is to make sure state agencies' efforts are coordinated and informed of each other's efforts. The Governor will announce today or tomorrow that Medicaid will cover in-office lead testing starting September 1, 2009.	

Council Discussion	**Advisory Council discussion took place on several issues, including:** • Mr. Chachere stated there should be a way to have public input into the task force. Mr. Clancy responded that stakeholder input is important, though at this time, the structure and operation of the task force has not been established. Ms. Valerie Gray, First Deputy Secretary to the Governor, will chair the task force. • Dr. Facelle and Mr. McClellan asked how recommendations could be conveyed from the Advisory Council to the task force, and if there was a formal procedure for obtaining a response from the task force to council recommendations. Mr. Clancy responded affirmatively, though the specific procedure has not been determined. • Dr. Manjunath asked if physicians were on the task force. Mr. Clancy clarified that the task force is comprised of state agencies and Governor's office staff, though it will seek input from other stakeholders. • Mr. Svenson referred to the Executive Order provided in the meeting packet, which includes statements indicating that the task force will consult with the Advisory Council, as well as outside advocates and experts, and issue a report both to the Governor and the Advisory Council. The task force and Advisory Council will be connected. • Dr. Manjunath expressed concern that the Medicaid fee for office-based lead testing should be large enough to motivate doctors to administer the test. If the fee is break-even or less, small practices might not pursue it. He noted that the cost savings will be great over the long-run, so it is worth reimbursing adequately.	Staff will develop a procedure to convey information from the Advisory Council to the Governor's Task Force
Regulations Update, Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health **Council Discussion**	Revisions to State regulations Subparts 67-1 and 67-3 went into effect June 20, 2009. Key provisions include: • Authorizing lead testing by Provider Office Labs and Limited Service Labs, and requiring electronic reporting of results to DOH; • Clarifying that follow-up services are required for all children with elevated blood lead levels (EBLLs) up to age 18 years; • Expanding the criteria for comprehensive follow-up services from a blood lead level (BLL) of 20 mcg/dL to a BLL of 15 mcg/dL. Letters and information on the new regulations were sent to local health departments and disseminated to pediatric health care providers via the Health Provider Network and public DOH web sites, as well as the NYS Chapters of the American Academy of Pediatrics, the Academy of Family Physicians, and the NYS Medical Society. Details regarding Medicaid reimbursement for office-based lead testing will be in the forthcoming July Medicaid Update. **Advisory Council discussion took place on several issues, including:** • Dr. Facelle suggested that it be clarified to local health departments that a hard copy of materials to health care providers has not been sent, to encourage local health departments to follow-up locally. Dr. Greenberg stated that counties have their own medical societies with email lists. DOH might want to include them in distribution efforts. • Dr. Broadbent and Dr. Greenberg commended DOH for keeping the emailed regulations letter signed by Dr. Birkhead to one page. Ms. Cordero suggested the use of bullets, so that key points are not buried in a lot of text. • Dr. Broadbent cautioned the use of the word "screening" because it is unclear to providers. Dr. de Long stated that DOH is using the term "blood lead testing" in correspondence, and the term was also clarified in recent amendments	Copy of the July Medicaid Update is attached.

Michael Cambridge, RS, Director, Bureau of Community Environmental Health and Food Protection **Council Discussion**	to Public Health Law Section 1370. Mr. Cambridge discussed revisions to Regulations Subpart 67-2, currently in progress. DOH has sent the proposed revisions to the Governor's Office of Regulatory Reform for review. The proposed changes update the regulations to reflect current practice and include: new definitions that are consistent with EPA rules; requirements that investigations be performed by certified personnel, and hazard control work be performed by trained personnel; lowers the definition of lead in paint to 1 mg/cm^2; new requirements for a written remediation plan and for clearance testing. DOH is currently exploring the impact of requiring abatement, versus interim controls, for all children with elevated blood lead levels. **Advisory Council discussion took place on several issues, including:** • Ms. Hurst asked if regulations require abatement if there is not a child with an EBLL but a dwelling tests positive for lead hazards. Mr. Cambridge explained that there are no regulations to require abatement or other lead hazard control, but notification of a new owner or occupant of lead hazards is required under federal law. • Dr. Broadbent asked if this regulation removes the need for localities to have their own regulations. Mr. Cambridge replied that 67.2 regulations are in addition to and separate from local housing codes. Mr. McClellan further explained that 67.2 is specific to environmental management of children with EBLLs, and that codes in Rochester and NYC, for instance, are not tied to identifying an EBLL index case. • Mr. Chachere expressed concern that the State is allowing use of interim controls to remediate lead hazards for EBLL cases, rather than requiring abatement exclusively, and EPA certified workers. Mr. Svenson responded that DOH is exploring using 67.2 for both EBLL-related abatement and primary prevention, and is exploring the requirement for certified workers. Certified workers are now required for all abatement projects. The cost of abatement is a major issue, and DOH is working to find additional funding. Dr. Facelle pointed out that New York City already requires abatement in response to EBLLs. Mr. Chachere urged DOH to go beyond the EPA's minimum requirements. • Mr. Chachere expressed concern that the draft regulations went to the Governor's office without review by the Advisory Council. Mr. Svenson explained that the Advisory Council did review them before the department sent them to GORR and the Governor's office for review. Any additional change to the proposed regulations would be sent back to DOH and shared with the Council. Mr. Chachere requested that the Council make a formal recommendation or vote on the revised version of the 67.2 regulations. • Ms. Mokrzycki and Mr. McClellan emphasized the need for consistency among EPA and New York State regulations and definitions, to eliminate confusion. • Ms. Mokrzycki suggested that there should be educational programs to teach local partners how to partner with federal agencies to get resources for abatement. Mr. Svenson stated that there are ten city/county primary prevention partnerships in New York, which is far ahead of other states. The local health departments (LHDs) have been very successful at leveraging funds.	Draft regulations to be distributed to Council members and scheduled for discussion at the next Council meeting. Council members may offer formal recommendations.

Primary Prevention of Childhood Lead Poisoning Update, Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection	Mr. Carroll provided an update on the status of the Childhood Lead Poisoning Primary Prevention Program (CLPPPP). Mr. Carroll explained that the primary prevention project does not depend on EBLL cases, but is targeted to high-risk areas with high concentrations of EBLLs. The pilot project started in 2007 with $3 million in eight cities/counties: Albany; Erie; Oneida; Onondaga; Orange; Westchester; Monroe; and New York City. In Year 2 (08-09), the funding increased to $4.9 million to include four more counties: Broome; Chautauqua; Dutchess; Schenectady. In year three (09-10) funding will increase another $2.5 million to $7.4 million total, and include five additional counties: Niagara; Rensselaer; Ulster; Fulton; Montgomery. The program is no longer a pilot, but is a permanent program. Mr. Carroll reviewed progress made to date, including number of home visits, inspections, referrals for testing, education. The year one final report, and preliminary report results for year two are on the DOH web site: (www.nyhealth.gov/environmental/lead/exposure/childhood/primary_prevention/pilot_program/)	
Council Discussion	**Advisory Council discussion took place on several issues, including:** • Dr. Facelle asked how 'lead-safe housing unit' is defined. Mr. Carroll replied that the county health commissioner can declare an area to be high-risk, and thereby mandate housing inspections for lead and require remediation as needed (issue of Notice and Demand). Interim controls do count as 'lead-safe' under current regulations. • Dr. Manjunath asked if it would be possible to pilot a project that focuses on BLLs of 5 to 9 mcg/dL, and whether that would change the priority areas. Dr. de Long stated that the pattern of children with 5-9 mcg/dL tends to parallel the ≥10 mcg/dL population. The primary prevention project allows communities flexibility in determining targeting methodology. Monroe County is using data for children 5-9 mcg/dL for targeting areas. • Dr. Manjunath asked if it is feasible to evaluate pre and post BLLs at the individual level, given the concern that lead hazard control measures can create lead exposures. Mr. Carroll and Dr. de Long said they will follow-up on this. • Dr. Manjunath asked if stimulus monies are being earmarked for lead poisoning prevention. Mr. Svenson replied that there has been an increase in HUD lead hazard control funding. HUD's weatherization program also received additional funding, and the new task force will explore how this can best be used for lead poisoning prevention. • Ms. Cordero asked how prevention programs have interfaced with the state's rural and neighborhood preservation programs. Mr. Carroll stated that most programs are in urban areas and he is not aware of linkages with these programs. Ms. Cordero stated that these programs do a lot of renovation and code enforcement work. There is a conference in October, at which the lead program could be promoted. Neighborhood preservation rules could be used by programs to find out where renovation is occurring. Mr. Carroll replied that DOH should explore this linkage, and that the Healthy Homes Program would also be interested. • Mr. McClellan asked if there is going to be some standardization of the program, based on existing local programs' experiences. Mr. Carroll replied that there will be more standardization, but it is important to continue to allow counties some flexibility to accommodate local conditions and resources. Ongoing technical assistance is provided	Further analysis of studies including this type of pre- and post-child-level BLL data incorporated into the literature review on effectiveness of lead hazard control interventions that is currently in progress Mr. Carroll will contact Ms. Cordero to discuss linkages with neighborhood preservation programs.

	to share effective strategies amongst grantees. Additional resources related to best practices will be developed in the future. • Ms. Cordero asked about the experience of working with immigrant populations. Mr. Carroll said that DOH has been working with Tom Keenan, a Council member from OTDA's Bureau of Refugee and Immigrant Assistance, to translate materials. Grantees have used resettlement programs for partnerships. Dr. Franko offered to send Ms. Cordero materials in Polish that the Bureau of Occupational Health has developed. • Mr. Chachere stressed the importance of data for targeting and suggested obtaining data by race, and by those on public assistance. Mr. Carroll stated that New York City uses vital records for newborns to target houses. DOH is also geocoding data to better target areas. • Dr. Broadbent asked how primary and secondary prevention efforts can be combined. Mr. Carroll stated that there is not a clear line between primary and secondary prevention, and that LHDs typically don't have two different programs, it's the same staff. Primary and secondary prevention programs often focus on the same neighborhoods, using different tools. Dr. de Long added that primary prevention projects must have a mechanism for educating and referring children and pregnant women at risk. LHD lead poisoning prevention program work plans also have primary prevention components. • Dr. Broadbent commented that the incidence of childhood lead poisoning in some rural counties is relatively high, and it could make sense to target primary and secondary prevention efforts in those counties. There are lessons learned in the urban areas that can be brought to rural areas, and the rural areas should be made aware that their incidence rates are high. Dr. Franko commented that rural counties such as Columbia are proactive and aware of the issue. • Mr. Svenson stated that the National Center for Healthy Homes is doing the primary project evaluation, and it would be a good idea to have them present to the council when they are ready. The goal is to develop a protocol to identify and maintain lead-safe housing. For the next round in October, DOH will become more prescriptive with its grantees to increase cost effectiveness.	Dr. Franko will send Ms. Cordero educational materials in Polish.
Take Home Occupational Exposure, Eileen Franko, Dr. P.H., Director, Bureau of Occupational Health (BOH) **Council Discussion**	Dr. Franko reviewed the follow-up services provided by BOH to adults age 16 years or older with an elevated blood lead test result. She reviewed statistics from the State's Heavy Metals Registry, including data showing that the number of women of childbearing age with a BLL of $\geq$ 10 mcg/dL has dropped from 428 in 2000 to 278 in 2008. Dr. Franko also reviewed the most common occupations for adult lead exposure, including bridge repair, "shooters," and residential remodeling. She also listed some of BOH's recent published articles and trainings. **Advisory Council discussion took place on several issues, including:** • Dr. Broadbent asked about how good a job obstetricians are doing in testing pregnant women for lead. Dr. Franko	

	replied that Regulations Subpart 67.1 require lead risk assessment with targeted blood lead testing. Because the state registry collects only blood lead test results, it is not known what percentage of pregnant women who are identified as being at risk are getting tested for lead. Dr. de Long added that risk assessment questions for pregnant women are posted on the DOH web site, part of the DOH Lead Poisoning Prevention Guidelines for Prenatal Care Providers (www.nyhealth.gov/environmental/lead/). These questions and the guidelines are being updated, and there will be additional education and outreach when completed. • Dr. Broadbent asked who is working on educating prenatal care providers about lead poisoning. Dr. de Long stated that, in addition to posting on the DOH web site, and collaborating with provider organizations, there is a statewide network of Regional Lead Resource Centers, contracted by DOH. Part of the work plans for these centers include outreach and education to prenatal care providers through a variety of channels including Grand Rounds, newsletters, and one on one consultation. • Dr. Manjunath asked if PCAP (Prenatal Care Assistance Program) requires lead testing or screening. Dr. de Long replied that the program requires a lead risk assessment, and testing if a risk is identified, in accordance with state regulations. • Dr. Manjunath asked if the new point-of-care testing technology could be of benefit in the OB/GYN setting. Dr. Franko remarked that the point-of-care testing is being used for adults. Dr. de Long stated that the extent that this device is used in prenatal care is not known. Pregnant women get blood drawn for a number of tests already, so getting blood drawn might not be a barrier as it is for some children. • Dr. Manjunath noted the possibility of working with the Centers for Disease Control, to require lead testing for immigrants, since, currently, blood is drawn for required testing for HIV and other illnesses. Identifying EBLLs would be beneficial for pregnant women and for identifying possible behavioral risk factors, such as use of certain cosmetics, that might continue to put them and their children at risk in this country. • Ms. Cordero stated that she is concerned about educating residential remodelers. In New York City, it has been difficult to access stores such as Lowe's and Home Depot. Dr. Franko replied that BOH has pursued education of sales people in these stores. Mr. McClellan also has experience conducting outreach to these large chains, and stated that each store must be dealt with separately, and that high turnover is a challenge. Ms. Cordero suggested that there is a need to reach someone at a higher level in these organizations, and to use their information channels. Mr. McClellan stated that the EPA is exploring how to conduct this kind of outreach, to provide education on its new rules. • Mr. Chachere asked if there is a protocol for evaluating other family members for take home lead when an occupational exposure is identified. Dr. Franko replied that during the follow-up interview, those questions are asked and information is provided on the risks.	
Lead Surveillance and Testing Update,	Dr. de Long introduced Susan Slade as the new manager of the Bureau of Child and Adolescent Health's Child Health Unit, including the DOH Lead Poisoning Prevention Program and the Children with Special Health Care Needs Program. Ms. Slade provided an update on surveillance and testing data. DOH is striving to make data timelier, and	

Dr. Rachel de Long, Susan Slade, RN, MS, Manager, Child Health Unit, BCAH	preliminary 2008 data should be finalized by the end of 2009. DOH is also working to incorporate New York City data into state surveillance and testing reports. Ms. Slade reviewed data showing that testing rates have increased while the prevalence and incidence of childhood lead poisoning has decreased markedly over the past ten years. Ms. Slade reported on enhancements to LeadWeb, the State's childhood lead testing database. There is a work group helping to inform the design of dynamic reports for local health departments. This work should be completed by the end of the summer. In addition, the linkage of the statewide immunization and lead registries has been initiated. Ms. Slade reviewed point-of-care lead testing technical requirements and recently revised regulations to cover this new technology. Ms. Slade ended her presentation with a review of a recent statewide mailing on the potential harm of BLLs less than 10 mcg/dL, and related new educational material, "What Your Child's Blood Lead Test Means." DOH has also instituted changes to the comment language for blood lead lab reports for results less than 10 mcg/dL. The language now states, "Blood lead levels in the range of 5-9 mcg/dL have been associated with adverse health effects in children aged 6 years and younger."	
Council Discussion	**Advisory Council discussion took place on several issues, including:** • Dr. Manjunath asked when the testing and surveillance regulations first went into effect. Dr. de Long responded that they were initiated in 1992. • Ms. Mokrzycki asked if the testing data are linked to housing-related data. Dr. de Long replied that LeadWeb includes environmental data and that additional linkages are being explored. Ms. Mokrzycki stated that it might be possible to match an EBLL child with what programs have been provided. In Syracuse they use the LeadPro data program that can track patient information by program intervention. One can see how much money has been spent, and how much the BLL has dropped. It is important to be able to analyze if people are being helped by programs, or if BLLs are going up after an intervention. It is important to bring housing and lead together. Mr. Carroll replied that this is a good goal, but noted that a challenge is maintaining confidentiality. Mr. Cambridge added that the primary prevention projects are working to strengthen the linkages. • Dr. Broadbent inquired as to the extent that LHDs have the ability to analyze their own data in LeadWeb. Dr. de Long and Ms Slade noted that static reports are already in place, to address common needs and day-to-day management, which every LHD can use. New dynamic reports will add further functionality, but will depend on the LHDs to utilize these. Dr. Facelle added that some LHDs don't have the staff to run their own reports, but the greater functionality of the system will increase their capacity. She noted that the development process has been positive, and that the existing and planned functionality meets the needs of local health departments. • Dr. Manjunath stated that the new immunization-lead database linkage will be very helpful to providers as historical data is added, and asked if LeadWeb will be accessible to health care providers. Dr. de Long replied that LeadWeb is for state and local health department use, but the lead testing information will be displayed to providers through the NYSIIS linkage. • Ms. Cordero stated that a priority is to get the children tested who are not being tested. The immigrant population is particularly challenging.	

	• Mr. Chachere stated that it would be helpful to have some charts in the reports that combine New York City and State data, to have the data together. • Mr. Chachere remarked that the number of children with EBLLs is not large, making increased enforcement and abatement more feasible. He urged that enforcement should be increased for children with BLLs of 10 to 15 mcg/dL. Dr. Broadbent also stated that it is time for the state to lower the action level to 10 mcg/dL. • Mr. Chachere stated that the increase in lead poisoning is between ages 1 and 2, but that is the same age for the fall off in testing. He concluded that it's possible there are a lot more children who are poisoned who are not getting tested. Dr. de Long replied that the data show that as more children are tested the number of children and rates continue to drop. This indicates that testing is being targeted to higher risk children; there is probably not the same incidence among those tested and those not tested. Dr. Facelle added that it is a challenge to get parents of a 2 year old at low risk to get tested. Parents and providers are reluctant to do it. • Dr. Manjunath stated that the new educational material explaining test results was well done. • Dr. Broadbent asked for clarity about the responsibility of Regional Lead Resource Centers (RLRCs). Are they responsible for outreach to health care providers, versus direct mailings from DOH? Dr. de Long responded that DOH used multiple approaches, including RLRCs, and that redundancy in its outreach efforts helps reinforce messages.	
Council Member Updates	**Advisory Council members provided the following updates on lead-related activities:** • Mr. Mahar explained briefly, for the benefit of new and continuing council members, how the Department of State (DOS) operates. o The DOS is responsible for the Uniform Code, which includes the building code, fire code, and property maintenance code. The Uniform Code is based on the international codes. New York City has its own codes. o New York State is a home rule state. This means every community is responsible for enforcement of the Uniform Code. There are minimum standards they must enforce, and they must have a local law stating how uniform codes will be enforced. The State cannot directly tell localities that they have to enforce a lead-based paint standard, for example. o The property maintenance code applies to all buildings, not just housing. It includes child care centers. o The property maintenance code has only one sentence dealing with paint, "Peeling, chipping, flaking, or abraded paint shall be repaired, removed, or covered" (PM 305.3). NYS tried to get one sentence about lead-based paint into the code at the national level three years ago. The next national meeting on updating the international code is in October, 2009. The Department of State will reintroduce a proposal for this code change into the national code book. It is easier for NYS to adopt the change if it is already in the national code book. o Mr. Mahar shared the text of the proposed code change and rationale, as prepared by the DOS. The proposed change to the code is, "Deteriorated lead-based paint shall be controlled using approved lead-	

	safe working practices." Mr. Mahar stated that DOS is working with the National Association of Homebuilders, which in the past opposed changing the code regarding lead paint. o Dr. Franko asked why the change applied only to interior surfaces, not exterior, and Mr. Mahar replied that this limitation makes the proposal more likely to pass. o Mr. Svenson asked whether some reference should be made to the age of the housing, rather than the paint, which could require testing to verify the presence of lead. Dr. Franko added that she spoke with state code officials at the last national meeting and they were concerned about any new language that would require testing of paint for lead. She urged Mr. Mahar to clarify in his testimony at the next national meeting that the proposed change would not require paint testing, but that lead paint would be assumed based on the age of the building. o Mr. Mahar stated that DOS's goal is to get a simple statement in the national code, which can then be used for justification for expansion at the state level. o Mr. Svenson suggested that this issue would be appropriate for the new state task force, which includes the Secretary of State, and that there could be action at the state level without corresponding action at the national level. Mr. Mahar added that it could also be done by the state legislature. o Mr. Chachere commented that the revision of the building codes is very important. NYS has the power to change its code now and should go ahead and do it. • Mr. Chachere asked to put on a future meeting's agenda the issue of tightening up the regulations for lead-safe work practices in the state, with the goal of developing some proposals, such as a ban on dry scraping, as currently exists in New York City. Educating staff at hardware stores is not going to reach enough people. Ms. Cordero agreed. • Dr. Facelle related a recent experience from Rockland County that highlighted the need for better coordination between local agencies. The LHD visited a child center and inspected the kitchen area, but did not notice lead paint hazards in the rest of the facility. The LHD is working with OCFS to improve coordination of inspections. • Dr. Broadbent praised DOH staff for the progress they have made. He suggested DOH should pursue the concept of Healthy Homes, and wondered if the Advisory Council could assist with thinking on this. Mr. Svenson replied that DOH is actively taking part in the Healthy Homes initiative, and has conducted training with LHD staff on the certifications and concepts involved. A representative from the CDC provided an overview of the Healthy Housing Initiative at a previous Advisory Council meeting. • Dr. Broadbent asked if DOH is working on other educational materials. Mr. Baskin, health educator in the BCAH, replied that they are working on a document explaining state regulations for child care providers, and working with Thomas Keenan, Advisory Council member from the Office of Temporary Disability Assistance, to translate the new flyer on lead testing into multiple languages. • Dr. Broadbent requested that material for Council meetings be sent earlier, at least one or two weeks in advance. • Ms. Hurst related that Monica Kreshik has changed positions and will be replaced by herself on the Council as the representative for DEC. • Dr. Broadbent asked if DOH was working with medical societies in the state to distribute information. Dr. de Long	This topic will be added to a future meeting agenda for further discussion The September 10th meeting was rescheduled for

	replied that DOH is working with them to distribute information on the new regulations. Feedback from the field would be helpful. • Dr. de Long informed the Council that the next meeting will be September 10. A call for agenda items will be sent, but members are invited to send in suggestions at any time. The PowerPoint presentations from this meeting will be sent out shortly.	October 19, 2009, and notification of change was sent out. PowerPoint presentations from the June 26th meeting were sent out electronically to Council members, along with a call for agenda items for the October meeting.
Public Comment	No comments were received.	
Adjournment	Meeting adjourned at 3:40 p.m.	

NEW YORK STATE ADVISORY COUNCIL ON LEAD POISONING PREVENTION
NYS DEPARTMENT OF HEALTH
MARCH 31, 2009
ALBANY, NEW YORK
EMPIRE STATE PLAZA, MEETING ROOM 5

Topics	Discussion	Follow Up
Attendees	**Council Members:** • Guthrie S. Birkhead, M.D., M.P.H., Deputy Commissioner, Office of Public Health (Council Chair) • Ray Andrews, Assistant Director for Code Development, Codes Division, NYS Department of State (Adjunct Member, sitting in for Tom Mahar) • Mary Binder, Environmental Analyst, Division of Housing and Community Renewal (Commissioner Designee) • David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) • Matthew J. Chachere, Staff Attorney, Northern Manhattan Improvement Corporation (Environmental Group) • Clotilde Perez-Bode Dedecker, President/CEO, Community Foundation for Greater Buffalo (Child Health Advocate) • Susan Duchnycz, Child and Family Services Specialist 2, Division of Child Care Services, NYS Office of Children and Family Services, (Commissioner Designee) • Abby Greenberg, M.D., Director, Center for Public Health, Nassau County Health Department; Representative, American Academy of Pediatrics – Division II (Professional Medical Organization) • Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY Buffalo (Undesignated At Large Public Member) • Thomas Keenan, Temporary Assistance Specialist, NYS Office of Temporary Disability Assistance (OTDA), Bureau of Refugee and Immigrant Assistance (BRIA) (Adjunct Member) • Dr. Kallanna Manjunath, Chief Medical Officer and pediatrician, Whitney M. Young J. Health Services (Undesignated At Large Public Member) • Betsy Mokrzycki, Program Manager, City of Syracuse Lead Program (Local Housing Authority) • Deborah Nagin, M.P.H., Director, NYC Department of Health and Mental Hygiene (NYCDOHMH) – Lead Poisoning Prevention Program (Adjunct Member) • Clifford Olin, President, EcoSpect, Inc. (Industry) • John Shannon, Administrative Director for the Upstate New York Laborers' Education and Training Fund (Labor Union) • Tom Zyra, Attorney, NYS Insurance Department Office of Legislative and Intergovernmental Affairs (Adjunct Member, sitting in for Stacy Rowland)	

	• Maureen Cox, Director, Division of Safety and Health, NYS Department of Labor (Commissioner Designee) **Additional Attendees:** • Michael Cambridge, R.S., Director, Bureau of Community Environmental Health and Food Protection, NYSDOH • Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection, NYSDOH • Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health, NYSDOH • Bruce Phillips, Counsel, Division of Legal Affairs, NYSDOH • Dick Svenson, Director, Division of Environmental Health Protection, Center for Environmental Health, NYSDOH **Absent Council Members:** • Alison Cordero, Deputy Director for Community Preservation, St. Nicholas Preservation Council, Williamsburg (Real Estate) • Philip J. Landrigan, M.D., M.Sc., FAAP, Director and Professor of Pediatrics, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital) • Andrew McLellan, President/Director, Environmental Education Associates Inc, Amherst, NY (Undesignated At Large Public Member) • Monica Kreshik, EJ Coordinator, NYS Department of Environmental Conservation (Commissioner Designee) • Lindsay Lake Morgan, R.N., Ph.D., A.N.P.; Assistant Professor, Decker School of Nursing, SUNY Binghamton (Educator)	
Welcome and Introductions	• The meeting was convened at 10:12 a.m. • Dr. Birkhead opened the meeting, and welcomed seven new council members. • Dr. Birkhead provided opening remarks regarding compliance with relevant executive orders: ▪ In accordance with Executive Order #3 and the Open Meeting Law, this meeting is being made available on the internet. The meeting notice and links to the webcast are at http://www.nyhealth.gov/events. (Note: this webcast is archived until April 30, 2009. All future webcasts are anticipated to be announced at this website and will be archived for one month following the meeting.);	

	▪ In accordance with Executive Law, section 166, members of the public who appear before the Council and represent any agency regulated by the Department of Health must fill out a record of attendance, provided at the registration table. • Dr. Birkhead introduced the seven new council members: Clotilde Perez-Bode Dedecker , President/CEO of Community Foundation for Greater Buffalo; John Shannon, Administrative Director, Upstate New York Laborers' Education and Training Fund, Oswego; Betsy Mokrzycki, Program Manager, City of Syracuse Lead Program; Dr. Kallanna Manjunath, Chief Medical Officer and pediatrician at Whitney M. Young Jr. Health Services, Albany; Alison Cordero, Deputy Director for Community Preservation, St. Nicholas Preservation Council, Williamsburg; Matthew J. Chachere, staff attorney, Northern Manhattan Improvement Corporation, also member of the NYS Coalition to End Lead Poisoning; Andrew McLellan, founder and training director, Environmental Education Associates, Inc. • Dr. Birkhead noted that several other Council members have been reappointed for another term to the Council: Clifford Olin, Dr. Abby Greenberg, Dr. Philip Landrigan, Dr. Lindsay Lake Morgan, and Dr. Juanita Hunter. • Dr. Birkhead provided several updates, including: • The analysis of 2006-07 data has been completed and will be posted on the DOH public Web site shortly. Staff has begun preliminary analysis of surveillance data from 2008. More information about 2008 data will be shared at the next meeting of the council. • The new educational materials about the importance of blood lead levels <10 mcg/dL and to help parents understand their child's blood lead test that the council commented on at the last meeting are being finalized and printed. They will be sent to all pediatric health care providers and local health departments statewide. At the same time, changes will be implemented to add new comment language to blood lead laboratory reports for results below 10 mcg/dL, to more accurately characterize the concern about blood lead levels of 5-9 mcg/dL. • The Department's Bureau of Occupational Health has expanded the threshold for interventions for women of childbearing age (ages 16-45 years) to 10 mcg/dL. The Bureau contacts these women to conduct telephone interviews, and provides them with information on sources of lead and methods	
General Updates Since Last Meeting		

	to reduce or eliminate their sources of exposure. In addition, letters are sent to all women who indicate that they are pregnant that include information about having the baby tested for lead after delivery. • The Bureau of Occupational Health is also working on outreach for contractors and construction workers. With the new Federal Stimulus package it is anticipated that there will be an increase in work with buildings and structures that contain lead, and DOH would like to proactively address the risks involved. • The Centers for Disease Control and Prevention (CDC) has continued steps to broaden their approach to lead poisoning prevention and especially primary prevention efforts to incorporate a "healthy housing" approach, as was described by CDC Project Officer Larry Franklin at the council meeting last October. On a recent grantee conference call, the CDC speaker indicated that the CDC's Lead Poisoning Prevention Branch is changing its name to the Lead Poisoning and Healthy Housing Branch. CDC has indicated that a competitive funding opportunity for states to develop healthy housing projects is still forthcoming, but that has not yet been announced. In the meantime, NYSDOH continues to receive annual cooperative agreement funding from CDC to help support childhood lead poisoning prevention work. This year DOH again was informed by CDC that cooperative agreement funding will be reduced by 2% from the prior year, consistent with similar funding reductions sustained over the last several years. • The draft report of the Advisory Council covering the period through June of 2008 is in the process of being completed. DOH appreciates the input provided by council members on the content and format of this report at the last meeting. Once this initial draft is completed, it will be distributed to council members for review and comment, to be incorporated in the final report.	
Review and Approval of Minutes	Dr. Birkhead asked members if there were additions or edits to the minutes of the last meeting. Dr. Greenberg indicated that her title had changed. It is now Director for Center for Public Health, and this should be changed on the minutes. A motion to accept the minutes was made by Dr. Hunter, seconded by Ray Andrews. Motion passed.	

Legislative Update **Jim Clancy, Alithia Rodriguez-Rolon, Office of Governmental and External Affairs, NYSDOH**	On December 16, 2008 the Governor released his Executive Budget. Although the current fiscal situation required a number of reductions and cost savings initiatives, the Governor is committed to lead poisoning prevention and included an investment for lead poisoning prevention in his budget. There is $2.5 million new dollars for the primary prevention program. This will enable DOH to expand to additional counties. In a year where NYS is facing a $17 billion shortfall, this is one of the few new investments in any area. The Article VII bill that accompanies the budget includes several amendments to Public Health Law related to lead poisoning prevention, including expanding and making permanent the primary prevention pilot program, and creating linkages between the statewide childhood lead registry (LeadWeb) and the statewide immunization information system (NYSIIS). These changes are included in the budget bill being voted on by the legislature. Copies of the current Article VII language were provided at the meeting, and it is also available on-line.	
Council Discussion	**Council discussion took place on several issues, including:** **Linking NYS immunization and lead registries**: Linking of the two registries will make reporting of blood lead testing conducted in the physician office easier as physicians can enter the lead test results directly into the registry. Physicians will also be able to easily see which patients are due for a lead test. The system can generate reminders and flag patient records. **Local health department access to data**: There was a question as to whether local health departments' ability to analyze local data will improve with the linkage of lead and immunization registries. It was clarified that local health departments (LHDs) will have access to the lead information in the immunization registry, which will provide them with new tools for targeting lead testing improvement strategies. In addition, improvements to the existing LeadWeb data system are in progress. There is a LHD/NYSDOH work group actively working on the development of new LeadWeb reports for LHDs. Currently, there are several static or 'canned' reports designed to address routine LHD reporting needs, e.g. list of children who were tested at 1 but not 2, with function to generate reminder letters. With extensive input from the work group, DOH is building a dynamic reporting function, so LHDs can customize their own data reports. DOH has hired a programmer to expedite this project. The static reporting is in place now, and the dynamic reporting should be in place later this year. **Linking of NY City and NY State registries:** New York City will continue to maintain a separate city	

	lead registry with a link to the city's immunization registry. A concern was raised that if a patient gets tested in NYC, a doctor in upstate NY will not have access to the information through NYSIIS. NYSDOH and NYCDOHMH programs are working on data transfer solutions to address this. **Ability to link with electronic medical records**: A question was raised as to whether the interface between NYSIIS and electronic medical records (EMRs) will be unidirectional or bidirectional. Currently providers with EMRs can transmit immunization information to NYSIIS. **Public access of data:** There was a question concerning how much county data will be available for public access. It was clarified that the data and reporting functions in the childhood lead registry are for local health department use, and confidentiality of individuals must be protected. DOH is working on expanding surveillance reports, e.g. adding maps, and sub-county analysis. There has been a major effort to geocode all test results to enable this kind of analysis. Lead data is also being incorporated into the Department's Environmental Public Health Tracking program, which includes a public access component.	Dr. de Long will follow-up with NYSDOH NYSIIS staff on this question.
Federal Fiscal Stimulus Funds for Housing **Pat Costello, Weatherization Assistance Program, Division of Housing and Community Renewal (DHCR)** **Mary Binder, Environmental**	Mr. Costello presented an overview of the DHCR's Weatherization Assistance Program, which works to improve the energy efficiency of homes. Program funds are used to assist low-income people save on energy bills. The program conducts an energy audit, and makes energy efficiency and safety improvements. The program will receive $394 million from the federal stimulus funding (American Investment and Recovery Act). Previous year's funding was $62 million. The increased funding will enable an increase in units served. New federal EPA rules for renovation and remodeling will not impact New York State's program too greatly because it has already been voluntarily following lead-safe work practices. The program assumes lead paint is in older buildings. Since 2001, the program has distributed EPA lead-safety literature to clients. All employees have to take a one-day lead-safe weatherization course. Each subgrantee must have an EPA-certified lead-safe renovator on staff. Workers are encouraged to be lead tested. Only one worker tested has failed in the past eight years. Six subgrantees wear air monitors to monitor lead levels for workers. One significant change with the new EPA rules is that the program will now need to have an EPA-certified renovator on-site, not just available. DHCR will also have an additional $252 million for capital projects. Most projects for rehabilitation are pre-1978. These are done using lead-safe practices, whether for families or senior housing. The program	

Analyst, Division of Housing and Community Renewal	also remediates lead in soil. Everything is done in compliance with HUD regulations and guidelines.	
Council Discussion	**Council discussion took place on several issues, including:** • **Protections for children:** Program does dust wipe clearance testing at all sites. Landlords are required to pay for this testing. Only the renovated space is tested, not the entire apartment. Children who already have high blood lead levels can be relocated, though this occurrence is rare. Program does ask if child has been tested for lead. • **Replacing windows:** Window replacement has been noted to be a highly effective intervention for reducing lead paint exposure. However, under the Weatherization Assistance Program, DHCR can only replace windows if it meets specific cost-effective/energy efficiency ratios. Usually, replacing windows does not meet these ratios. However, if funding for window replacement could be supplemented by an external source, then cost to DHCR might be reduced enough to allow it. A Council member suggested that if supplemental funds could be identified, they could be leveraged to support window replacement by DHCR. It was also noted that if the cost of lead poisoning were included in the calculation, the intervention would likely become cost effective. • **Protecting workers:** According to the OSHA standard, a worker with a blood level of 40 mcg/dL requires medical monitoring, 50 mcg/dL requires removal from site. A comment was made that family members of any worker with an elevated blood lead level should also be tested, and this should be part of the standard protocol. • **Clearance testing:** A question was raised about whether there are data on the number of jobs that don't pass clearance the first time. It was stated in response that there have been few problems reported and no complaints about the clearance process. • **Paperwork/hurdles for families to receive services:** It was noted that some housing agencies say there is a lot of paperwork to complete for the weatherization program, and a concern was raised about any other hurdles involved. In response, Mr. Costello said he believes there are few hurdles. Most subgrantees have 2 to 3 year waiting lists, and there is very little marketing needed.	
Primary Prevention of	Tom Carroll provided an update on the status and proposed expansion of the Childhood Lead Poisoning Primary Prevention Program (CLPPPP). The pilot project started in 2007 with $3 million in eight	

Childhood Lead Poisoning, Update **Thomas Carroll**, **Section Chief, Bureau of Community Environ-mental Health and Food Protection**	cities/counties, Albany, Erie, Oneida, Onondaga, Orange, Westchester, Monroe, and New York City. In Year 2 (08-09), the funding increased to $4.9 million to include four more counties: Broome; Chautauqua; Dutchess; Schenectady. Governor Paterson, in his executive budget, proposed a funding increase of $2.5 million for Year 3 (2009-2010). This increase will allow expansion to additional high-incidence target communities. The project is targeting the oldest housing within the highest incidence cities in New York. The Year 1 final evaluation report is expected to be on the web site within one week. (www.nyhealth.gov/environmental/lead/exposure/childhood/primary_prevention/pilot_program/early_lessons/index.htm) LHDs that are funded through CLPPPP develop local primary prevention plans that: identify the scope of problem locally; develop local partnerships and community outreach; develop feasible approaches to targeting, inspection, hazard control, and enforcement; build capacity of local health departments and community partners, and, improve funding capacity for hazard control projects. Between rollout and September, 2008: 6,290 households were reached with direct outreach and referral; home visits were conducted for 1,289 children under age six, and 582 were referred for blood lead testing; 1,514 housing units were investigated and 699 were found to have lead hazards; 215 lead-safe housing units were created; 518 property owners and renovators were trained in lead-safe work practices. Key issues include getting agency collaboration to get into houses. Some property owners are resistant. There is also some resident resistance. Residents are worried about the inconvenience, or getting in trouble with the landlord. Enforcement is also an issue. Counties need to get the legal tools for investigations and timely response, such as the search warrant they have in Rochester, or Housing Courts. Counties have the legal authority to demand improvements, with properly trained people. Counties are trying to make training attractive to contractors and property owners by, for example, offering assistance to fix problems in exchange for participation. Counties are always looking for new partners, including code enforcement, and the Department of Social Services. Mr. Carroll described the outreach plans of the new counties, and invited Council members to call his bureau to find out more (1-800-458-1158 x 27600). Council members were asked to provide input on the ongoing implementation and proposed expansion of the program.	
Council	**Discussion took place on several issues, including:**	

Discussion	**Progress**: A council member stated that progress is astounding. **Additional strategies:** Several specific strategies were suggested by Council members, including: • Targeting census tracts rather than ZIP codes; • Assuring that children are referred for lead testing and receive follow-up services; and • Reducing the action level for comprehensive follow-up services to 10 mcg/dl. **Legal authority:** A council member stated his impression that, prior to this project, legal authority for enforcing the remediation of properties with lead hazards seemed to be absent, except in New York City and Rochester. It was clarified that existing New York State Public Health Law does allow the local health commissioner to declare an area of high risk, which permits inspections and corrections. This enforcement power currently exists, and is being used by project counties to conduct primary prevention activities. **Geographic coverage:** A question was raised about the existence of primary prevention efforts in counties that have not been targeted through CLPPPP. DOH is focusing on the highest incidence cities and counties first for its primary prevention program. However, high-risk zip codes can cross county lines. All counties are eligible to receive other general Lead Poisoning Prevention Program grant funding from NYSDOH. **Going 'deep' vs. broad:** A council member suggested that, if the goal is to eliminate childhood lead poisoning, it would make sense to work intensely within a small number of counties, as opposed to working less intensely in a larger number of counties, stating that none of the 12 counties have sufficient funding to totally address their high risk housing stock. It was suggested that DOH work to eliminate lead poisoning in one high area then take that approach to the next place. Another council member commented that in any county there will always be a child who will be lead poisoned, stating that DOH should go deep, but also continue to expand. DOH staff noted that DOH is taking that approach by targeting the highest risk areas first, then expanding to additional high risk areas over time. The proposed expansion for 2009-10 includes expansion within existing target counties as well as the possibility for bringing on additional counties. **Evaluation:** A council member commented that it is "great" that the pilot project is now permanent, but	

	also that it is important to continue to try new approaches to see what is working. It was suggested that DOH continue piloting activities and evaluating their effectiveness. It was clarified by DOH staff that making the pilot permanent does not mean evaluation will stop. **Public access to data:** It was suggested that more information be made public, including: accomplishments; details of problems/challenges; details for addressing these challenges; addresses of at-risk dwellings. DOH staff noted that the final report will contain a number of recommendations that have this information. DOH is working on putting data together to make it useable while ensuring confidentiality. Another council member noted that one of the challenges of maintaining a housing registry is keeping it up to date; if a house gets fixed, or a house deteriorates, this needs to be reflected in the registry for it to have meaning. A registry sounds good, but it is difficult to do. It was suggested that DOH look at who has been successful in creating housing registries.	
Remarks by Commissioner Daines **Council Discussion**	Dr. Daines provided brief remarks in response to the presentation on primary prevention. He thanked the Council for its efforts and noted that the Council is fulfilling its function as evidenced by the rich discussion of the issues. He noted the marked decrease in lead poisoning over the previous decade, but stated that more works still needs to be done, such as increasing the testing rates. He highlighted the advances made in the expansion of primary prevention efforts and the proposed integration of the lead and immunization registries. **Discussion took place on several issues, including:** **Progress:** The primary prevention program has brought partners together to get counties to realize their powers. The program does not provide renovation funding, but does coordinate efforts. The focus on primary prevention has really changed the landscape. **Usefulness of combining immunization and lead registries:** One council member noted entering historical immunization data is an issue for providers. It was clarified that lead data will be populated automatically in NYSIIS from the lead registry and does not make additional work for providers. A physician on the council noted that the immunization registry has been helpful when providing care to children from different parts of the state, to minimize duplication of immunization and expressed strong support for the proposed integration. Another member noted that in New York City, there is a combined on-line lead and immunization registry. When these were combined and put on-line, immunization data	

	got better, and the lead program gained information that immunization gets, such as Medicaid status. **Regulatory proposals 67-1 and 67-2:** A question was asked about the status of changes to lead regulations. Proposed changes to Subparts 67-1 and 67-3 have been posted for public comment, with comments received currently under review. Proposed changes to subpart 67-2 are anticipated to be ready for public comment by the next meeting. A council member asked if the council could see the proposed revisions to 67-2 before it is posted for public comment, and this was affirmed. **Use of surveillance data**: A council member commented that there needs to be a way for local health departments to be able to analyze local data. DOH staff again noted active progress, in conjunction with a LHD workgroup, to develop LeadWeb systems enhancements for LHDs to be able to customize local data reports, and a programmer has been hired to do that. DOH is also putting together new surveillance maps and analyses for county use.	Proposed revisions to 67-2 will be shared with Advisory Council for further discussion when ready.
Renovation and Remodeling **Eileen Franko, Dr. P.H., Director, Bureau of Occupational Health (BOH)**	Dr. Franko reviewed findings from a recent study of lead poisoning due to renovation that she and other BOH staff co-authored with the Centers for Disease Control (CDC), and compared it to an earlier study published in 1997. The study was published by the Centers for Disease Control: Children with Elevated Blood Lead Levels Related to Home Renovation, Repair, Painting Activities – New York State, 2006-2007. Morbidity and Mortality Weekly Report. January 30, 2009. Volume 58, Number 3. pages 55-57. Authors: Eileen Franko, Dr.P.H, Janine Palome, BSN, and Mary Jean Brown, ScD (CDC). The study looked at environmental investigations performed for children with blood lead levels $\geq$20 ug/dL in which renovation and remodeling was identified as a likely source of lead exposure. The study found that homeowners performing work that disturbs lead-based paint is still as much, if not more, of a contributing factor to elevated blood lead levels as it was 13 years ago. In 1993-94, 6.9% of environmental investigations triggered by a lead level of $\geq$20 ug/dL identified renovation/remodeling activities as a likely source of exposure, compared to 14.3% of investigations in 2006-07. The study found that a higher percentage of urban vs. suburban areas are now doing renovations. The most common types of paint removal activity were scraping and/or sanding, and painted component removal. In both studies, the work was mostly performed by resident owner or tenant. About 74% of the houses in the most recent study were pre-1930. In conjunction with this study, the Bureau of Occupational Health ran an internet-based media campaign	

	from June 12, 2008 to June 30, 2008. The campaign disseminated information on lead risks and safe methods for renovating older homes. Internet banners appearing on Thisoldhouse.com, About.com, and HGTV.com had high click-throughs. The DOH renovation web page (www.health.state.ny.us/environmental/lead/renovations_and_remodeling.htm) received more hits during the media campaign than before and after, a total 6,628. The media banner generated 9,685,315 impressions, and cost $97,765. It is not known if people used the information. The June/July, 2009 issue of *Fit Pregnancy* has an interview with Dr. Franko. The Bureau submitted an article for the May issue of *Light Construction* on the new EPA standard. The March, 2009 issue of Journal of Occupational and Environmental Hygiene contains an article from the Bureau on metal recycling. The Bureau has also conducted ongoing code officer training.	
Council Discussion	**Discussion took place on several issues, including:** **Owner vs. tenant occupied housing rate**: A question was asked about how the 64% owner occupied and 36% rental rates in the study compare to the statewide rates. This would indicate whether there is disproportionate tenant exposure. Dr. Franko did not have the data available by recall, but stated it is available. **Education of homeowners:** Concern was expressed about the extent of education and outreach on the renovation risks as exposure due to renovation appears to continue as a very significant problem. It was noted the media campaign reached a very small proportion of homes. A suggestion was made that more needs to be done in this area. For example, New York City has a ban on dry scraping. Could this be replicated in other geographic areas? **New EPA Remodeling and Renovation Rules:** A request was made to have council discuss these new rules and how the public will be educated on them as an agenda item in an upcoming council meeting. A council member stated that he feels existing EPA regulations are not protective enough due to lack of quantitative lead dust clearance requirements. The new rules will prohibit the most unsafe work practices. However, the clearance levels have not yet been defined. The EPA now calls dust testing "verification," not "clearance." The procedure utilizes a dust wipe and measures whiteness of the cloth against a card. It is very subjective, does not have to be kept, or shared with the occupant. The EPA creates a baseline. A council member urged New York to go above that baseline to be more protective of the public's health. The findings of the BOH study would be supportive of this direction.	

EPA training requirements for renovators: In 2010, all contractors will be required to have EPA training. The EPA will certify training providers. Renovators will have to be taught by a certified trainer, and receive a certificate. A council member suggested that the state consider taking over the training for EPA, rather than have EPA run the training program.

Protection of adults: The BOH includes the Heavy Metals Registry, which is a registry of all blood lead test results for adults. BOH follows up with all adults when an elevated test result is reported (10 mcg/dL for women of childbearing age; 15 mcg/dL for other adults), and finds it is often associated with renovation and remodeling. The Bureau provides education to the person who has been exposed. A suggestion was made to go to the New York State Building Officials Conference which provides required training to code officials. The Bureau has trained over 1,300 code officers over the past three years. The Veterans Administration also may be interested in lead-safe work practices training.

Higher exposure rate in urban areas: It is not clear why there is a higher exposure rate due to renovation in urban areas. It was conjectured that it might be a reflection of higher screening rates in urban areas. A question was asked about whether the primary prevention program evaluates whether its activities lead to an increase in renovation activity. This question is not addressed specifically in the evaluation protocol.

The cohorts in both studies consisted of all the environmental investigation conducted over two years (BLLs $\geq$ 20 mcg/dL). This cohort decreased from 4,608 cases in 1993-94 to 972 cases in 2006-07. The numbers of cases in suburban and rural areas declined, but the number of urban cases did not decline significantly (60 to 57), resulting in a larger overall percentage of urban cases in 2006-07. This could indicate that education is not reaching urban areas as effectively as other areas. A concern was expressed about the need for culturally competent materials for urban areas. Local health departments tailor education to their own geographic areas. A request was made for additional ideas from council members for targeting urban areas.

Data analysis by race/ethnicity: A question was asked about data analysis by race/ethnicity and the extent that educational materials are needed in Spanish and other languages. Ethnicity data were not analyzed. However, most educational materials are available in Spanish.

Improving Childhood Lead Testing **Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health**	Dr. de Long reviewed current childhood lead testing requirements in New York State and at the federal level, and then focused on two major initiatives to improve testing: office based testing and integration of immunization and lead registries. The NYS childhood lead testing rates have been improving for the general population. About 64% of children are tested at age one year, and about 52% are tested at age two, as required by law. About 83% of children are tested at least once by age 3, but only 41% are tested twice by age 3, as required. Improving this measure of two tests by age three is a high priority for improvement. About 86% of children in Medicaid managed care have been tested at least once by age two. DOH is working on a project to match Medicaid data with lead registry data to assess additional screening measures for this important population. It is difficult to find comparison data with other states. National survey data (NHANES) just published in *Pediatrics* this month found that about one-third of parents recall ever having their child under age five tested for lead, and about 42% for parents of children on Medicaid. **Office-Based Lead Testing:** One barrier to testing identified by providers and parents is the need to go to another site for a lead test. In-office testing can overcome this barrier. Office-based testing could be performed by private physician office labs, or "limited service" registrant labs, such as clinics. They are both overseen by NYSDOH Wadsworth Laboratory. Currently there is one portable device on the market, with the trade name of LeadCare II. This device is CLIA-waived, which means the FDA determined that this device is simple and free from harm. The test uses a finger stick, usually with capillary blood. The results are available within a few minutes. If the result is 8 mcg/dL or higher, the provider needs to get a venous blood sample and send to a permitted clinical lab for analysis. This differs from the usual standard for confirmation of capillary blood results of $\geq$ 10 mcg/dL because the device has an error standard of plus/minus 6 mcg/dL, which is the OSHA standard, rather than the CLIA standard of +/- 4 mcg/dL. It is important that the error range is clear to providers for quality control. The availability of in-office testing requires updates to state regulations. Current regulations only allow lead testing to be performed by fully permitted clinical labs and thus only require reporting by these labs. Proposed changes to regulations authorize lead testing by physician office labs (POLs) and "limited service" registrant labs, and require reporting results of testing by these labs to the state lead registry. This will enable local health departments to provide follow-up, and to keep DOH data complete. Currently, reporting can be done via fax or internet. DOH is now responding to comments on the proposed changes. Eventually, lead test reporting by POLs will be done using the immunization registry. Physicians are already required to report immunizations so this will streamline reporting. DOH is also exploring the	

Council Discussion	potential for expanding Medicaid reimbursement for office-based lead testing. **Lead-Immunization Data System Linkages**: DOH is planning to put childhood blood lead data into the existing statewide immunization information system (NYSIIS). The integrated registries can be used to generate lead testing reminders and quality improvement reports for health care providers. WIC providers can also use the registry to assess lead testing status and make referrals. Local health departments and DOH will be able to see which children have been immunized but not tested for lead, as a key tool for targeting lead testing improvement activities. To link the registries, DOH has proposed necessary changes to Public Health Law through the 2009 Article VII bill. DOH plans to implement the linkage by September, 2009. **Discussion took place on several issues, including:** **Terminology of "test" vs. "screen":** It was noted that there is still some ambiguity about the difference between the two words, and educational material should distinguish between screening and testing. These terms are being clarified in materials, and in the proposed amendments to public health law. **How lead testing is measured:** It was noted that sometimes numbers are more important that percentages and they should be distinguished. It was also suggested that DOH not report on one test by age three because the 82% figure conveys a better impression than reality, and there is still a long way to go. It was clarified that this particular measure is being retained for comparison among states, as it has recently been adopted as a national measure by CDC. **Lead testing at same time as WIC hemoglobin testing:** A council member asked if DOH is considering this approach. In general, DOH emphasizes lead testing as part of routine preventive care in a child's medical home. Many local health department lead programs also work closely with WIC to improve lead testing. **Mobile testing site:** A council member asked if having a mobile testing site, for community testing, would be practical. It was noted that these can be viable strategies, but that Wadsworth still has to certify the lab for that specific purpose, and the lab has to meet reporting requirements. Mobile testing sites should contact DOH about the specific requirements. Wadsworth has additional requirements for community testing.	

	Tracking Medicaid testing: A council member noted that there is longstanding interest in expanding measures for lead testing of children in Medicaid, and asked when lead data will be matched with Medicaid data. It was noted that this is a priority project and should be completed in the next six months. The member stated that once this data is available, the council should discuss recommendations. **Fee for LeadCareII:** A council member noted that the use of LeadCareII could increase screening rates, and urged DOH to generate a fee for its administration. It was again noted that the DOH Lead Poisoning Prevention Program is working with the Office of Health Insurance Programs on this issue.	
Assessment of Expanding Follow-Up Services for Children with BLLs 10-14 mcg/dL **Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health (BCAH);** **Ben Baskin, M.P.H., Health Educator, BCAH;**	Several recent proposals have called for expanding requirements for comprehensive follow-up services, including environmental management, to children with BLLs $\geq$ 10 mcg/dL. As part of a broader lead poisoning prevention agenda, Governor Paterson directed DOH to review available scientific research and data as to whether the State should further revise the threshold for comprehensive interventions to 10 mcg/dL. DOH reviewed and assessed the literature, data and other factors to inform this discussion, and presented preliminary results of that review to the Council for initial discussion. A DOH working group will be formed to further assess this information. Council members are invited to participate. **Background:** DOH has proposed regulations to expand the criteria for comprehensive follow-up services from $\geq$ 20 mcg/dL to $\geq$ 15 mcg/dL. There has been a dramatic decline in the number of cases $\geq$ 20 mcg/dL. There were 422 fewer new cases in 2007 than in 1998. This decline provides an opportunity to expand criteria with existing resources. At least ten local health departments already provide comprehensive services to children $\geq$ 15 mcg/dL; 22 others service a subset of children with BLLs 15-19 mcg/dL. The CDC recommends individual interventions, including environmental investigations, for BLLs $\geq$ 15. **Surveillance Data:** Further expansion of criteria from $\geq$ 15 to $\geq$ 10 mcg/dL would increase annual caseload statewide, including New York City, from about 800 to over 2,900 cases among children under age 6. This is over a 3.5-fold increase statewide, with over half the cases in NYC. **Review of scientific literature:** Over 50 studies were reviewed, with many limitations and some inconsistent findings noted. Overall, lead hazard control is associated with modest reductions in blood lead levels (BLLs) of 10% - 30%. Lead dust control alone has not been shown to be effective, except for repeated intensive professional cleaning. The effectiveness of secondary prevention measures decrease as baseline BLLs decrease, and it is difficult to further reduce BLLs that are already in the 10-14 mcg/dL	

	range through lead remediation. For example, remediation may lower a BLL of 15 mcg/dL by 0 to 3 mcg/dL. BLLs below 20 mcg/dL may more likely be the result of multiple lead sources, making effective lead hazard control more difficult. As benefits decrease, consideration of risks increase. Lead abatement has some risk, and can increase BLLs if lead safe work practices are not strictly followed. Lead remediation activities may have the greatest effect as primary prevention measures. Further review and discussion of these findings is warranted.	
Deborah Nagin, M.P.H., Director, Lead Poisoning Prevention Program, NYC Department of Health and Mental Hygiene (NYCDOHMH)	**The approach in New York City**: NYC serves as one of the sites of the NYSDOH funded primary prevention program. Since 1995, NYC has seen a 90% decline in children with elevated BLLs. There are still almost 2,300 kids with BLLs of ≥10 mcg/dL. The largest percentage of these children is under age three years. In 2003, a study in NYC found that BLLs of children under three years old are more responsive to intervention. In 2004, Local Law 1 passed in NYC that required environmental intervention at 15 mcg/dL or higher. The NYC lead program collaborates with home visiting programs, whose staff has been trained to identify lead paint hazards and make referrals. NYC offers inspections to families of newborns and children with asthma. As a new strategy this year, NYC is using lead registry data to identify high-risk housing with young children and then offer inspections to families that have children under three years old with BLLs of 10-14 µg/dL, and families with newborns (< three months) in the same building. NYC has also added an exterior survey to all inspections to see if poor exterior conditions are a good predictor of poor interior conditions. By July 1, 2009, NYC will be sending letters to families and doctors of children with BLLs of 5-9 mcg/dL, and is currently sending letters to families and doctors of children with BLLS 10-14 mcg/dL if the child is greater than three years old. NYC also provides lead safe work practice training and identifies financial resources to support lead hazard remediation. Initial assessment of results: 679 referrals for environmental inspections; trained newborn home visiting staff to identify hazards; completed 504 environmental inspections in homes of newborns and children with asthma; 100% of inspections were in homes with young children; 44% of homes had lead paint hazards; 79 environmental inspections and education for children with BLLs 10-14 mcg/dL; 51 with identified lead paint hazards (65%); 13 environmental inspections of newborns, with 9 identified with lead paint hazards (69%). Benefits of new strategies include: capitalizes on our biggest strengths – our data registries; focuses on younger children; expands knowledge base of risk factors for children with BLLs of 10-14 µg/dL.	

Michael Cambridge, R.S., Director, Bureau of Community Environ-mental Health and Food Protection **Council Discussion**	**Summary and discussion**: Mr. Cambridge summarized the key points, emphasizing that environmental management of cases where the BLL is below 15 mcg/dL may have minimal impact on lowering the child's BLL; BLLs in this range may be attributable to multiple lead exposure sources; the literature demonstrates that BLLs below 10 mcg/dL still have a negative health impact; and the need to engage other agencies/programs to address these issues. The literature and CDC recommends utilizing primary prevention to control or eliminate lead hazards in children's environments. DOH is targeting high risk areas and prioritizing primary prevention of lead poisoning. Several key questions were posed for Council discussion: • What approach/model makes sense for children with BLLs 10-14 mcg/dL? • Are there specific subsets of children who should be targeted? • How do we balance primary and secondary prevention activities? • What is the target for the intervention? • What is the expected endpoint of the intervention? **Discussion took place on several issues, including:** **Coverage of NYC primary prevention services**. Local Law 1 in NYC covers buildings of three units and greater. The NYC DOHMH will also inspect one and two family buildings. **Cost analysis:** The cost of expanding services is a major concern for upstate counties. The NYCDOHMH representative noted that they did a cost analysis when the city's Local Law 1 was developed and dropped the inspection level to 15 mcg/dL for children up to 18 years of age. The changes did increase management costs. **Whether to pursue additional secondary prevention measures at 10-14 mcg/dL:** A council member stated that if there are no primary prevention statutes in a jurisdiction that force owners to remediate then as a safety measure, secondary interventions should be conducted at 10-14 mcg/dL to prevent the blood lead level from rising further. The member advocated that the council should recommend a state statute that requires primary prevention. The issue should be to fix lead hazards, whatever the child's BLL. In NYC, an action level is not needed, because if there is a child under six, one can get an order to fix the hazards, regardless of BLL. Another member noted that NYC is finding a way to target with limited	

	resources. A weakness is the large turnover of rental properties. If a home currently has no children, it could have children next year. Another council member stated that the permanent loss of IQ at the lower BLLs justifies intervention as low as 10mcg/dL, both for secondary prevention, and primary prevention for siblings and neighbors. However, all parents who are concerned should be able to receive help. It was suggested by another that there could be different blood lead action levels depending on the age of the child, citing a model used in Chicago. **Safety of lead remediation**: A council member voiced concern that remediation must be done safely or it could cause BLLs to rise, and would be worse than if nothing were done. Another noted that there's always a risk, but the work has to be done safely. Children can be protected if the work is done safely. There was debate about how to weigh risks versus benefits of remediation at these lower BLLs. **Educational needs:** A member noted that the educational literature produced should target families and remodelers. It should also take into account the different urban, rural, and suburban experiences. The format used for the new forthcoming "under-10" education material ("What Your Child's Blood Lead Test Means") could be continued. **How to merge or coordinate secondary and primary prevention approaches:** A local secondary prevention approach might be different than a primary prevention model. It was suggested that interventions could be lowered to 10 mcg/dL only in those places where there are primary prevention programs with the resources in place to respond. Another member noted that there is a need to refine targeting to reach the highest risk populations. Primary prevention programs must figure out how to target, and this can include using cases with high BLLs. The member also noted that there is a need to develop both a culture and policies to maintain housing.	
Council Member Updates	**Council members provided the following updates on lead-related activities:** • Tom Keenan, OTDA, reported on a two-year grant from the EPA to develop materials for refugees. He is currently developing an educational video, in collaboration with DOH and others. • Susan Duchnycz, OCFS, reported that OCFS has been working with DOH on new lead education	

	materials, including materials for child care providers. • Ray Andrews, Department of State, reported that in order to get federal stimulus money, the State is updating its Energy and Uniform Code. • Deborah Nagin, NYCDOHMH, reported a new proposal to amend the NYC Health Code is under consideration by the NYC Board of Health. The proposal would require signage in apartment buildings reminding tenants about the NYC prohibition on sanding or scraping of lead paint; need for window guards; that landlords must repair peeling paint; and that tenants should let landlords know if children are living there. There is an April 29 public hearing. • Dr. Broadbent requested that council presentations be distributed electronically. • Matthew Chachere asked about the process the council uses to develop recommendations to the legislature and Governor. Dr. Birkhead responded that the council identifies issues, develop the position of the council, and then make recommendations in the annual report, or in a letter. Mr. Chachere suggested that council recommendations should be timelier than the annual report. For example, the council should have an opportunity to review the final form of Regulation 67.2 before it gets to public comment. Dr. Birkhead urged council members to bring in agenda items and make recommendations as relevant.	Council presentations will be distributed electronically to members.
Public Comment	No comments were received	
Adjournment	Meeting adjourned at 3:50 p.m.	

New York State Department of Health

Advisory Council on Lead Poisoning Prevention

Report for
January 1, 2006 – June 30, 2008

David A. Paterson
Governor

Richard F. Daines, M.D.
Commissioner of Health

NEW YORK STATE ADVISORY COUNCIL ON LEAD POISONING PREVENTION[1]

State Agency Designee Members

Guthrie S. Birkhead, M.D., M.P.H.
Council Chair
Deputy Commissioner, Office of Public Health
NYS Department of Health

Division of Housing and Community Renewal
Mary Binder
Environmental Analyst
NYS Division of Housing and Community Renewal

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NYS Department of Labor

Public Members

Rolaine Antoine
Parent Representative
Queens Village, New York

David N. Broadbent, M.D., M.P.H. F.A.A.P, F.A.C.P.M.
Community Group Representative
Co-chair, Coalition to End Lead Poisoning in New York State

Thomas Ferrante
Labor Union Representative
Manager of Training and Technical Services
Total Safety Consulting

Abby Greenberg, M.D., F.A.A.P.
Local Government Representative
Director, Center for Public Health
Nassau County Health Department
Representative, American Academy of Pediatrics, Division II

[1] Members as of June 2008; See meeting minutes (Appendices B, C, and D) for membership specific to each meeting period.

Public Members (continued)

Juanita Hunter, Ed.D.
Professional Medical Organization Representative
Professor Emeritus, School of Nursing
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Lindsay Lake Morgan, R.N., Ph.D., A.N.P.
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Philip J. Landrigan, M.D., M.Sc., F.A.A.P.
Hospital Representative
Professor and Chairman, Department of
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Ellen Migliore, R.N., M.S.
Child Health Advocate Representative
Public Health Nurse
Herkimer County Health Department

Clifford Olin
Industry Representative
President
EcoSpect, Inc.

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Vice President
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Adjunct Members

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Thomas P. Mahar
Code Compliance Specialist III
Assistant Director, Regional Services
NYS Department of State

Deborah Nagin, M.P.H.
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Thomas Keenan
Temporary Assistance Specialist
NYS Office of Temporary and Disability
Assistance
Bureau of Refugee and Immigrant Assistance

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INTRODUCTION

Lead poisoning continues to be a major preventable environmental health problem impacting young children in New York State (NYS). Over the last decade, blood lead levels among children have steadily declined in NYS and nationwide. This decline in the incidence and severity of lead poisoning among children has been noted as one of the greatest public health successes of the last century. While significant progress has been made, substantial exposure to lead still exists and continued efforts are needed to address the problem of childhood lead poisoning in NYS. Under the leadership of Governor David A. Paterson, NYS is committed to achieving the goal of eliminating childhood lead poisoning. Elimination of childhood lead poisoning is essential to improving the lives of New York's children, especially socio-economically disadvantaged children who are disproportionately affected by lead poisoning.

Exposure to lead is associated with a range of serious health effects on young children. Lead is a system toxin that affects virtually all body systems. Lead exposure has been associated with anemia, hearing loss, diminished skeletal growth and delayed pubertal development, dental caries, hypertension, osteoporosis, pregnancy complications and low birth weight. Lead exposure is an important cause of preventable brain injury and neurodevelopmental dysfunction and associated detrimental effects on children's cognitive and behavioral development, including measurable declines in IQ. Although there is no established threshold at which lead causes harmful effects, the federal Centers for Disease Control and Prevention (CDC) has defined lead poisoning as a blood lead level (BLL) of $\geq$ 10 mcg/dL. At this level, public health intervention is indicated.

The majority of children with lead poisoning are exposed to lead from deteriorating lead paint and lead dust in their homes. Prior to being banned nationally in 1978, lead paint was used in homes, and was widely used prior to 1950. NYS has the largest number and percent of pre-1950 housing of all states in the nation. Lead exposure in older homes may occur as a result of deteriorating paint, as well as contamination during repairs and renovations if lead-safe work practices are not followed. Additional sources of lead exposure may include lead-contaminated soil and water and imported food, pottery, cosmetics, traditional medicines, toys and jewelry. Children and pregnant women in certain immigrant communities that use traditional medications, foods, cosmetics and cooking utensils containing lead may be at especially high risk for exposure to lead from these sources. Children may also be exposed to lead if their parents or guardians have occupations or hobbies that expose them to lead. Infants whose mothers have high blood lead levels may be exposed to lead during pregnancy or through breastmilk. Because medical treatment options for lead poisoning are limited, primary prevention strategies that identify and reduce lead hazards in children's environments are critical to protect children from lead exposure before they become lead poisoned. A growing body of research indicates that children's development can be adversely affected at blood lead levels (BLLs) below the CDC-defined action level of 10 mcg/dL, further highlighting the need for primary prevention efforts.

Secondary prevention strategies also remain essential components of lead prevention efforts. Early identification of children with elevated blood lead levels (EBLLs) through routine blood lead testing is essential to assure coordination of follow-up services to minimize harmful effects and prevent further exposure to lead. Under current NYS regulations adopted pursuant to NYS Public Health Law, health care providers are required to test all children using blood lead tests at or around age one year and again at or around age two years. Health care providers are also required to assess all children age 6 months to 6 years at least once annually for lead exposure using a risk assessment tool, with blood lead testing for all children found to be at-risk based on those assessments.

Children with EBLLs receive follow-up services to minimize the adverse effects of lead and to reduce further exposure to lead in their environments. Health care providers, families, local health departments (LHDs) and the state Department of Health (DOH) work together to assure that children with EBLLs receive these services. Specific follow-up services vary by blood lead level category. All children with blood lead levels greater than or equal to 10 mcg/dL require risk reduction education, nutritional counseling and follow-up testing to monitor blood lead levels. Beginning at 20 mcg/dL, children also require detailed lead exposure assessments, nutritional and developmental assessments, and environmental management that includes inspections of their homes and other places where they spend significant amounts of time, with remediation of lead hazards identified. Children with BLLs greater than or equal to 45 mcg/dL may benefit from specialized medical treatment called chelation therapy that helps remove lead from the body; at very high BLLs children require hospitalization for treatment.

The Centers for Disease Control and Prevention (CDC), along with the President's Task Force on Environmental Health Risks and Safety Risks for Children, have called for the elimination of childhood lead poisoning (defined as blood lead levels at or above 10 mcg/dL among children age 6 years and younger) by 2010. This goal is consistent with the long-standing work done in NYS under the leadership of the DOH and serves as a call to action to strengthen current lead poisoning prevention activities. In response to the CDC's charge, the NYS Department of Health (DOH) has taken a leadership role in developing and implementing a strategic plan for the elimination of childhood lead poisoning in NYS by 2010. This plan, *Eliminating Childhood Lead Poisoning in New York State by 2010,* was published in 2004.[2] This state plan is a companion to the strategic plan developed by New York City Department of Health and Mental Hygiene (NYDOHMH) that specifically covers New York City.[3] The plan is intended to serve as a roadmap to guide the work of DOH and partner organizations' statewide in efforts to eliminate childhood lead poisoning. At the same time, it is a living document that may be refined in response to changing needs and opportunities in NYS. This report serves to update and further define current progress and priorities for achieving elimination.

The DOH implements a comprehensive public health approach to prevent and eliminate childhood lead poisoning that includes: surveillance, data analysis and laboratory reporting; education for families, health care providers, professionals and the public; promotion of childhood lead testing; assurance of timely, comprehensive medical and environmental management for children with lead poisoning; policy and program activities to advance primary and secondary prevention of lead poisoning; and response to emerging lead-related public health issues, such as lead poisoning among immigrant and refugee children and recalls of lead-contaminated consumer products. Across all of these areas, universal population-based strategies are balanced with more intensive strategies targeted to the communities and populations at highest risk, and emphasis is placed on establishing and maintaining strong partnerships with a range of federal, state and local agencies, organizations and other stakeholder groups. Additional detail on key progress in all of these areas is presented in subsequent sections of this report.

NYS's Advisory Council on Lead Poisoning Prevention meets regularly to discuss issues relevant to the development and implementation of the statewide plan for lead poisoning elimination and to advise the DOH regarding recommendations it deems necessary. This council is charged with reporting to the Governor and the Legislature about the progress made in the elimination of lead poisoning in NYS. This report serves to describe the progress made during the period from January 1, 2006 to June 30, 2008.

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[2] New York State Department of Health. (2004). *Eliminating Childhood Lead Poisoning in New York State by 2010*. Available online at http://www.nyhealth.gov/nydoh/environ/lead/finalplantoc.htm

[3] New York City Department of Health and Mental Hygiene (2005). *NewYork City Plan to Eliminate Childhood Lead Poisoning.* Available online at http://www.nyc.gov/html/doh/downoads/pfd/lead/lead-plan.pdf

NEW YORK STATE ADVISORY COUNCIL ON LEAD POISONING PREVENTION

The Lead Poisoning Prevention Act of 1992 (NYS Public Health Law, Title X, Section 1370-b) established the New York State Advisory Council on Lead Poisoning Prevention within the Department of Health (DOH). Required Council members include the Commissioners or their designees of: the DOH; the former Department of Social Services, now fulfilled by the Office of Children and Family Services (OCFS); the Department of Environmental Conservation (DEC); the Division of Housing and Community Renewal (DHCR); and the Department of Labor. In addition, the Council includes fifteen public members appointed by the Governor, with at least one public member representative of each of the following: local government; community groups; labor unions; real estate; industry; parents; educators; local housing authorities; child health advocates; environmental groups; professional medical organizations and hospitals. In recognition of the importance of participation from other essential partners, the Department has reached out to additional key agencies to assist with Council deliberations as adjunct members. Current adjunct members represent the New York State Department of State (DOS), New York State Department of Insurance (DOI), New York State Office of Temporary and Disability Assistance (OTDA) and New York City Department of Health and Mental Hygiene (NYCDOHMH).

The authorizing Public Health Law (Section 1370) charges the Council with the following roles and duties:

- To develop a comprehensive statewide plan to prevent lead poisoning and to minimize lead exposure;
- To coordinate the activities of its member agencies with respect to environmental lead policy and the statewide plan;
- To recommend adoption of policies with regard to the detection and elimination of lead hazards in the environment;
- To recommend the adoption of policies with regard to the identification and management of children with elevated lead levels;
- To recommend the adoption of policies with regard to education and outreach strategies related to lead exposure, detection and risk reduction;
- To comment on regulations of the DOH under this title when the Council deems appropriate;
- To make recommendations to ensure the qualifications of persons performing inspection and abatement of lead through a system of licensure and certification;
- To recommend strategies for funding the lead poisoning prevention program, including but not limited to ways to enhance the funding of screening through insurance coverage and other means and ways to financially assist property owners in abating environmental lead, such as tax credits, loan funds and other approaches; and
- To report on or before January 1 of each year to the Governor and the Legislature concerning the development and implementation of the statewide plan and operation of the program, together with recommendations it deems necessary.

The New York State Advisory Council on Lead Poisoning meets regularly to discuss issues and strategies relevant to the prevention and elimination of childhood lead poisoning in New York State. During the time period corresponding to this report, the Council met eight times: March 13, August 24 and October 23, 2006; March 15, June 15 and September 10, 2007; and March 6 and June 19, 2008. Meetings took place in Albany, New York. All meetings were open to the public, and since September 10, 2007 have been Webcast pursuant to Governor Spitzer's Executive Order #3. The Council's work in this period

focused on surveillance, blood lead testing, case management and primary prevention efforts in relation to the state's comprehensive plan to eliminate childhood lead poisoning in New York State.

Meetings during this period included relevant updates from the DOH Center for Community Health (CCH) and Center for Environmental Health (CEH), the NYCDOHMH, and other member agencies and groups. Meetings also included additional presentations and discussions on key priorities related to the elimination of lead poisoning; invited guest presenters with local, state or national expertise and experience on key topics; open council discussion; and public comment. Key issues and topics raised and discussed by the Council during this period include:

- Increasing lead screening rates, with emphasis on obtaining a second lead test by age 3;
- Promoting the collection, analysis and timely release of statewide surveillance data;
- Ideas for the expansion of data analysis and dissemination;
- Addressing the importance of education for health care providers, families, professionals, and the public, including educational interventions for children with BLLs below 10 mcg/dL;
- Promoting policy and program activities to expand primary prevention of lead poisoning in conjunction with continuing secondary prevention activities;
- Use of portable blood lead analyzers in private physician office laboratories (POLs) and limited service laboratories to reduce barriers for parents obtaining blood lead tests;
- Monitoring progress of proposed regulation changes;
- Strengthening collaborative efforts of state and local community-based organizations to promote both primary and secondary prevention activities; and
- Response to emerging lead-related public health issues, such as recalls of lead contaminated consumer products and lead poisoning among immigrant and refugee children.

With Council feedback and input, significant progress was made during the period covered by this report toward implementing the statewide elimination plan and achieving the goal of elimination. As described in subsequent sections of this report, the majority of the issues noted above have been addressed as part of these implementation efforts; other issues remain under discussion by the Council. Minutes of all meetings are also included as Appendices B, C and D of this report.

LEAD POISONING IN NEW YORK STATE: PROGRESS TOWARD ELIMINATION

The analysis and application of data are important tools used by the Department to assess the extent of the childhood lead poisoning problem, to identify high-risk communities and populations with the highest need for interventions, and to monitor and evaluate the effectiveness of interventions. In 2008, the Department completed and published a comprehensive report of childhood lead surveillance data for 2004 and 2005 for New York State, excluding New York City. This report demonstrates that NYS has made significant progress during the last decade toward the elimination of childhood lead poisoning, while highlighting areas for further action. Council members provided extensive input on the development, modification, and prioritization of key data elements for this surveillance report, and continue to provide recommendations for future reports. Analysis of surveillance data from 2006 and 2007 is in progress. Preliminary analysis of 2006-2007 data indicates that the positive trends demonstrated in the 2004-05 report continued through 2007.

Key surveillance indicators from the complete 2004-05 report and preliminary results of analysis of 2006-07 data that are described below provide a snapshot of lead testing and progress toward elimination of lead poisoning in NYS, excluding NYC. Additional detailed state, county, and ZIP-code level analyses of 2004-2005 data, including many tables, figures, and maps, can be found in the complete surveillance report published on the DOH Web site at:
www.health.ny.gov/environmental/lead/exposure/childhood/surveillance_report/2004-2005/

The NYC Department of Health and Mental Hygiene has released annual reports for New York City 2004, 2005 and 2006 blood lead surveillance data titled “Preventing Lead Poisoning in New York City.” These reports may be accessed online at: http://www.nyc.gov/lead.

Progress in Testing Young Children for Lead Poisoning

Under current NYS regulations adopted pursuant to NYS Public Health Law, health care providers are required to test all children using blood lead tests at or around one year and again at or around age two years, and to assess all children age six months to six years at least once annually for risk of lead exposure using a risk assessment tool, with blood lead testing for all children found to be at risk.

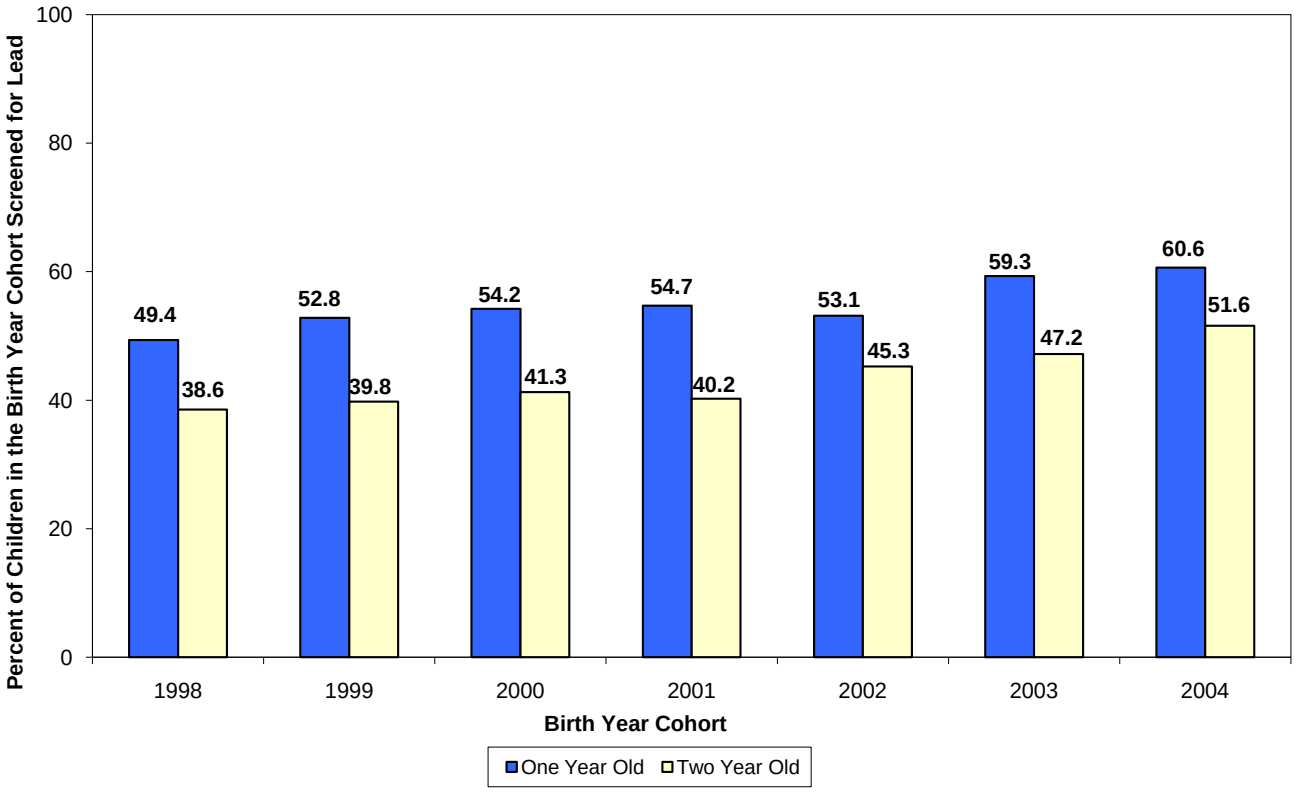
Blood lead testing rates are described for groups of children born in a given year (i.e., birth cohorts) because this is the most accurate way to estimate the number of children in a given age group who require blood lead screening tests. Testing rates for a group of children born in one and two for children born in 2002 are based on blood lead tests that occurred from 2002 through 2005.

Data Highlights

- **Lead testing rates for children at or around age 1 are improving.** In NYS (excluding NYC), a 7.5 percent increase in blood lead testing rates for children at or around age 1 was observed among children born in 2002 compared with children born in 1998. Fifty-three percent of children born in 2002 were tested for lead at or around age one, compared with 49.4 percent of children born in 1998. Preliminary analysis of data through 2007 show that this measure further improved, with 60.6 percent of children born in 2004 tested for lead at or around age one year (refer to Figure 1).

- **Lead testing rates for children at or around age 2 are also improving.** A 17.1 percent increase in blood lead testing rates for children at or around age two years was observed among children born in 2002 compared with children born in 1998. Forty-five percent of children born in 2002 were tested for lead at or around age 2, compared with 38.6 percent of children born in 1998. Preliminary analysis of data through 2007 show that this measure further improved, with 51.6 percent of children born in 2004 tested for lead at or around age two years. Although testing rates for two year-old children are improving, the percentage of children tested at age two years is lower than the percentage tested at age 1, making this an important target for blood lead testing promotion efforts (refer to Figure 1).

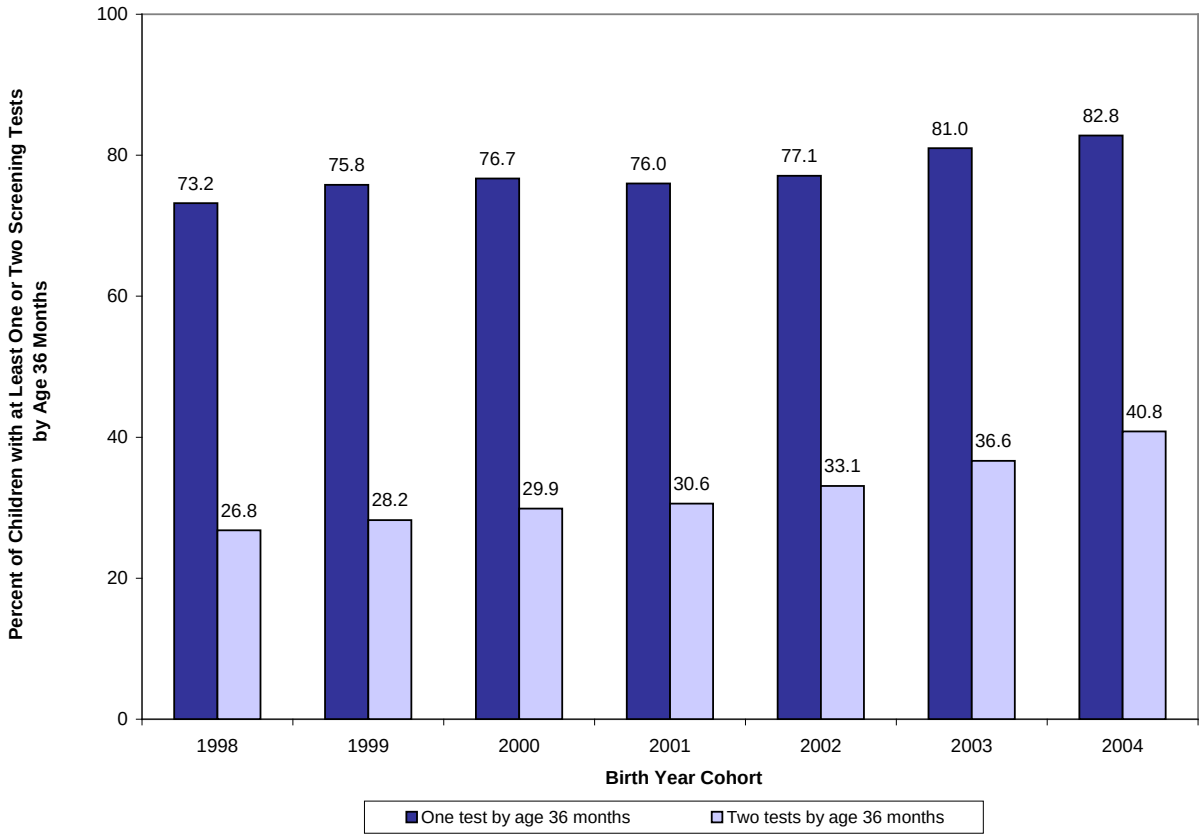
Figure 1: Percent of Children Tested for Lead at or Around Age 1 and at or Around Age 2; 1998 - 2004 Birth Cohorts (1998 to 2007 Blood Lead Test Data)[1,2]
New York State Excluding New York City



[1] At or around age 1 is defined as 9 months to < 18 months, and at or around age 2 is defined as 18 months to < 36 months.
[2] Birth Cohorts beyond 2004 are not included in this analysis because those children had not yet reached 36 months of age by 2007.

- **A high percent of children receive at least one blood lead test by age three years, but fewer receive two tests by age three consistent with NYS requirements.** Of children born in NYS (excluding NYC) in 2002, 77.1 percent received at least one blood lead test by age 36 months. Preliminary analysis of 2007 data indicates continued improvement in this measure, to 82.8 percent of children born in 2004. Although the percentage of children receiving at least two lead tests by age 3 is significantly lower than the percentage of children receiving one test by age three years, trend data indicate this measure is improving. The percentage of children who received at least **two** blood lead tests by age 3 increased from 26.8 percent of children born in 1998 to 33.1 percent of children born in 2002. Preliminary analysis of 2007 data indicates continued improvement in this measure, to 40.8 percent of children born in 2004 (refer to Figure 2).

Figure 2: Percent of Children Tested for Lead at Least One or Two Times by Age 36 Months; 1998 - 2004 Birth Cohorts (1998 to 2007 Blood Lead Test Data),[1] New York State excluding New York City



[1]Birth cohorts beyond 2004 are not included in this analysis because those children had not yet reached 36 months of age by 2007.

Progress in Reducing the Incidence of Childhood Lead Poisoning

Incidence is the measure of the number of children identified for the first time within a specified time period with confirmed BLLs $\geq$ 10 mcg/dL, the current definition of lead poisoning. Although there is no established threshold at which lead causes harmful effects, the federal Centers for Disease Control and Prevention (CDC) has defined a BLL of $\geq$ 10 mcg/dL as the action level for public health intervention.

Incidence is described both in terms of the total number of new cases of childhood lead poisoning as well as the rate, or proportion, of children tested for lead who are newly identified with lead poisoning.

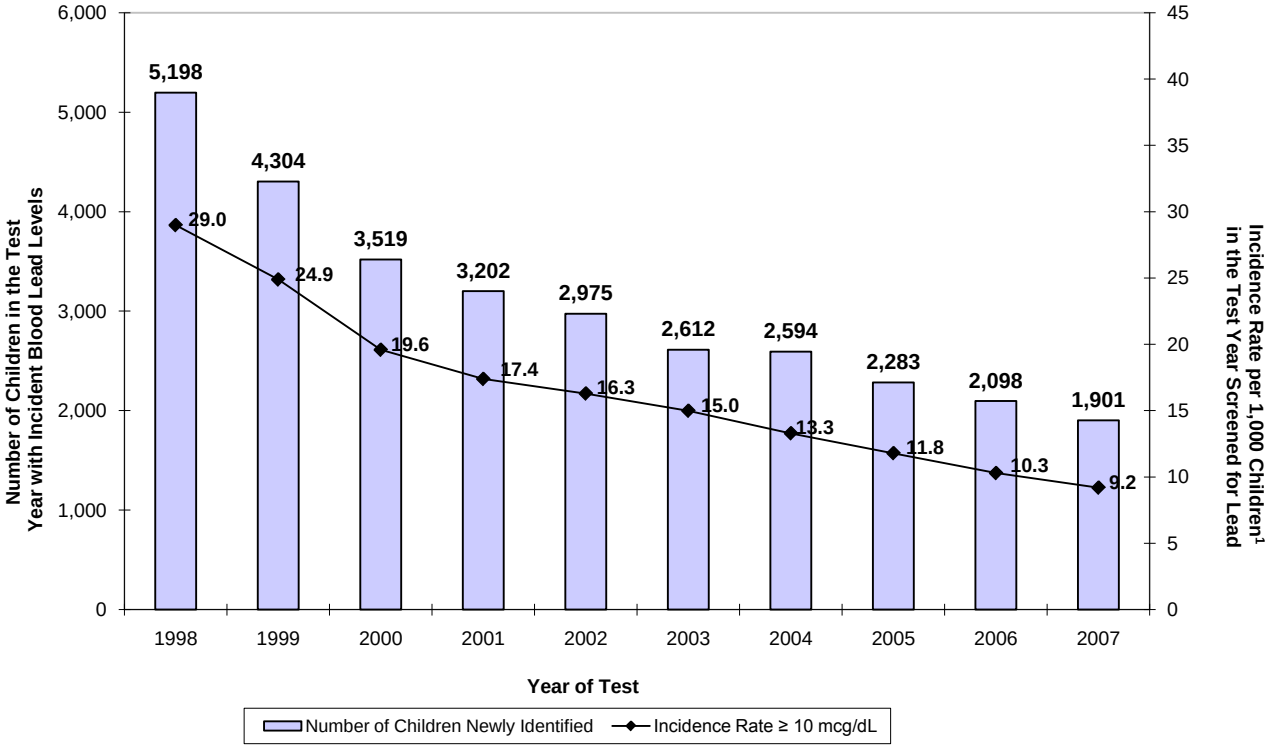
Children with EBLLs receive follow-up services to minimize the adverse effects of lead and to reduce further exposure to lead in their environments. Health care providers, families, and local health departments (LHDs) work together to assure that children with EBLLs receive these services. The specific services required vary by blood lead level category.

Data Highlights

- **The number of children with elevated blood lead levels (EBLLs) is steadily declining across all blood lead level (BLL) categories.** Trend data for NYS (excluding NYC) show the dramatic improvement in the number of children identified with confirmed BLLs $\geq$ 10 mcg/dL, the current definition of lead poisoning established by the CDC. In 1998, 5,198 children less than six years old were newly identified with BLLs $\geq$ 10mcg/dL, compared with 2,283 children in 2005. This represents a striking 56.1 percent decline in the number of children with EBLLs since 1998. Preliminary analysis of 2007 data indicates continued steady decline in the number of children with lead poisoning to approximately 1,901 children under age six who were newly identified with BLLs $\geq$ 10 mcg/dL in 2007 (refer to Figure 3).

- **The rate of incidence of lead poisoning among young children is also steadily declining**. Between 1998 and 2005 for NYS (excluding NYC), a nearly 59.3 percent decline in the rate of incidence of lead poisoning was observed, from 29.0 per 1,000 children (2.90 percent) under age six tested in 1998 to 11.8 per 1,000 children (1.18 percent) under age six tested in 2005. Preliminary analysis of 2007 data indicates further improvement in this measure. The rate of incidence declined to approximately 9.2 per 1,000 (0.92 percent) of children tested for lead under age six who were newly identified with BLLs $\geq$ 10 mcg/dL in 2007 (refer to Figure 3).

Figure 3: Incidence of Blood Lead Levels ≥ 10 mcg/dL Among Children Under Age 6; 1998 to 2007 Blood Lead Test Data New York State Excluding New York City



[1] Incidence Rate: Total number of children under age 6 identified for the first time with confirmed BLLs ≥ 10 mcg/dL divided by the total number of children under age 6 that had lead tests in that given year, multiplied by 1,000.

- **The incidence of childhood lead poisoning varies greatly across the state.** In 2005, the majority of children newly identified with BLLs ≥ 10 mcg/dL (approximately 60 percent of incident cases outside of NYC) resided in the seven highest incidence counties upstate: Albany, Erie, Monroe, Oneida, Onondaga, Orange, and Westchester. Preliminary analysis of 2006-2007 data shows the same concentration of incident cases within these seven counties.

Children with Blood Lead Levels Below 10 mcg/dL

A growing body of scientific research highlights concerns about the effects on children's development of BLLs below 10 mcg/dL, the blood lead level established by the CDC as the definition of lead poisoning and the level requiring medical and public health intervention. In light of these emerging concerns, the 2004-05 data report and forthcoming 2006-07 report include a new indicator measuring the number and percent of children with BLLs in the range of 5–9 mcg/dL.

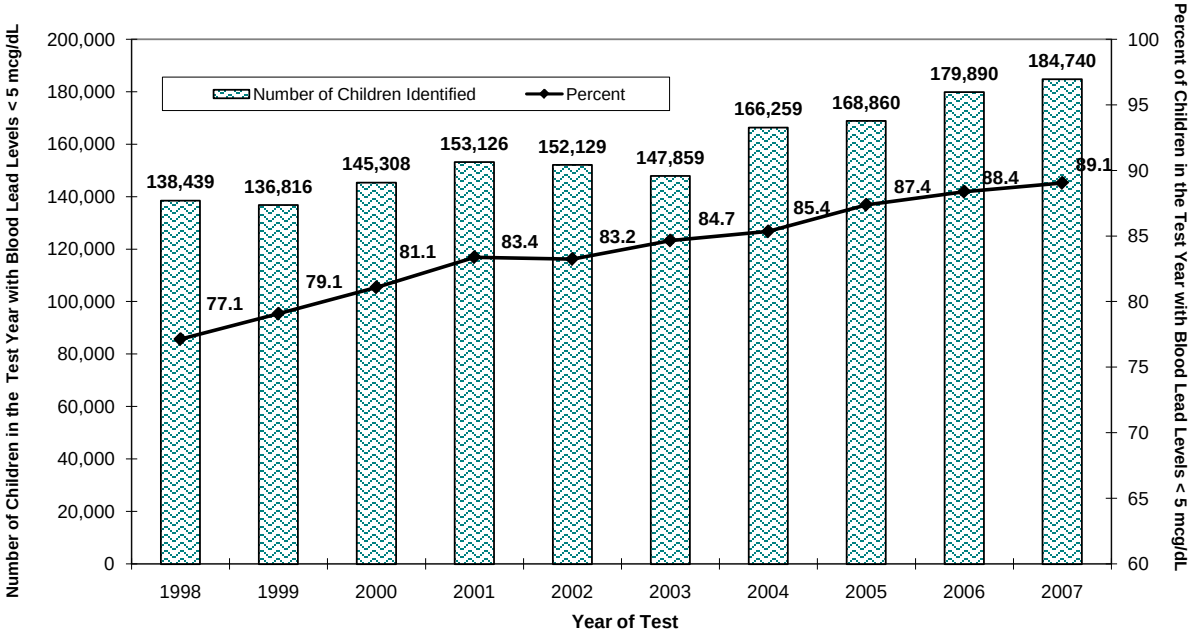
Under current NYS Public Health Law and implementing regulations, as well as national CDC guidelines, all parents should be provided with anticipatory guidance on the major causes of lead poisoning and means for preventing lead exposure as part of routine health care, with consideration of

children's environments. Children whose BLLs are below 10 mcg/dL on their first routine blood lead test at or around age 1 need to have a second lead test at or around age two to assure that BLLs are still within this range. Children with one or more identified risk factors for lead exposure based on a clinical risk assessment should be tested at least annually beginning at age six months and continuing up to age six. In addition, population-based community education and primary prevention strategies should be advanced to eliminate children's exposure to lead in their environments.

Data Highlights

- **Most children have blood lead levels below 5 mcg/dL**. In 2005 in NYS (excluding NYC), a total of 168,860 (87.4 percent of children tested) had the lowest measurable BLL results of 0 to less than 5 mcg/dL. Data trends show the number and percent of children under age six in this group of lowest BLLs continue to increase. In 2007, 184,470 children under age six were identified with BLLs below 5 mcg/dL, representing 89.1 percent of the children tested for lead in that year (refer to Figure 4).

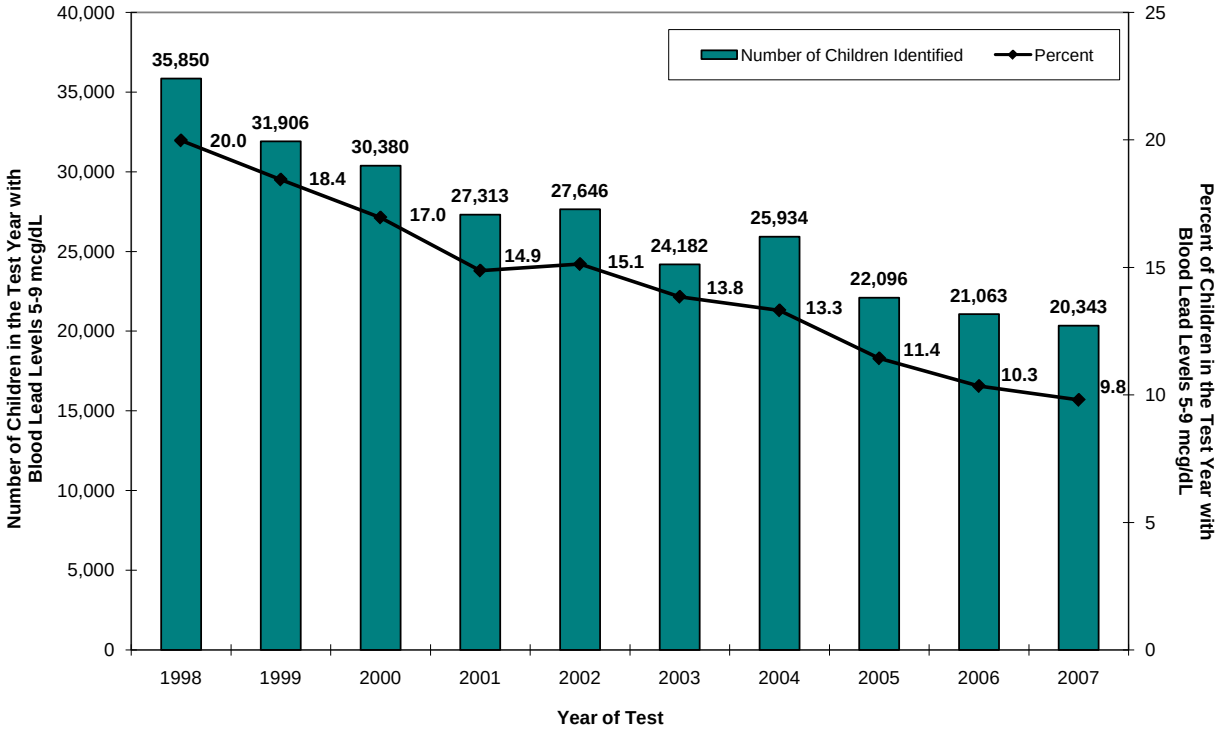
Figure 4: Number and Percent of Children Under Age 6 with Blood Lead Levels below 5 mcg/dL;[1] 1998 to 2007 Blood Lead Test Data, New York State Excluding New York City



[1] The number of children with a BLL < 5 mcg/dL divided by the number of children that had a screening test in that given year multiplied by 100. Values reported below 10 mcg/dL are subject to increased measurement error and should not be interpreted as an absolute value

- **Trends for BLLs 5-9 mcg/dL parallel those for BLLs over 10mcg/dL.** The total number of children with BLLs between 5-9 mcg/dL declined 38.4 percent between 1998 and 2005, from 35,850 children in 1998 to 22,096 children in 2005. The percent of children with BLLs of 5-9 mcg/dL declined 43 percent over the same period, from 20 percent of children tested in 1998 to 11.4 percent of children tested in 2005. Preliminary analysis of 2006-2007 data indicate that both the number and percentage of children with BLLs 5-9 mcg/dL continued to decline, to 20,343 children (9.8 percent of children tested) in 2007 (refer to Figure 5).

Figure 5: Number and Percent of Children Under Age 6 with Blood Lead Levels of 5-9 mcg/dL; 1998 to 2007 Blood Lead Test Data,[1] New York State Excluding New York City.



[1] The number of children with a BLL of 5 -9 mcg/dL divided by the number of children that had a lead test in that given year multiplied by 100. Values reported below 10 mcg/dL are subject to increased measurement error and should not be interpreted as an absolute value

KEY ACCOMPLISHMENTS AND STRATEGIES FOR CONTINUED SUCCESS

A Continued Commitment to the Elimination of Childhood Lead Poisoning

The New York State Department of Health (DOH) is committed to achieving the elimination of childhood lead poisoning. As a central focus of this commitment, the Department has worked in partnership with many other state and local agencies, organizations and stakeholder groups to develop and implement a strategic plan, *Eliminating Childhood Lead Poisoning in New York State by 2010*. Published in 2004, this state plan is a companion to the strategic plan developed by New York City Department of Health and Mental Hygiene (NYCDHMH) that specifically covers New York City (NYC). The New York State plan outlines a series of goals, objectives and strategies within three overarching focus areas: surveillance and screening, targeting high-risk populations, and primary prevention. The complete plan can be found on the DOH Web site at www.health.ny.gov/environmental/lead/index.htm.

The plan is intended to serve as a roadmap to guide the work of the Department and partner organizations statewide in efforts to eliminate childhood lead poisoning. At the same time, it is a living document that may be refined in response to changing needs and opportunities in NYS. Eliminating childhood lead poisoning continues to be a top public health priority for the DOH. This report serves to update and further define current progress and priorities for achieving elimination.

The Department implements a comprehensive public health approach to prevent and eliminate childhood lead poisoning. As knowledge of the problem of lead poisoning and the identification of effective strategies for elimination has grown, the framework outlined in the elimination plan has also expanded. The Department's current comprehensive public health approach encompasses and goes beyond the objectives and strategies outlined in the original elimination plan to include:

- surveillance, data analysis, and laboratory reporting;
- education to families, health care providers, professionals, and the public;
- policy and program activities to promote secondary prevention of lead poisoning, including blood lead testing of children and pregnant women;
- assurance of timely, comprehensive medical and environmental management for children with lead poisoning;
- policy and program activities to advance primary prevention of lead poisoning to reduce lead hazards before children become poisoned; and
- response to emerging lead-related public health issues, such as lead poisoning among immigrant and refugee children and recalls of lead-contaminated consumer products.

Across all of these areas, universal population-based strategies are balanced with more intensive strategies targeted to the communities and populations at highest risk, and emphasis is placed on establishing and maintaining strong partnerships with a range of federal, state and local agencies, organizations and other stakeholder groups. In particular, strengthening local capacity for carrying out effective lead prevention work has been a focus of the Department's efforts in the last several years. Additional detail on key progress in these areas is described below.

Achieving Elimination: Progress and Priorities for the Future

During the period covered by this report (January 2006 to June 2008), significant progress has been accomplished across multiple programs and initiatives. With ongoing input and support from the Advisory Council and many partner agencies and organizations, the Department will continue to build on these accomplishments over the coming year to achieve further progress toward elimination. Key accomplishments and ongoing priorities include:

Continuation and expansion of surveillance activities to guide, target, and monitor lead poisoning prevention activities

- In 2006 and 2007, with ongoing input and feedback from Advisory Council members, extensive analysis of 2004 and 2005 childhood lead surveillance data was completed, culminating in the release of a comprehensive data report for 2004-2005 childhood lead surveillance data in 2008. Based on extensive input from the Advisory Council, the analysis was significantly expanded to incorporate additional age-specific blood lead testing measures, descriptions of incidence patterns for multiple categories of blood lead levels and additional demographic and geographic analyses.

- Preliminary analysis of 2006-2007 data was completed in early 2008, and additional analysis is currently in progress. The Department will continue to solicit feedback and recommendations from the Advisory Council to further develop future data reports.

- Underlying this data analysis work has been an ongoing major project to design, develop, and implement a new statewide Web-based lead registry and data system that supports timely and accurate analysis of childhood blood lead data. In 2006, LHD lead programs transitioned from the previous local PC-based system (LeadTrac) to the new statewide Web-based system (LeadWeb). In 2006 and 2007, efforts focused on system enhancements to improve the accuracy and completeness of new and historic data and the development of basic reporting functions for counties to assist in local tracking and follow-up activities. In 2007 and 2008, efforts focused on linking blood lead level results with address information and geocoding data to support expanded geographic analysis, as well as implementing new case coordination and environmental management modules for LHD tracking of follow-up services. Regular conference calls with LHD programs and an ongoing focus group of dedicated LHD representatives provided invaluable input throughout this process.

- Continued expansion of data analysis remains a key priority. Completion of geocoding and expanded geographic analysis of key lead testing and incidence measures, including sub-county level analysis, will be a critical tool to targeting and monitoring prevention activities. An additional priority is the implementation of expanded dynamic reporting capabilities within the data system to support LHD prevention and follow-up efforts.

Expanding education of the public, parents and professionals to promote both primary and secondary lead prevention practices

- In 2006 and 2007, the Advisory Council provided input on the development and distribution of updated, evidence-based educational messages and materials for parents to promote lead prevention behaviors and increase the "demand" for lead testing by encouraging parents to obtain lead testing for their children. This work resulted in the publication and distribution of two new educational pamphlets in 2007.

- The Advisory Council also provided input on messages and strategies for effectively reaching physicians and other health care providers. In December 2006, an article on childhood lead poisoning prevention and lead screening was published in the *Medicaid Update*. This newsletter is sent to more than 42,000 medical practitioners and facilities in NYS.

- The Advisory Council also provided input on the development of materials for inclusion in a clinical toolkit for health care providers. The toolkit, which is currently under development, includes practical information, materials, and resources that can be used in health care provider practices related to patient education and counseling, options and techniques for lead testing, and management of elevated blood lead levels. As a subset of these efforts, a work group was convened by the Department in 2008 to provide input on the development and distribution of new educational materials for parents and health care providers of children with blood lead levels below 10 mcg/dL. A statewide mailing to health care providers will be sent.

- During this time period, the Department also developed and distributed a variety of lead outreach and education items for contractors and homeowners, including Lead Check Swabs for home inspections and a New York-specific version of the federal Lead Paint Safety Field Guide.

- Increasing awareness of the problem of lead poisoning and effective prevention strategies directed to the public, parents, and professionals remain important priorities. Specific priorities include completion and dissemination of the clinical lead prevention toolkit, new educational materials for parents and health care providers related to children with blood lead levels below 10 mcg/dL and updating the Department's public Web site to provide timely, evidence-based, and practical lead prevention information to a variety of target audiences.

Additional policy and program activities to promote secondary prevention of lead poisoning, including lead screening and follow-up services for children and pregnant women

- In 2006, the Advisory Council provided input and feedback on modifications to the medical referral form that health care providers complete for children referred to the Special Supplemental Nutrition Program for Women Infants and Children (WIC). This form was changed to reinforce NYS requirements for blood lead testing at or around age 1 and again at or around age two to prompt documentation of lead tests at required ages. The updated form and information on the importance of routine blood lead testing for children in WIC was sent to all pediatric and family practice physicians and other health care providers and WIC providers in NYS.

- The Advisory Council provided input on several joint efforts between the Department and OCFS to support child care providers' role in blood lead testing and lead prevention education. In 2006, the Department and OCFS jointly developed and disseminated an educational letter to child care providers in NYS. In 2007, the Department worked with OCFS and the State University of New York Training Strategies Group to develop new videoconference training materials on lead prevention for child care providers.

- The Advisory Council has provided ongoing input on the potential for new office-based "point of care" lead testing devices to help reduce known barriers to improving lead testing rates. These discussions contributed to the work of a DOH working group convened to assess information and issues related to office-based lead screening technology. As a result of this work, the Department prepared a formal proposal to change state regulations to authorize use of office-based lead test methods in health care practitioner offices and to require reporting of results from such testing.

- In 2008, the Department introduced legislation that would link lead testing information from the statewide childhood lead registry with the statewide immunization information system, to reinforce and prompt lead testing for children and to provide a convenient vehicle for practitioners using point-of-care lead testing technology to report the results to the Department.

- The Department continues to provide grant funding to support a statewide network of regional lead resource centers that provide outreach, education, consultation, and technical assistance to health care providers and LHDs on lead testing and management of children and pregnant women with lead poisoning. In 2007-08, a competitive application and awards process was completed to fund three Regional Lead Resource Centers at Montefiore Medical Center, SUNY Upstate Medical University (including a partnership with Albany Medical Center), and Kaleida Health Care (including a partnership with University of Rochester). Informed by input from the Advisory Council on effective strategies and messages for health care providers, the focus of resource center activities in this funding cycle has expanded to better emphasize blood lead testing and other clinical preventive practices.

- The Advisory Council provided input and feedback on a series of steps to expand follow-up services to pregnant women with elevated blood lead levels. The DOH Bureau of Occupational Health (BOH), which receives all blood lead test results for adults, conducts telephone interviews with women of childbearing age (ages 16 to 45) who have elevated blood lead levels to determine

potential sources of exposure and provide tailored risk reduction education, including information to share with their health care providers about testing their infants after delivery. These activities complement the follow-up provided for pregnant women by prenatal health care providers and by occupational health clinics for women with occupational lead exposure. In 2006, BOH lowered the blood lead level threshold for women of childbearing age that triggers interviews and follow-up risk reduction education for women ages 16 to 45, from $\geq$ 25 mcg/dL to $\geq$ 15 mcg/dL. Further expansion of the number of women contacted, by lowering this threshold to10 mcg/dL, was implemented in 2009. Advisory Council members also discussed NYC's efforts to address prenatal lead poisoning, including recently updated NYCDOHMH guidelines for the prevention, identification, and management of lead poisoning in NYC pregnant women. Informed by these discussions, the Department is currently revising its statewide lead prevention guidelines for prenatal care providers.

- The Advisory Council reviewed and provided input on proposed regulatory changes related to the provision of medical and environmental follow-up services for children with elevated blood lead levels (EBLLs). Informed by these discussions, the Department prepared a formal regulatory proposal that will expand environmental inspections and comprehensive medical follow-up services to more children with EBLLs by lowering the blood lead level threshold requiring such services from 20 mcg/dL to 15 mcg/dL, which exceeds the national standard of 20 mcg/dL, established by the CDC. These changes complement an additional forthcoming proposal that will update regulations related to environmental health services that add and modify provisions of current regulations related to environmental assessment and remediation to be consistent with definitions and workforce requirements enforced by the Environmental Protection Agency. This proposal also will modify sampling requirements when using X-ray fluorescence analyzers for sampling lead-based paint to account for advancements in technology. Modifications are also made to require the use of remediation plans and trained workers when certain lead hazard control measures are used.

- Improving lead testing and follow-up for children and pregnant women remains a priority. Specific priorities include: securing passage of legislative changes to support linkage of the lead registry and immunization information system to promote lead testing; finalizing and implementing regulation changes related to point-of-care lead testing technology and expanded environmental management services for children with elevated blood lead levels; implementing expanded telephone follow-up for pregnant women with elevated blood lead levels; and completing updated guidelines for prenatal care providers on the prevention, identification, and management of lead poisoning in pregnant women.

Expansion of primary prevention strategies to identify and reduce lead hazards before children become lead poisoned

- The 2007-08 State Budget amended NYS Public Health Law and appropriated new funding totaling $3 million to support a new primary prevention pilot program to develop and implement local primary prevention plans in targeted high-incidence communities. Work on this initiative progressed rapidly in 2007 and 2008. Based on analysis of 2005 childhood lead poisoning incidence data, seven counties (Erie, Monroe, Onondaga, Oneida, Albany, Orange and Westchester) and New York City were targeted for the first year of this initiative. Based on 2005 data, these eight localities collectively account for 80 percent of the newly identified cases of childhood lead poisoning each year, and each contains at least one targeted high-incidence ZIP code. Target counties received grant funding to develop and implement local childhood lead poisoning primary prevention plans in and near the target areas, including identification and inspection of high-risk properties, community involvement, capacity building, and enforcement. LHDs collaborate with code enforcement officials, local housing authorities, and other community partners to accomplish this work. The Department has engaged the National Center for Healthy Housing, a highly respected and uniquely experienced expert national organization, to provide consultation and assistance to the Department and the target communities in the development, implementation, and evaluation of this pilot program. Expansion of the program is planned for four to six additional counties, with total annual state funding increased to more than $5 million in the 2008-09 State Budget. Advisory Council members provided ongoing input and feedback on the development and implementation of this important new initiative. The 2009-10 State Budget includes an additional $2.5 million in funding for this program, will expand the program to an additional five counties.

- During this time period, the Advisory Council provided ongoing feedback on the lead prevention component of the Department's Healthy Neighborhoods Program, a door-to-door outreach program in targeted high-need areas that provides residents with practical information and tools to reduce environmental hazards in their homes, including risks for lead exposure. In 2007, a new data collection process was introduced to allow for uniform collection of field data and analysis of individual de-identified data for comprehensive evaluation of field visits and of program outcome measures.

- Advisory Council members have discussed the importance of incorporating lead prevention within local codes enforcement inspections. In collaboration with the Department of State (DOS) Advisory Council representative and other DOS staff, the Department provided lead awareness training to certified codes enforcement officers across NYS. By June 30, 2008, more than 1,257 codes enforcement officers received this training. Currently, an evaluation of the effectiveness of this training and its impact on primary prevention is being conducted.

- In 2008, Advisory Council members discussed the issue of unsafe residential renovation and remodeling practices as a potential source of lead exposure for children, and provided input on the development of new educational messages and strategies to address this issue. These discussions informed the development of an internet-based educational campaign on renovation and remodeling conducted late in 2008.

- In August 2007, several major national toy manufacturers issued a large volume voluntary recall of children's toys found to be contaminated with lead paint. The DOH, working with the Governor's Office and the state's Consumer Protection Board (CPB), took actions to protect the health and safety of children in NYS. Commissioner Daines issued a mandatory recall of the affected toys within the State. Staff from the Department, other agencies, and LHDs inspected retail venues to assess compliance with the mandatory recall. Working with other agencies, the Department developed and distributed educational information, including recommended lead screening guidelines for children exposed to the contaminated toys, to physicians, day care providers, parents, and the public. In fall 2007, the Department and CPB randomly selected more than 40 children's products for additional lead testing, resulting in the identification and recall of additional products. Informed by these activities, CPB worked with the Governor to develop new legislation to increase product safety warning information, including new requirements for labeling of children's products, use of product safety owner's cards for children's products, and display of recall notices by retailers and online stores. Advisory Council members provided ongoing feedback on education and outreach activities and discussed the proposed legislation with CPB prior to its enactment later in 2008.

- Expanding primary prevention strategies to effectively identify and reduce lead hazards before children become lead poisoned remains a top priority for the Department. Primary prevention is central to achieving the goal of elimination. Specific priorities include implementing expansion of the childhood lead poisoning primary prevention program to additional high-incidence communities, completing an evaluation of the pilot program to identify successful tools and strategies for local programs, and disseminating findings across programs and to other LHDs to support local primary prevention work.

Supporting local childhood lead poisoning prevention programs and other local lead prevention activities

- The Department continues to provide grant funding, training and technical assistance to LHDs to support local lead poisoning prevention programs (LPPPs). LHDs are the frontline providers of lead poisoning prevention services in communities across the state, including public awareness and community education, promotion of lead testing for children and pregnant women, collection of lead testing data to support surveillance activities, and coordination of follow-up services for children with lead poisoning in collaboration with children's health care providers. Consistent with the emphasis of the elimination plan and Advisory Council discussions on targeting high-incidence communities, beginning in April 2007, annual state funding totaling $400,000 was redirected to increase grant awards to the 10 upstate counties with the highest incidence of children with blood lead levels $\geq$ 10 mcg/dL to support expanded prevention work. Current grant funding to LHD LPPPs is more than $7 million annually.

- Consistent with the elimination plan, Advisory Council members have emphasized the importance of strategic partnerships to incorporate practical primary prevention activities across programs. The Department has worked with LHDs to expand training and support the incorporation of visual lead hazard identification in a variety of other local programs that include home visiting and provide residents with education and referrals as needed.

- Advisory Council members have highlighted the importance of leveraging available funding to support local lead prevention efforts. The Department continues to coordinate communication with local Housing and Urban Development (HUD) grant recipients and regional HUD representatives through periodic videoconferences to highlight progress in meeting HUD grant milestones, discuss challenges, share accomplishments, and provide updates from the federal level related to additional funding and training. Advisory Council members representing other state agencies have assisted in identifying available resources to support temporary relocation of families, housing rehabilitation, outreach to high-risk refugee populations, and other activities.

- In 2006, the Department secured one-time funding from the CDC to support a variety of prevention projects developed by five local coalitions in targeted high-incidence areas across the state. Advisory Council members reviewed and provided feedback on the educational materials and other strategies developed by the five coalitions, a health care provider needs assessment and training DVD, a parent and community education DVD and webcast, and radio and television public service announcements. These one-time local projects helped inform subsequent development of guidance for LHD LPPPs and primary prevention pilot projects.

- Further strengthening of local capacity for elimination of lead poisoning remains a priority, with emphasis on targeting the highest risk communities. Specific priorities include continued provision of local data, training and other tools to support local health departments in conducting effective lead prevention strategies, and continued efforts to facilitate local partnerships between LHDs and other community partners.

Appendix A

Abbreviations

Abbreviation	Definition
Ag&Mkts	Department of Agriculture and Markets
BCEHFP	Bureau of Community Environmental Health and Food Protection
BLL	Blood Lead Level
BOH	Bureau of Occupational Health
CCH	Center for Community Health
CEH	Center for Environmental Health
CDC	Centers for Disease Control and Prevention
CLPPP	Childhood Lead Poisoning Prevention Program
CPB	Consumer Protection Board
CPSC	Consumer Protection Safety Commission
DEC	Department of Environmental Conservation
DFH	Division of Family Health
DHCR	Division of Housing and Community Renewal
DO	District Office
DOH	Department of Health (also NYSDOH)
DOI	Department of Insurance
DOL	Department of Labor
DOS	Department of State
EBLL	Elevated Blood Lead Level
EPA	Environmental Protection Agency
HNP	Healthy Neighborhoods Program
HUD	Department of Housing and Urban Development
LHD	Local Health Department
NYCDOHMH	New York City Department of Health and Mental Hygiene
NYCRR	New York State Codes, Rules and Regulations
NYS	New York State
OCFS	Office of Children and Family Services
OHIP	Office of Health Insurance Programs
OTDA	Office of Temporary and Disability Assistance

Appendix B

2006 Advisory Council Meeting Minutes

March 13, 2006
August 24, 2006
October 23, 2006

NYS DEPARTMENT OF HEALTH
MARCH 13, 2006
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow Up
Attendees	**Council Members:** • Guthrie Birkhead, M.D., M.P.H., Director, Center for Community Health-Council Co-Chair • Ronald Tramontano, Director, Center for Environmental Health-Council Co-Chair • Rolaine Antoine (Parent) • Mary Binder, Environmental Analyst, Division of Housing and Community Renewal • David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) • William Dorr, Assistant Director, Bureau of Early Childhood Services, NYS Office of Children and Family Services • Thomas Ferrante, Manager of Training and Technical Services, Total Safety Consulting (Labor Union) • Abby Greenberg, M.D., Director of Disease Control, Nassau County Department of Health (Local Government & American Academy of Pediatrics-District II) • Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY-Buffalo (Professional Medical Nursing Organization) • Tom Mahar, Code Compliance Specialist II, NYS Department of State • Ellen Migliore, R.N., M.S., Public Health Nurse Herkimer County Health Department (Child Health Advocate) • Deborah Nagin, Director, New York City Department of Health & Mental Hygiene- Lead Poisoning Prevention Program • Clifford Olin, President, EcoSpect, Inc. (Industry) • Robert Perez, Principal Industrial Hygienist, NYS Department of Labor • Alicia Sullivan, Assistant Counsel, NYS Office of Temporary and Disability Assistance **Additional Attendees:** • Michael Cambridge, Director, Bureau of Community Environmental Health and Food Protection • Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health • Eileen Franko, Dr.P.H., M.P.H., Director, Bureau of Occupational Health	

NYS DEPARTMENT OF HEALTH
MARCH 13, 2006
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow Up
Absent	• Richard Svenson, Director, Division of Environmental Health Protection • Thomas Carroll, Section Chief, Bureau of Community Environmental Health & Food Protection • Carl Johnson, Deputy Commissioner, NYS Dept. of Environmental Conservation • Lindsay Lake Morgan, R.N., Ph.D., A.N.P., Assistant Professor, Decker School of Nursing, SUNY Binghamton (Educator) • Philip Landrigan, M.D., M.Sc., D.I.H., Director, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital) • Bethney Lortie-Denno, Special Assistant to the Superintendent, NYS Insurance Department • Bruce Phillips, Counsel, NYS Department of Health • William S. Schur, Vice President of Schur Management Company, Ltd., (Real Estate)	
Welcome and Introductions: Dr. Birkhead & Mr. Tramontano	The meeting was convened at 10:05 am. • Dr. Birkhead opened the meeting and welcomed the members. • Dr. Birkhead initiated a roll call of the members and reviewed the meeting agenda.	

Review of minutes	Draft minutes from the October 20, 2005 Advisory Council meeting were reviewed.
	• Corrections on 10/20/05 minutes:
	  • Under CCH Update, Annual Immunization meeting should be identified as the New York State AAP Immunization Meeting;
	  • Under Council member comments, clarify that the concern about potential contamination of capillary samples refers to contamination during sample collection.
	  • Under Council member comments, identification of additional locations for testing, such as child care settings, should be listed as a separate bulleted item.
	  • Under Council Member Updates, Dr. Broadbent states that AAP recommends two screenings in childhood.
	• Minutes accepted as amended.
	
	Request from Council Member to send minutes out electronically in advance of meetings.
		Final corrections were incorporated; Minutes from the 10/20/05 meeting will be distributed to Council members.
		
		CCH will provide minutes for 3/13/06 meeting electronically prior to the next meeting.

Topics/Speaker	Discussion	Follow Up
Center for Community Health (CCH) Update	Dr. de Long reported on CCH's work to implement the elimination plan. (See handouts distributed at the meeting). • The next 5 year competitive application submitted to CDC in February. The application was strong on primary prevention and strategic partnerships, with continued focus on surveillance, education screening and case management. • The next surveillance update will be released soon with 2002-03 data. Screening rates continue to increase with a corresponding decline in lead poisoning incidence and prevalence rates. • Surveillance priorities- complete the deployment of LeadWeb, improve quality and timeliness of data reporting, and expanding data analysis. • The WIC Medical Referral form updated to reference BLL at 1 and 2 years old, with the word 'optional' removed. • A roundtable with Local Health Departments will be held on March 27, 2006 to discuss strategies for improving screening rates and primary prevention. • Work continues on the Clinical Lead Prevention Toolkit. • The December 2005 Medicaid Update had an article on lead poisoning. • CCH has collaborated with OTDA and OCFS to advance screening messages through provider networks. • Case management guidelines for LHDs are being finalized, and will be disseminated to the LHDs with training. • An expanded methodology that incorporates multiple health outcomes and demographic factors was applied to better identify high-risk communities. Five upstate counties – Albany, Erie, Monroe, Onondaga, and Oneida were identified. Coalitions serving each of these counties are eligible for current funding. **Council members comments included:** • Clarification of the specific names of coalitions funded in high-risk communities. A Council member recommended that NYS fund the Statewide Coalition as well.	A list of coalitions will be distributed to

Topics/Speaker	Discussion	Follow Up
	• Question of what to do about a child with a lead level less than 10. Concern that labs report lead level less than 10 as "normal"; would prefer that term is not used. • Anticipatory guidance - Nassau County provides a home visit to any child less than 12 months with a BLL over 5. • Need for nurse practitioners be engaged with AAP and AFP in the Clinical Toolkit. • Members requested that copies of the CDC application be disseminated to the Council members.	Council members. 2006-2007 grant will be disseminated at the next Council meeting.
Center for Environmental Health (CEH) Update	Tom Carroll reported that the Centers have been working closely together. (See handouts distributed at the meeting). • Meetings continue with OCFS to develop process for day care centers for environmental hazard assessment of day care centers. • CEH has continued work with DHCR on the State Consolidated Plan and with EPA on real estate disclosure. • LHD Roundtable on March 27, 2006, will engage LHDs in discussion of designation of 'area of high risk' and expansion of primary prevention. • Development of LeadWeb has continued, and the deployment of the environmental health component is beginning. Additional features are under development. • The Healthy Neighborhood database development will provide data on a large number of addresses. **Council members comments included**: • Value of data mapping at census tract or block level; • Need to target welfare recipients' housing, as a large proportion of lead poisoned children are poor. • Clarification that day care refers to day care centers. Plans are being developed to target family day care in the future. Visual observation of chipping and peeling paint is part of annual inspection. Several council members related that they have not identified day care centers as a primary source of lead paint for children with elevated lead levels. Concern expressed for	

Topics/Speaker	Discussion	Follow Up
	unlicensed day care utilized by several families, particularly the poor. Dr. Franko reported on Bureau of Occupational Health's activities and on the recently proposed federal EPA rules related to renovation and remodeling. (See handouts distributed at the meeting). • Training on lead hazards has been conducted throughout the state to 652 local code enforcement officials. Evaluation will be done on training using a case-control study, through a survey of attendees that went to training and those that did not go to training. • A presentation was done at the Capital District Home Show; participants were primarily home owners renovating homes. • Employer Surveillance has shown a decline in employee blood lead level. Local Health departments were provided with information on the care of adults with elevated blood lead levels. • EPA has proposed rules establishing requirements for renovation of homes built before 1978. The proposal is part of a comprehensive EPA plan of training that also includes work practices and outreach campaigns. • Three previous studies confirmed that activities that cause small particles to be distributed throughout the environment cause an increase in child BLLs. With the cost of housing, people are more likely to renovate and remodel older homes, and the industry has grown 110% in the past few years. • EPA has established work practice standards. Their proposal will support primary prevention by providing work practice, interior, waste disposal and cleaning standards. The comment period ends 4/10/06. Council members were encouraged to submit comments directly. **Council members comments included**: • Responsibility for enforcement of EPA standards; Dr. Franko responded that the federal standard is enforced by Region II EPA. If NYS does not have a program to enforce the standards, the responsibility for enforcement will remain with EPA Region II. • Dust wipe clearance test not included in the EPA standards; Dr. Franko responded that dust wipe clearance test was not included due to the cost;	

Topics/Speaker	Discussion	Follow Up
	• Comparison of proposed EPA rules to HUD guideline book; Dr. Franko responded that the HUD guideline book is more educationally oriented and does not include a requirement for work process standards. • Identification of person doing clearance; it was believed to be a third party, not the contractor or the inspector. • Identification of entity doing the certification of renovators and inspectors; Dr. Franko responded that it would depend on the authority or agency. If NYS does not have a program to certify the renovators and inspectors, the responsibility for certification will remain with EPA Region II.	
New York City Update	Deborah Nagin reported on NYC's update on implementation of the NYC elimination plan. (See handouts distributed at the meeting). • Analysis of decline in EBLLs indicates that NYC would still have lead poisoning in 2010. • Need to increase efforts with primary prevention identification of non-paint sources. • Newborn initiative provides general information with newborns in high risk areas, including identification and intervention on environmental hazards. Bushwick neighborhood has been targeted. • Increased work on identification of herbal medications, primarily from India. NYS has developed an enforcement action utilizing Commissioner's Order and extensive outreach efforts. The met with Indian Consulate to provide education regarding the importance of products manufactured in India meeting US safety standards. **Council members comments included:** • Labeling of products that contain heavy metals, need to have products appropriately labeled; • Need to get FDA to enforce the limits established. Herbal remedies are largely unregulated. The NYC Board of Health will be reviewing information to make a determination as to whether to lower the applicable age for Local Law 1 from under 7 years of age to under 6 years of age. • Process for identification of adults with EBLLs (adults typically have become symptomatic); • Surveillance activities to track non-paint exposure sources; • Implications of utilization of herbal remedies due to the inability to afford medications.	

Topics/Speaker	Discussion	Follow Up
Proposed changes to NYS Regulations Part 67.2	Proposed revisions were discussed at an earlier meeting, and comments were received from Council members and other parties. In response, additional changes have been made to the proposal. Tom Carroll presented on the updated proposed changes to Subpart 67-2 and responded to comments received. (See handouts distributed at the meeting). • Described response by LHDs for children with EBLLs - exposure investigation examining many possible sources of lead, including family behaviors; • Coordination of case management is critical to success of intervention. This includes manage management of child's blood lead levels, medical assessment, environmental exposure investigation, management of environmental records and education; • Ownership is established and exposure report is prepared which includes a list of hazards; • Notice and Demand is issued. This is a legal document which requires owner to eliminate conditions conducive to lead poisoning. The Notice and Demand requires a specific timeframe for compliance and remediation plan; • The remediation plan is an agreement with a property owner, and requires specific information on remediation of individual components, timeframes and documentation of specific safety measures and/or interim controls; • Interim controls receive intensive oversight, effective for a period of less than 20 years. Interim controls include: paint stabilization, friction treatments, specialized cleaning, education, monitoring and maintenance and installation of temporary enclosures utilizing safe work practices; • Permanent abatements must be performed by an EPA certified firm. Abatement includes complete paint removal, component replacement, enclosure, and encapsulation; • Follow-up visits are made related to enforcement. Owner can be fined via an administrative proceeding or in municipal court. Closures also made related to dormancy. Vacant dwellings are followed; • Barriers include screening issues, secondary vs., primary prevention, federal vs. state requirements, cultural barriers, liability, ownership issues, funding for repairs; • Revised draft of 67-2 (copy handout); • Discussed public comments (copy handout).	

Topics/Speaker	Discussion	Follow Up
	Comments from council members included: • A question from the NYS Insurance Department representative as to whether CEH has in-house guidance regarding acceptable remediation plans. Mr. Carroll responded that the proposed amendment to Part 67-2 would require the building owner to submit a remediation plan to the LHD for approval. CEH is currently developing the remediation plan. • Requested clarification on improvements in XRF technology; newer XRFs save substantial time in the field by allowing for electronic handling of data. • Use of EPA certified abatement contractors when a lead hazard is discovered and abatement is required. Mr. Carroll clarified that abatement must be performed by an EPA certified contractor. Interim controls do not require services of an EPA certified contractor. In the proposed amendment to Part 67-2, the interim controls would require approval from the LHD via the remediation plan.	
Proposed changes to NYS Regulations Part 67-1 and 67-3	Dr. de Long presented on the potential changes to Subpart 67-1 and 67-3 that are under consideration for further development. (See handouts distributed at the meeting). Subpart 67-1 specifies screening and follow-up of children by health care providers, laboratory and specimen collection, screening of pregnant women, and required follow-up by local health units. Requirements were summarized related to universal lead screening; annual risk assessment; enrollment in child care/preschool; risk assessment of pregnant women; lead testing arrangement for under and uninsured children; follow-up testing and services for children with EBLLs; and specific functions of LHDs to identify and track children with EBLLs. **Potential revision:** Clarify follow-up services for all children with EBLLs regardless of age. This requirement has been interpreted inconsistently due to the age-specific requirement for screening. Key issues to be considered include: Would we require the same follow-up services for older children? What educational materials would we need? What is the impact on LHDs? **Council members comments included:** • NYC has found this to be a larger number than expected, largely attributable to their immigrant population	

Topics/Speaker	Discussion	Follow Up
	Potential Revision: Lowering level of intervention for mandatory environmental inspection to15 ug/dL. Key issues to be considered include: What is the evidence base? CDC has not changed their recommendation to perform environmental assessment for children with results under 20 ug/dL. From an individual case management perspective, there is no clear evidence that performing environmental intervention on a child with BLL under 20 ug/dL reduces that child's BLL. However, from a primary prevention perspective, environmental remediation may reduce future lead exposures of the index child and other children. CDC and AAP do recommend intervention for children with **persistently elevated**, BLL 15-19 ug/dL, defined two or more confirmed blood lead values 15-19 ug/dL at least 90 days apart. There are no specific guidelines for other follow-up services (nutrition, developmental assessment, education) for children with BLLs in this range. **Council member comments:** • In the experience of NYCDOHMH, intervening at lower lead levels allows the LHD to work with children before they have higher lead levels. Younger child benefit the most from interventions done on children with BLLs under 20 ug/dL. • Concern that a number of children with EBLLs may be much greater than currently identified, • Potentially twice as high. Dr. de Long acknowledged that incidence and prevalence numbers cited are based on screening rates below 100%, but clarified that the number is unlikely to be twice as high because screening rates are nearly 70% and high risk communities typically have higher screening rates Next steps- Complete assessment of LHD practices, impact on state and local practices. **Potential revision:** Change requirement for confirmatory venous test for capillary tests with results $\geq$10 ug/dL instead of previous 15 ug/dL. This change is needed to be consistent with updated CDC standards. **Potential Revision:** Change requirement for confirmatory venous test for capillary tests with results $\geq$10 ug/dL instead of previous 15 ug/dL. This change is needed to be consistent with updated CDC	

Topics/Speaker	Discussion	Follow Up
	standards. **Potential Revision:** 67.3 – Laboratory reporting of lead levels: Should we mandate electronic reporting, expansion of required fields, and reporting of test results from portable in-office testing machines? • Electronic reporting is considered a more efficient mechanism for reporting since results are transmitted to NYS and LHDs at the same time. New York City has amended their health code to required electronic laboratory reporting during 2006. Mandating electronic reporting statewide may improve consistency of reporting. • Expanding the fields required for laboratory lead test reporting could facilitate more children and follow-up by LHDs tracking children with EBlls. Currently patient and provider telephone number, provider license number and guardian name are not required lead test laboratory reporting fields. These are some of the additional requirements currently under consideration. • Portable in-office blood lead testing machines are utilized in physicians' offices to screen children. As currently written, Part 67-3 does not require physicians to report the results of in-office lead tests, with potential for a resultant gap in screening data and potential problems for children with EBlls who require follow-up and environmental intervention.	
Other State Agency Update or New Business-General Advisory Council Discussion	• OCFS - continuing to work with DOH to educate provider community and field staff on negative impact of lead on children. A Council member commented that OCFS should look at the impact of lead poisoning on juvenile delinquency. • Department of State - Unified Code in receipt of a more restrictive housing standard put proposed by City of Rochester. This standard will be reviewed at hearing in Albany on March 15, 2006. • OTDA - due for meeting with DOH to further develop plans for distributing information to TANF recipients and other target populations. • Dr. Broadbent requests meeting in 2-3 months, handouts in advance, electronically if possible.	

Topics/Speaker	Discussion	Follow Up
Public Comments	• Mr. John Fenimore spoke representing himself. Expressed concerns about controlling costs, landlords not maintaining buildings, not doing routine maintenance to control lead hazards. Costs of abatement do not allow return on the landlords' investment. • Russ Haven spoke representing NYPIRG. He was encouraged to see longer comment period on Part 67-2. He announced a symposium on March 16, 2006 at the Albany Law School regarding Lead Poisoning in NYS, and distributed information.	
Closing Comments	**The meeting was adjourned at 3:10 p.m.**	

NYS DEPARTMENT OF HEALTH
AUGUST 24, 2006
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow Up
Attendees	**Council Members:** • Guthrie Birkhead, M.D., M.P.H., Director, Center for Community Health-Council Co-Chair • Ronald Tramontano, Director, Center for Environmental Health-Council Co-Chair • Rolaine Antoine (Parent) • Mary Binder, Environmental Analyst, Division of Housing and Community Renewal • David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) • Thomas Ferrante, Manager of Training and Technical Services, Total Safety Consulting (Labor Union) • Kimberly Galvin, Deputy Superintendent, NYS Insurance Department • Abby Greenberg, M.D., Director of Disease Control, Nassau County Department of Health (Local Government & American Academy of Pediatrics-District II) • Philip Landrigan, M.D., M.Sc., D.I.H., Director, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital) • Tom Mahar, Code Compliance Specialist II, NYS Department of State • Ellen Migliore, R.N., M.S., Public Health Nurse Herkimer County Health Department (Child Health Advocate) • Lindsay Lake Morgan, R.N., Ph.D., A.N.P, Assistant Professor, Decker School of Nursing, SUNY Binghamton (Educator) • Doug Morrison, NYS Department of Environmental Conservation representing Monica Kreshik • Deborah Nagin, Director, New York City Department of Health & Mental Hygiene- Lead Poisoning Prevention Program • Robert Perez, Principal Industrial Hygienist, NYS Department of Labor • Bruce Phillips, Counsel, NYS Department of Health • Alicia Sullivan, Assistant Counsel, NYS Office of Temporary and Disability Assistance • William S. Schur, Vice President of Schur Management Company, Ltd., (Real Estate) • Kathleen Pickel representing William Dorr, NYS Office of Children & Family Services	

Topics/Speaker	Discussion	Follow Up
Absent	**Additional Attendees:** • Michael Cambridge, Director, Bureau of Community Environmental Health and Food Protection • Barbara Leo, R.N., N.P., Program Manager, Childhood Lead Poisoning Prevention Program, Bureau of Child and Adolescent Health • Eileen Franko, Dr.P.H., M.P.H., Director, Bureau of Occupational Health • Richard Svenson, Director, Division of Environmental Health Protection • Thomas Carroll, Section Chief, Bureau of Community Environmental Health & Food Protection • Wendy Shave, Senior Health Plan Quality Analyst, Capital District Physicians Health Plan • Ms. Molly Clifford and Mr. Kirkmire, Neighborhood Empowerment Teams City of Rochester • Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY-Buffalo (Professional Medical Nursing Organization) • Clifford Olin, President, EcoSpect, Inc. (Industry)	
Welcome and Introductions: Dr. Birkhead & Mr. Tramontano	The meeting was convened at 10:10 am. • Dr. Birkhead opened the meeting and welcomed the members. • Dr. Birkhead initiated a roll call of the members, and reviewed the meeting agenda.	
Review of minutes	Draft minutes from the March 13, 2006 Advisory Council meeting were reviewed. Minutes accepted as provided.	
Center for Community Health (CCH) Update	Barbara Leo reported on CCH's work to implement the elimination plan. • The Childhood Lead Poisoning Prevention Program (CLPPP) has received approval for 5-year grant award for the continuation of the CDC Lead Cooperative Agreement for the period of July 1, 2006 through June 20, 2011. The application focused on primary prevention and strategic partnerships, as well as continued emphasis on surveillance, screening and education of general public and targeted groups (landlords, etc.). • On June 20th and 21st, CLPPP and New York State Association of County Health Officials (NYSACHO) jointly held a meeting for local health department nursing and environmental health staff. Participants attended plenary sessions and a variety of workshops presented by	

Topics/Speaker	Discussion	Follow Up
	experts on topics such as strategies for outreach to medical providers, prenatal lead exposure; guidelines for screening and management, primary prevention, and non-lead paint sources. • 160 attendees, including 90 from nursing and 70 from environmental health. • Evaluations of individual sessions and the entire meeting were very positive. Many attendees requested that this event be available annually. • On March 27, 2006, NYSDOH held a Roundtable to discuss the role of local health departments in implementation of the NYS Lead Elimination Plan. Local health departments and NYSACHO representatives participated in a discussion on the following topics: Improving Lead Screening Rates, Commissioner's High Risk Designation Authority to Promote Primary Prevention, and Intervention without Index Child with an Elevated Blood Lead Level. The latter topics are discussed in the CEH update below. • One-time funds were awarded to the five existing lead poisoning coalitions in Albany, Oneida, Onondaga, Monroe and Erie**.** An annual meeting of the coalitions was held on June 26th in Syracuse to discuss their grant projects, provide a forum to share with other coalitions from across the state what they have learned, best practices, and any materials developed. Additional presentations included discussions on coalition building, HUD training and grants, and working with local parents. Each coalition had the opportunity to report on their projects, as follows: • The Greater Capital District Coalition for Childhood Lead Safety (Albany) developed a television commercial to raise parent awareness on lead testing. This commercial was aired on local television during primetime viewing hours. • The Safe Housing Coalition (Utica) provided lead-safe work practice training for landlords and homeowners. They also provided training to health care providers on screening, sources of exposure and treatment options. Finally, the coalition developed a consumer brochure, poster and television commercial on common paths of lead exposure, lead information, and risk reduction. • Project CLEAN (Syracuse) trained residents from high-risk communities to provide lead poisoning prevention education to community members. One unexpected finding of this initiative is many residents report that they have higher priority needs and that lead testing is often overlooked. The coalition works with a community partner organization that has	

Topics/Speaker	Discussion	Follow Up
	community educators, and is considering adding lead poisoning education into their environmental health curriculum. • The Rochester Coalition to End Lead Poisoning developed a video for new parents on sources, screening, and potential effects of lead poisoning. Prior to distribution, the coalition conducted focus groups with community residents in high-risk areas to ensure that the messages were well-received and appropriate. The video was developed in English, Spanish, and American Sign Language. • The Western New York Lead Coalition conducted a needs assessment of physicians. They also designed a CD-ROM and DVD to be distributed to physicians, schools, and additional interested parties. • Case management and environmental modules for LeadWeb have been deployed in all local health departments for daily use. Staff are currently developing a comprehensive lead data analysis plan for use starting with 2004-2005 data. • A letter was mailed to all pediatric and family practice health care providers to inform them of recent changes to the WIC Medical Referral form. The revised WIC form includes the removal of the word "optional" from the form, and adding a line to capture information if a child was tested for lead at age 1 and 2 and the date of the test. • The program is working with Office of Children and Family Service (OCFS) and with Office of Temporary Disability Assistance (OTDA) to develop a letter and supporting material for child care providers. The information will include brochures and order forms for NYSDOH materials. • The program is working with the Bureau of Women's Health to update the "Lead Poisoning Prevention Guidelines for Obstetricians and Gynecologists". Once finalized, this will be mailed to all prenatal health care providers and local health departments. In addition to this, the program is updating the "If You're Pregnant, Get Ahead of Lead" brochure for the general public. • The case management guidelines for LHDs are under final development. The program will hold regional trainings to present the information to local health departments and regional offices once the guidelines are released.	**Council requested copies of WIC letter and form.**

Topics/Speaker	Discussion	Follow Up

	• **Comments from council:**
	  • Ms. Migliore asked if the program can work with the medical directors of HMOs to provide them with the same information that health care practitioners receive. She stated that it is important that the HMOs recognize the importance of lead poisoning prevention, and may work to establish reimbursement for lead poisoning screening. Ms. Shave, a representative from CDPHP added that it is important to contact the right person at the HMO. The department will bring this issue up at the next quarterly Medical Directors' meeting. Dr. Landrigan added that screening would be more effective if doctors were reimbursed
	  • Dr. Broadbent requested copies of coalition materials be distributed to council members, and suggested that they be presented at the next council meeting, if time permits. Dr. Greenberg asked if the Western New York coalition has followed up with physicians to evaluate the effectiveness of the lead poisoning DVD.
	  • Dr. Broadbent also commented about the challenges addressing suburban health care provider's misconceptions that lead poisoning isn't a risk. He noted that training for local health departments may be useful to teach them how to talk with physicians, or developing a system to alert the physician when a patient is due or overdue for a blood lead test.
	  • Ms. Nagin asked who uses the WIC medical referral form, whether child's date of birth is included, and if the actual screening level is used. Dr. Birkhead responded that the date of birth and blood lead level is included on the WIC referral form. Physicians fill out the forms for incoming and recertification of clients, and submit them directly to WIC; Dr. Greenberg commented that the WIC form is an excellent and helpful reminder to physicians. She noted that the Department should consider adding lead screening as part of the Early Intervention intake forms.
	  • Dr. Landrigan stated that immigrant women from certain countries (including Mexico and South Asian nations) often exhibit elevated blood lead, and thus are at greater risk for prenatal exposure to the unborn child.
	  • Ms. Antoine commented that she was interested to see the language used in the letter to providers and the WIC medical referral form. Ms. Leo responded that a copy of the WIC medical referral form and letter will be provided to the council members.	

Topics/Speaker	Discussion	Follow Up
	• Dr. Broadbent commented on the use of the state-wide immunization registry to include lead screening. Dr. Birkhead added that a recent law was passed to develop and implement a mandatory immunization registry for New York State. It is likely that the immunization registry will be developed to link to other Department registries, including Lead. • Dr. Broadbent asked if neonatal lead poisoning information is included in the information given to mothers leaving the hospital post-delivery. Ms. Leo commented that local health departments may provide literature for a "going home" package, and that the program would look at this in the future. • Ms. Nagin commented that a master child index of immunization and lead was developed as a major initiative in New York City. She also commented on state PBII work plan initiative performed by local health departments, and that immunization is a viable access point.	
Center for Environmental Health (CEH) Update	• Mr. Carroll presented on the interagency efforts of Center for Environmental Health (CEH). • The Center is continuing to work with BCAH and OCFS to complete daycare inspections. The Center is also working with OCFS to develop education and training opportunities for OCFS field staff. • Onondaga County has implemented a foster care dwelling inspection program, which CEH is considering for expansion as a model program for primary prevention. • CEH is working with the Division of Housing and Community Renewal to assist with the New York State Draft 2007 action plan. CEH is representing the NYSDOH as a member agency of the New York State Task Force on the National Affordable Housing Act (NAHA). To date, Housing and Urban Development (HUD) grants have provided over $106 million to address 9,589 units, of which 7,163 have been completed thus far. • CEH is working with the regional office of the Environmental Protection Agency (EPA) to refine the efforts for real estate disclosure regulations, to get a more direct relationship between agencies and to reduce resistance and obstacles for enforcement. • CEH collaborated with CCH and NYSACHO for the June 20/21st local health department meeting noted earlier in the meeting. CEH staff presented on developing primary prevention strategies, recognizing and assessing non-paint lead hazards, the HUD grant process, and the environmental health module of LeadWeb. CEH invited representatives from EPA to	

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	discuss the Children's Health Initiative and the proposed lead-based paint renovation, repair and painting rule. • CEH has started to provide training for the data management section of the environmental health module of LeadWeb. These trainings are broadcast via the internet to 20 training sites, and provide hands-on training for the system. CEH is currently evaluating and promoting proper data management. The modules includes several features, including automated e-mail referrals for units needing inspections, matching records to lab reports, systems to allow communication between multiple counties regarding one unit, and a database of landlords. Additional features under development include automatic Notice and Demand generation, advanced reporting and analysis features, and GIS mapping capabilities. • The Healthy Neighborhoods Program (HNP) has 13 programs across the state, including five programs in their second year. Programs were able to receive an increase in funding. CEH is currently evaluating lead and asthma activity data for 2003-2005. The program has visited 7,590 dwellings with 3,954 children and 6,438 adults in Clinton, Erie, Niagara, Onondaga and Oneida counties. Fifteen percent (15%) of the dwellings were found to have possible sources of lead contamination; half of the dwellings with deteriorated lead paint or dust accumulations were improved within 90 days. Three-quarters of the children were already screened for blood lead, indicating that the targeting of neighborhoods is on track. • Finally, Mr. Carroll noted that CEH is working with NYC to avoid program disruptions due to the proposed revision to regulation 67-2. CEH is also eliciting comments from other key stakeholders and interested parties, and coordinating efforts with CCH regarding regulatory changes to 67-1. • **Comments from Council:** • Dr. Broadbent asked if counties continue to have concerns about the potential for lawsuits. Mr. Carroll noted that individual county counsels interpret the legal risk differently. CEH has discussed with Division of Legal Affairs to advise counties which perceived risks are valid. • Dr. Broadbent asked for clarification about the regulatory change in subpart 67-2. Mr. Carroll noted that language differences between NYS and NYC are the key issues. CEH	

Topics/Speaker	Discussion	Follow Up
	wants to ensure that regulations calling for a "notice and demand" to be issued will not disrupt NYC's procedures to issue a "Commissioner's order to abate". They are also looking at consistency between NYC and rest of state, and maintaining the same strength to effect abatement. The time frame to complete the regulatory change process is difficult to determine. • Ms. Antoine asked what the timeframe was for landlords to correct violations. Mr. Carroll noted that Healthy Neighborhoods Program uses a 90-day timeframe, but this is not mandated. New York City has specific timeframes; regulation 67-2 leaves the timeframe up to the commissioner. The commissioner has the latitude to develop a timeframe that is appropriate for the amount of work, the landlord, and the tenants. • Dr. Broadbent asked if any counties are using the high risk declaration process. Mr. Carroll stated that this has been used to correct problems within entire apartment buildings rather than single dwellings. Dr. Birkhead commented that the recent round table discussion described by Ms. Leo included discussion to bring this option back to the counties. • Eileen Franko provided an update on recent activities with the Bureau for Occupational Health (BOH). • BOH presented several programs at the June 20/21st local health department meeting, including code enforcement training, how to do an effective program evaluation, and effective presentation skills. Evaluation from participants showed great interest in continued training sessions. A CDC grant has allowed for BOH to perform a case-control study to evaluate the effectiveness of these trainings, based on a California study that suggests that these may not be effective. • A recent public meeting for landlords and contractors was performed in Cohoes, which over 200 people attended. There was interest for additional meetings. • BOH recently sent letters to over 400 bridge and highway contractors in New York State, offering industrial hygiene services. BOH identified a large contingent of Portuguese bridge workers and contractors, and is currently working to translate several relevant educational materials into Portuguese.	

Topics/Speaker	Discussion	Follow Up
	• Analysis of 2005 Heavy Metals Registry data indicates that six times as many males were reported to have exposure to heavy metals than females. • BOH has provided surveillance and assistance to more than 300 companies through June 06, as well as consultation to 29 employers and 5 site visits. • BOH is working with EPA to discuss a proposed rule to establish requirements to protect children during renovation, repair and painting activities that disturb lead-based paint. • BOH is looking to produce more materials for contractors. The Journal of Light Construction has published a troubleshooting guide to address lead hazards. Dr. Franko has been invited to speak about lead hazards at an upcoming national contractor's conference. • BOH is looking at new lead detection methods, including a new chemical spot test for dust wipes. The test is developed for contractors, and is intended to determine the effectiveness of hand-washing to remove lead residues. • BOH is currently interviewing women of childbearing age identified with BLL >25 mcg/dL to determine the sources of exposure. If a woman is pregnant, a letter is sent to her obstetrician, recommending testing cord blood. The data systems do not currently allow matching adult and child to correlate prenatal exposure. As a surrogate, children under 6 months of age with BLL >10 mcg/dL are assumed to have been exposed prenatally. BOH is now interviewing women with BLL >15 mcg/dL, and is considering lowering the interview level to women with 10 mcg/dL. • **Comments from Council:** • Ms. Migliore questioned if the PCAP program is considering screening for all pregnant women? • Dr. Landrigan inquired about the process of bringing brochures to hardware stores. Dr. Franko replied that the primary need is to educate the homeowners, but getting the information into chain hardware stores is difficult. She described anecdotal reports that either cashiers don't provide the literature, or the hardware stores want modifications in either language or placement, to protect or promote specific brands or products. Additionally, she said that it is difficult to find the right contact person within chain hardware stores to implement education at a regional or state level. Dr. Landrigan	**Will follow-up with PCAP.**

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	mentioned that the chair of the CDC Foundation is affiliated with Home Depot, and may be an appropriate contact. Ms. Nagin added that New York City has a program with several hardware stores that uses a "healthy homes" approach, but reiterated that some stores modify the information or placement.	
New York City Update	• Ms. Nagin presented on basic concerns of prenatal lead poisoning and New York City's efforts to eliminate prenatal lead poisoning. • Lead is known to be transmitted freely across the placenta. Pregnancy can cause lead stored in the woman's bones to leach into the bloodstream, so past exposure can affect the baby. This is of particular concern to foreign-born women. • New York City receives laboratory blood lead test reports of all city residents daily from NYSDOH. Services provided to lead-poisoned women vary between three categories. Women with blood lead levels of 10-14 are provided with educational materials. Women with blood lead levels of 15 or greater receive educational material, and the provider is contacted to determine pregnancy status. If the woman is pregnant, she is referred to the CLPPP program for case coordination and environmental follow-up. These services include an interview with the lead poisoned pregnant women, a visual inspection and risk assessment at home, and in the workplace if applicable. • A majority (80%) of adult lead tests in 2005 were for females (54,310). Of this, 97% were tests for women of reproductive age. Nearly 500 women of reproductive age (<1% of all women tested) had BLL >10 mcg/dL. Of this, 85 pregnant women were newly identified with blood lead levels >15 mcg/dL, and 3 were identified with levels >45 mcg/dL. These women received intervention services. • Most of these pregnant women were foreign born, and a third had lived in the United States for less than a year. • Overall, the majority of lead poisoned pregnant women reside in Queens and Brooklyn. Some hospitals in Queens routinely test every pregnant woman, leading to higher numbers. • NYC DOHMH has updated guidelines for "Prevention, Identification and Management of Lead Poisoning in NYC Pregnant Women". Components include anticipatory guidance and risk reduction education, risk assessment and blood lead testing, reporting, and medical management.	

Topics/Speaker	Discussion	Follow Up
	• Comments from council: • Dr. Broadbent asked what percent of women are tested for lead during pregnancy. Ms. Nagin responded that the large percent of adult tests being from females is possibly the result of screening and testing of pregnant women. She did not have the number of pregnant women in New York City per year readily available.	

Implementing Rapid Office-Based Lead Testing	• Ms. Shave, a senior health plan quality analyst at Capital District Physicians Health Plan (CDPHP), was invited to present on the implementation of rapid office-based lead testing. She included a background epidemiological survey of lead poisoning in the Capital District, including current rates of testing for various payers, and frequency of lead poisoning in Capital District cities and suburbs. Additionally, she discussed efforts that CDPHP has done to improve lead testing rates, including:
	  • Continuing efforts to raise practitioner and member awareness, through the development of internal HMO registries, reminders sent to parents, rosters of children needing to be tested provided to physicians, newsletter articles, and incentive programs.
	  • Encouraging practitioners to draw blood in-office. Barriers to this include environmental contamination, lack of reimbursement specific to the blood draw, and lack of appropriate supplies to perform blood lead draws. In response, CDPHP has worked with lab vendors to distribute supplies, distributed information about clean protocol for obtaining blood samples, and developed a payment and incentive strategy for testing and sending out blood lead samples to certified laboratories.
	  • Additionally, rapid testing equipment for in-office use has been approved for use as of January 2006.
	• CDPHP has noted a slight increase in blood lead testing for Medicaid children since the onset of a variety of interventions (63.0% for children born 1/2003 through 6/2003 compared to 67.5% for children born 7/2003 through 12/2003). These interventions, implemented at various times in 2005 as noted, are as follows: newsletter articles (throughout), lead registry (January), member mailings (January), provider rosters (April), payment for finger-sticks (May), incentive payments sent to providers (September), and in-office lead tests (Jan. 2006).
	• The number of physicians billing for in-office blood draws is small (63 providers of 1200) but	

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	growing monthly.
	• CDPHP plans to increase direct outreach to parents, identify missed opportunities by providers (i.e. testing for anemia but not lead levels), and using the registry data to track testing at 1 and 2 years of age, determining prevalence of lead poisoning in plan population, and assuring appropriate follow-up for high blood lead levels.
	• Comments from Council
	  • Dr. Broadbent requested clarification about the QARR measures cited. Ms. Shave commented that lead testing is part of the QARR measures every other year, as the federal government alternates some of the measures. CDPHP measures lead screening rates every year.
	  • Dr. Broadbent also asked about the financial incentives to doctors. Ms. Shave responded that the amount is based on a complex calculation, but can amount to thousands of dollars, depending on membership.
	  • Dr. Broadbent commented about the fact that literature will eventually need to be developed for children with blood lead levels below 10 mcg/dL. Ms. Shave responded that CDPHP has not yet developed this material, but will work with NYSDOH on this issue, as more information is available to the effects of low-level lead poisoning. Dr. Landrigan followed-up by stating that an international environmental heath organization has officially recommended that the interventions for lead poisoning in children begin at 5 mcg/dL.	

City of Rochester Lead Paint Poisoning Ordinance	• Ms. Clifford and Mr. Kirkmire were invited to discuss the recently implemented City of Rochester Lead Paint Poisoning Ordinance, enacted on July 1, 2006. They gave a brief history of the ordinance and its' inception, as well as information about how the ordinance has been implemented. • The ordinance is based on the assumption that any structure built before 1978 contains lead paint; it applies to the interior and exterior surfaces of residential buildings, as well as the exterior surfaces of non-residential buildings. Violations include deteriorated paint that exceeds 20 ft^2 on exterior surfaces, 2 ft^2 in any interior room, or >10% of the surface area of a small building component. Additionally, bare soil within 3 ft of a residential drip line, and dust lead hazards are considered violations.	

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	• Inspections include visual inspection for deteriorated paint and bare soil. When no interior deteriorated paint is found, dust wipe tests are conducted if the building is located in a "High Risk" area. • If a violation is found, tenants are given 3-day notice and are relocated, unless treatment will not disturb lead based paint, only exterior surface violations are found, or interior work can be completed in either one eight-hour period or within 15 days and each day is completed with clean-up and proper protection. In emergency situations, the work can begin before the 3-day notice has expired. The ordinance also provides a clause that allows tenants to terminate their lease if the interior work is not completed within sixty days. For all buildings with violations, a sign is posted in English and Spanish; all work must be done utilizing lead-safe work practices. • Lead safe work practices prohibit use of open flame, machine sanding or grinding without HEPA exhaust filters, abrasive blasting or sandblasting without HEPA exhaust filters, heat guns above 1,100 degrees, dry painting or scraping, or chemical paint stripping in poorly ventilated space. Additionally, specialized cleaning is used after hazard reduction activities. • The ordinance has been implemented in "high risk areas" during the first year, and includes dedicated certified lead inspectors, a wipe testing procedural policy, a lead hotline, and public access website. • Between July 1st, 2006 and August 21, 2006, over 200 inspections have occurred. 143 buildings have completed the wipe test clearance, with 15 buildings being cited for lead dust hazards (90% of the buildings have passed inspection). **Comments from council:** • Mr. Morrison asked if there were provisions made for landlords with multiple violations. Ms. Clifford replied that landlords were able to work with enforcement to remediate the affected buildings in a timely fashion. • Ms. Binder asked if there were sufficient resources to deal with the requirement that landlords obtain clearance through private vendors. Ms. Clifford responded that there have been no concerns as of yet. • Dr. Broadbent asked whether dust wipe clearance was medically important. Ms. Clifford responded that the City has not collected data yet about the effects of dust wipe clearance	

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	through this ordinance. Dr. Broadbent also asked if relocation had been an issue. Ms. Clifford stated that no tenants had been relocated as of yet. In the instance of relocation, the tenant pays rent to the landlord of the relocation property; if the lead contaminated landlord does not have open lead-safe properties, the tenant stops payment to that landlord during the remediation process. • Dr. Broadbent asked what the response was due to the lack of funding for repairs. Ms. Clifford responded that this has not been an issue yet, but limited assistance can be provided. So far the response has been positive from both tenants and landlords. Ms. Nagin added that New York City has a fund for lead remediation assistance that landlords of high-risk areas can access, but none have accessed it.	
Other State Agency Update or New Business-General Advisory Council Discussion	• The Department of Housing and Community Renewal (DHCR) reported that as a result of recent flooding activities in 12 counties, and declaration of these counties as disaster areas, more funds ($375 million) have been funneled through DHCR to provide for new and rehabilitated low-income housing that is either lead abated or lead free. An additional $5 million from the Department of Housing and Community Renewal will allow for communities to relocate, as well as purchase floodplain property to be demolished and used for community sites. • Department of State reported that in September, New York State is introducing a proposal to add a sentence to the ICC code that says that deteriorated lead based paint shall be encapsulated or removed using approved lead safe work practices. New York State's Property Maintenance Code is based off the ICC code. • OTDA – Met with DOH to discuss how to get information to the client base. Currently, OTDA is examining including lead testing information in their client informational package as another area to add lead awareness. • Dr. Landrigan announced that the State Assembly Committee on Environment appropriated $200,000 to establish a network of Centers of Excellence in Children's Environmental Health, which would be academic clinic centers. These would see children with diseases of environmental origin, including lead, and would evaluate situations in which there was environmental exposure to determine if a disease occurred. The Centers of Excellence are based on the statewide network of Centers of Excellence for Occupational Medicine and the National	

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	Pediatric Enviromnental Health Centers.	
Public Comments	• No comments.	
Closing Comments	• Final announcement: Council members were provided with dates for the last meeting in 2006 and the three meeting dates in 2007. Council members were asked to examine the dates and contact the Department with issues. • Meeting adjourned at 2:45pm.	

NYS DEPARTMENT OF HEALTH
OCTOBER 23, 2006
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow Up
Attendees	**Council Members**: • Guthrie Birkhead, M.D., M.P.H., Director, Center for Community Health – Council Co-chair • Rolaine Antoine, Parent, Queens Village • Mary Binder, Environmental Analyst, Division of Housing and Community Renewal David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) • William Dorr, Assistant Director, Bureau of Early Childhood Services, NYS Office of Children and Family Services • Kimberly Galvin, Deputy Superintendent, NYS Insurance Department • Abby Greenberg, M.D., Director of Disease Control, Nassau County Health Department; Representative, American Academy of Pediatrics – Division II (Local Government) • Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY Buffalo (Professional Medical Organization) • Monica Kreshik, Esq., Environmental Justice Coordinator, Department of Environmental Conservation • Lindsay Lake Morgan, R.N., Ph.D., A.N.P., Assistant Professor, Decker School of Nursing, SUNY Binghamton (Education) • Ellen Migliore, R.N., M.S., Public Health Nurse, Herkimer County Health Department (Child Health Advocate) • Clifford Olin, President, EcoSpect, Inc. (Industry) • Robert Perez, Principal Undustrial Hygienist, NYS Department of Labor • Alicia Sullivan, Assistant Counsel, NYS Office of Temporary and Disability Assistance **Additional Attendees**: • Michael Cambridge, Director, Bureau of Community Environmental Health and Food Protection • Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection • Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health • Eileen Franko, Dr.P.H., M.P.H., Director, Bureau of Occupational Health • Barbara Leo, M.S., F.N.P., Program Manager, Childhood Lead Poisoning Prevention Program, Bureau of	

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	Child and Adolescent Health • Barbara McTague, Director, Division of Family Health • Bruce Phillips, Counsel, NYS Department of Health • Benjamin Wise, Public Health Specialist, Childhood Lead Poisoning Prevention Program, Bureau of Child and Adolescent Health • Patrick Parsons, Ph.D., Director, Lead Poisoning/Trace Elements Laboratory, Wadsworth Center **Absent Members** • Thomas Ferrante, Manager of Training and Technical Services, Total Safety Consulting (Labor Union) • Philip Landrigan, M.D., M.Sc., D.I.H., Director, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital) • Tom Mahar, Code Compliance Specialist III, NYS Department of State • Deborah Nagin, Director, New York City Department of Health & Mental Hygiene- Lead Poisoning Prevention Program • William S. Schur, Vice President of Schur Management Company, Ltd., (Real Estate) • Ronald Tramontano, Director, Center for Environmental Health-Council Co-Chair	
Welcome and Introductions: Dr. Birkhead	The meeting was convened at 10:13 a.m. • Dr. Birkhead opened the meeting and welcomed the members. • Dr. Birkhead initiated a roll call of the members and reviewed the meeting agenda.	
Review of minutes	Draft minutes of the August 24, 2006 Advisory Council meeting were reviewed. • Minutes accepted as provided.	
Center for Community Health (CCH) Update	Barbara Leo provided an update on the recently released lead data report and requested input from Council members on the next lead data report, currently under development. • The 2002-2003 supplemental data report was completed and sent to local health department Commissioners and Public Health Directors, lead program staff and regional office staff. The report is being posted to the Department's public website. • The update summarizes data on childhood blood lead levels in NYS for children under six years tested in 2002-2003 (excludes NYC data).	

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	• The supplemental data report demonstrated that both incidence and prevalence numbers and rates continue to decrease. • The new web-based lead registry, LeadWeb, provides a live data system in which the Department has access to current blood lead test result data across the state and counties have access to their own current data. The 2002-2003 data report supplement included the following indicators (all information is reported by county and statewide excluding NYC, unless otherwise noted): • **Screening:** At least one lead test by age 72 months and other time intervals (0 - <16 months; 16 - < 24 months; 24 - < 36 months; 36 - < 72 months). • **Prevalence**: Raw number and rate (per 100) of prevalent cases (BLL 10-19 mcg/dL and ≥ 20 mcg/dL). • **Incidence**: Raw number and rate (per 100) of newly identified cases (BLL 10-19 mcg/dL and ≥ 20 mcg/dL). • **Environmental Assessment**: numbers of children referred for environmental investigation with BLL ≥ 20 mcg/dL; number of dwellings investigated; number of dwellings identified with lead hazards; number of dwellings with satisfied notice and demands; number of dwellings investigated based on a child with BLL 10-19 mcg/dL, and number of field visits; all data reported by county, district office, NYC, and total New York State. Additionally, the previous comprehensive 2000-2001 data report provided the following additional information: • **Areas of High Risk:** information on high risk zip codes, identified as zip codes with an incidence rate of 5.0 (per 100) or greater (three times the state-wide incidence rate of 1.7 per 100 children) is provided to identify areas of high risk. • **Demographic Information**: included are statewide 2000 census data maps of percent of housing stock built pre-1950, as well as high incidence zip code specific data and county-wide data from these zip codes from the 2000 census: number and percent of houses built before 1950 (total, renter-occupied and owner-occupied), number of families with children under 5 years, and population and percent of families with children under 5 years living in poverty.	

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	Advisory Council Discussion: Input was requested from Advisory Council members for the 2004-2005 data report currently under development. The following questions were posed to the council members. 1.) What data currently reported is most useful, and what additional analyses would be most useful? 2.) How should high risk areas be defined? 3.) What analyses should be discontinued? • Dr. Broadbent asked why the 2004 or 2005 data are not available online, and also suggested that the department re-analyze current (2002-2003) data to produce high risk zip code data. He would also like to see the number of births, percent of children tested, and a more categorical breakdown of the lead levels (i.e., 2-4 mcg/dL, 5-9 mcg/dL, 10-14 mcg/dL, 15-19 mcg/dL, 20+ mcg/dL). Dr. de Long responded that data for 2004-2005 are being assessed for completeness and quality, and new algorithms to analyze the data are being developed. Ms. Leo added that the data reports typically have been developed in two-year blocks, based on birth year cohorts • Ms. Migliore stated that she would like to see the current 10-19 mcg/dL level split between 10-14 mcg/dL and 15-19 mcg/dL. She noted that the screening rates and prevalence rates are helpful. She suggested that additional housing statistics, such as pre-1978 housing stock may be useful, and finally commented that analysis of the correlation between housing stock and BLL, as well as the correlations between other risk factors and BLL may be helpful. Ms. Leo responded that with the deployment of the environmental health portion of LeadWeb, housing information for cases receiving environmental investigations will be available in the future. • Dr. Broadbent commented that screening rates at ages one and two years are not clear the way that data is reported. Ms. Leo responded that the Department's new (2004-2005) surveillance report will include additional indicators for lead screening at or around age 1, and again at or around age 2. Recent analysis conducted by the program to help develop these indicators demonstrates that lead screening tests peak between 9 and 17 months of age, and again between 18 and 27 months of age. Dr. Broadbent also asked if there was value in presenting data for other years that are not required or recommended unless it is medically indicated (e.g., screening rates at 3, 4, or 5-years of age). • Dr. Broadbent noted that information about suburban and urban testing performance data would be	

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	useful; using the census tract information would be ideal, although zip code information would suffice. Ms. Leo noted that the 2002-2003 data report was produced as a brief supplement to the comprehensive 2000-2001 report, so it did not include zip code data. Future reports will continue to assess areas of high risk. She noted that when identifying areas of high risk, neighborhood or individual residence-level data can not be reported, to protect the privacy of individual children. Mr. Dorr noted that Office of Children and Family Services (OCFS) will be able to use high risk data to guide targeted communication and education to child care providers in these areas. • Ms. Migliore asked how the department determines whether a child with elevated blood lead levels is low income. Ms. Leo replied that insurance provider or income level is not a required laboratory reporting field, but we have done and will continue to perform data matches with the Medicaid databases to identify the screening status of children enrolled in Medicaid. In the future this may be used to provide the managed care organizations with a list of the children in their plan not screened for blood lead tests as required by NYS regulations. • Dr. Broadbent suggested that a link to the New York City Department of Health and Mental Hygiene (NYCDOH&MH) website should be created on the NYSDOH Childhood Lead Poisoning Prevention Program's (CLPPP's) web page and vice versa. • Council members agreed that incidence and prevalence data and housing stock information are both important to defining high-risk areas, particularly with the emphasis on primary housing-based prevention. Information provided by census tract or zip code would help identify specific areas that have a higher likelihood to contain lead hazards. • Dr. Broadbent noted that aggregate data (for example, the total number of children tested for lead in 2001-2002) is less useful than data broken down more discretely.	
Center for Environmental Health (CEH) Update	Thomas Carroll presented on recent collaborative activities led by the Center for Environmental Health. • Developing interagency activities has continued to be a major focus of the elimination plan implementation. • CEH is working with the Office of Children and Family Services (OCFS) and the State University of New York (SUNY) Training Strategies Group to develop training videos on childhood lead poisoning prevention for day care providers. • CEH is working with LHDs and local child and family services to examine foster homes.	

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	Currently, some counties inspect foster care settings for lead hazards before a child is placed within the dwelling. CEH is interesting in assessing what works for these counties, and what issues they have had. • Four new federal HUD grants were recently awarded (see attached information) for $10.8 million, including nearly 1,000 units for abatement. One grantee (Andrew McLellan of Lead Connections) is working to increase the number of certified lead abatement firms and contractors, and is targeting four western NY cities to educate these groups on the advantages of certification and using certified workers to conduct abatement. • CEH coordinates a HUD grantees group that is discussing ways to improve operations and methods (best practices) for grant activities. HUD represents the largest pool of resources to abate lead hazards in housing in New York State. • The environmental portion of the new LeadWeb system is operational. Training has been provided to county and district office environmental staff. CEH has been working with counties to ensure that data is entered properly. Additionally, CEH plans to incorporate historical information into the system in the near future. CEH is currently reviewing features and reports for LHDs, including legal documents and GIS mapping. • CEH is participating with the Environmental Public Health Tracking Grant (EPHTG) to link existing environmental health datasets in order to examine various environmental health problems in ways that have previously been unavailable. CEH is particularly interested in a link with real property databases to generate more reliable maps and information. CEH has begun to meet with EPHTG staff to facilitate connecting LeadWeb with other environmental databases. • CEH continues to work to evaluate the lead and asthma components of the Healthy Neighborhood Program (HNP). A training meeting was held for all HNP's in October 2006. HNP is also developing a new data system with scannable forms to reduce data entry work. Staff are hoping to be able to examine data from new perspectives to provide further guidance on program activities. • CEH staff attended a CDC Partners Conference, in which using Medicaid reimbursement for environmental inspections, Healthy Neighborhoods Program and the Healthy Homes concept were emphasized. • CEH attended a Children's Environmental Health Symposium, which is developing a childhood	

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	environmental health advisory council. • CEH continues work with NYCDOH&MH to ensure that any changes to Subpart 67-2 would not conflict with NYC's Local Law 1. Additionally, CEH is working with other stakeholders to obtain their feedback regarding proposed amendments to Subpart 67-2. **Comments from the Advisory Council:** • Ms. Migliore asked if the HUD grants were used to rehabilitate existing structures, or to provide for new construction. Mr. Carroll responded that each grant's activities vary, but always provide rehabilitation for existing structures. Variations occur in the level of rehabilitation (abatement or interim controls), target housing (Section 8 housing, all at-risk housing, etc.), but are provided to high-risk residential dwellings. • Dr. Broadbent asked what is done when lead hazards are found during Healthy Neighborhoods Program inspections. Mr. Carroll responded that problems are referred to the appropriate agency/agencies. Additionally, Healthy Neighborhoods Program staff help tenants find services as needed. • Dr. Broadbent also asked if there was any effectiveness data on the HNP referral process. Mr. Carroll responded that previous evaluation of the asthma-related interventions of HNP demonstrated that the interventions are very cost-effective. Additionally, preliminary data on the lead components of HNP show good compliance within 90 days, and similar cost-effectiveness. • Dr. Broadbent asked if more children with elevated blood lead levels would receive environmental interventions. Dr. de Long noted that the regulatory changes being considered include a possible proposal to lower the blood lead level that initiates an environmental action. • Mr. Dorr asked why some high-risk zip codes identified in the 2000-2001 annual report do not appear to have HUD grants. Mr. Carroll responded that local governments need to apply for the grants, and some governments do not apply because the application process and workload are challenging. The local governments must initiate the grant application process, but the state provides data and technical support. • Dr. Birkhead asked for more information about the environmental public health tracking grant system. Mr. Carroll responded that this project is still in the early stages of development. Currently, the real property dataset appears most likely to be useful. The data system will be able to match addresses for houses in joint datasets. Geocoding information can help with mapping and analysis by geographical region. Additional information, such as source of water supply, is also available, to provide a more complete picture of the	

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	area. • Dr. Broadbent added that there are lots of data and technology available for mapping, and that the Advisory Council can help provide ongoing input. Mr. Carroll added that the largest challenge is linking different databases. Additionally, the system has to be designed to be specific without identifying individual children.	
	Bureau of Occupational Health (BOH): Dr. Franko provided an update on recent activities within the Bureau of Occupational Health. • LHDs in the Capital Region have requested that the code officer training be conducted. Fulton and Montgomery counties plan to receive a joint training in the future. A training session was held in Kingston with 62 officers; a Herkimer training had five officers and other interested community members, including a county legislator and property managers. The legislator felt that she learned a lot about codes. • **Training evaluation:** Approximately 800 attendees have provided evaluation data. BOH is drafting a report of the training evaluation. Additional code officer trainings offered by the BOH director**:** • Training was conducted in Minneapolis, Minnesota, for the Journal of Light Construction. This event had more than 10,000 attendees. • At this training, BOH staff did an assessment of educational tools to figure out what helps people get their information about safety and health issues, and what type of messages we should give them. Participants received a one-page fact sheet with "fact/fiction"- style information, and provided feedback about the sheet. **Interventions for Pregnant Women**: • BOH recently reduced the blood lead level triggering follow-up interventions for pregnant women. Currently, all women of childbearing age (16-45) with BLL $\geq$ 15 mcg/dL are contacted, compared to the previous action level of 25 mcg/dL. **Current investigations of interest**: • An Onondaga County Office Building was recently contaminated with lead from rehabilitation work. Over 100 personnel were tested; only one employee had elevated BLL (27 mcg/dL), but also had outside	

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	potential sources of exposure (from herbal medicines). Improper abatement can result in elevated blood lead levels. • A retired Nassau County resident initially was identified with a blood lead level of 100 mcg/dL, with two follow up blood lead levels at 82 mcg/dL and 54 mcg/dL. Source examination resulted in no typical sources. BOH worked with Nassau County Department of Health in the person's home. They found Jambrulin, an ethnic medicine, with 18,800 ppm of lead that comes from India. In this case Jambrulin was taken for diabetes and contained high levels of lead. • A developmentally disabled person swallowed a 4 cm. medallion, and resulted in an EBLL of 60 mcg/dL. The medallion is being tested; county officials are trying to identify other possible source. **Industry evaluation:** • BOH is currently performing site visits to conduct environmental sampling of electronics recycling businesses. The primary focus is to examine if the destruction of CRT (cathode ray tube) monitors (i.e. televisions, older computer monitors) produce high levels of lead contamination at landfills. BOH is concurrently developing controls to identify where contamination came from. **Comments from the Advisory Council:** • Ms. Migliore commented that the code enforcement officer training is a great experience, and is useful for a wide variety of professionals and policy-makers. • Dr. Hunter asked whether there was follow-up done for the interviews with pregnant women, to see if the interventions were effective in reducing or preventing placental transmission of high blood lead levels. Dr. Franko responded that any adult with a BLL of 20-25 receives a follow-up contact to identify potential sources, occupational exposures, and other risks. Women of childbearing age with BLL 15 or greater receive the same follow-up services. Additionally, environmental staff goes to worksites to identify the actual source. BOH does not have the regulatory authority to enter or assess the home for exposure sources, but does provide education. With regard to occupational sources, BOH follows up with the employer to remove the source, with potential Occupational Safety and Health Administration (OSHA)	

Topics/Speaker	Discussion	Follow Up
	follow-up. BOH also provides the employer with information and follow up to ensure the removal of any exposure source.	
Presentation of Lead Poisoning Coalition Outreach Initiatives	Ben Wise presented the materials developed by the five coalitions funded through the Centers for Disease Control (CDC) Childhood Lead Poisoning Prevention Program Cooperative Agreement. • Five existing coalitions in areas of high-risk were awarded one-time funding of $28,000 each to perform a needs assessment and implement an intervention in their community. Department staff provided technical assistance and guidance during the contract cycle. • Representatives from the five coalitions, as well as Department staff met to discuss their experiences and share their projects on June 26, 2006. The **Syracuse Regional Lead Task Force** developed an intervention to serve the high-risk zip codes of 13204 and 13205, in the City of Syracuse. The coalition teamed up with community organizations in the two zip codes – the Dunbar Association and La Liga – to conduct a neighborhood outreach campaign. Staff from these two organizations planned the intervention and trained and educated community volunteers. These volunteers gathered information from several hundred residents about knowledge and perceived hazard of lead through door-to-door interviews within the identified zip codes. The staff and volunteers identified several barriers, including the short timeframe for the project, a lack of community support and lack of community participation. They also noted that unannounced visitors were often met with apprehension or suspicion, and that while many community members knew about lead poisoning, they placed it low on their priority of needs or concerns. The **Capital District Coalition for Lead Safety** serves the target communities of Albany, Schenectady, Troy, Fort Plain and Gloversville. This coalition developed a public service announcement (PSA) to increase public knowledge of childhood lead poisoning and the importance of screening blood lead testing at ages one and two. They noted that high-risk areas have a greater than statewide average of housing stock built before 1950, as well as more persons living in poverty. These two risk factors predispose children to lead poisoning. The coalition developed a thirty-second PSA to address lead poisoning prevention and screening at one and two years of age. This PSA was aired over a sixteen week period, with a target audience of parents of infants	

Topics/Speaker	Discussion	Follow Up
	and toddlers. The PSA was also aired on local TV and on the coalition's website. This PSA was shown at the Advisory Council. The **Safe Housing Coalition of Central New York** serves the City of Utica. This coalition wanted to increase community awareness, education and training, on the dangers of childhood lead poisoning and ways to reduce its prevalence. The coalition performed a needs assessment, and noted that property owners lacked proper knowledge regarding maintenance standards and effective techniques for upkeep and removal of peeling and chipping paint. The coalition also identified that health care providers needed additional education and awareness of the NYS regulations and the rationale for universal screening. The coalition provided lead safe work practices training to rental property owners on a monthly basis in the target area during the grant period. Additionally, the coalition offered training to health care providers on lead testing regulations, need for universal screening, common exposure sources, and steps for risk reduction. Additionally, the coalition developed a PSA, which was aired on local television stations. This PSA was shown at the Advisory Council meeting. The **Coalition to Prevent Lead Poisoning** serves the Rochester area. The purpose of their grant was to provide leadership and advocacy using a collaborative approach, and focusing on primary prevention. The coalition identified that the community needed increased knowledge about lead paint poisoning, particularly among expecting parents and new mothers. The coalition developed a ten-minute video in English, Spanish and American Sign Language, entitled "Lead Awareness for Parents". The video provides a general overview on lead hazards, highlights the importance of getting children tested, potential household dangers, nutrition, and interim lead controls. The video will be distributed on DVD to health care professionals, community groups, community members and businesses, and the CPLP public forum, and is available as a streaming video on the coalition website. This video was shown at the Advisory Council meeting.	

Topics/Speaker	Discussion	Follow Up
	The **Western New York Lead Coalition** serves the target communities of Buffalo, Niagara Falls and Penn Yan. The coalition aimed to develop a primary prevention model to eliminate childhood lead poisoning, focusing on the environmental and health issues by identifying and eliminating barriers and sharing resources, educational opportunities, and networking. The coalition identified the community need to improve blood lead screening rates of children at ages one and two, by providing information to health care providers in the service area. The coalition distributed a needs assessment questionnaire to approximately 800 physicians in the Western NY area; a copy of the questionnaire was provided to council members. These questions were designed to evaluate the physicians' perceptions of lead testing and their preferred format for a teaching tool. The resultant product, a DVD, focused on the need for lead testing for children at ages one and two. This product will be disseminated after production. The pre-production video was shown at the Advisory Council meeting. **Comments from the Advisory Council:** • Dr. Broadbent commented that there needs to be a clear distinction between the words "screening" and "testing" because of confusion in the definition of the word screening, and that materials should avoid overstating the case. Additionally, educational and training materials should avoid the concept of a "safe level" when talking about lower levels of lead and the potential effects. He added that the coalitions should try to assess the measure of effect through post-distribution data analysis. The coalitions should provide more information about fees and/or insurance company reimbursement to PCPs, as well as the availability of in-office testing, as applicable. Finally, he asked if these materials could be distributed to the Advisory Council members. • Ms. Antoine added her opinion that the Rochester Coalition to Prevent Lead Poisoning materials were not very convincing for health care providers, and that the Western NY piece seemed too long for primary care providers (PCPs) to sit through, particularly with no interaction to discuss the materials. Mr. Wise noted that the intended audience for the Rochester coalition was parents and community groups, as well as PCP offices to be shown in waiting room televisions. • Dr. Hunter noted that providers other than health care providers would be appropriate audiences for these materials, and asked if these materials were shown in front of focus groups. Dr. de Long responded that the	**Department staff are following up with coalitions about getting additional copies of the DVDs for interested Council members.**

Topics/Speaker	Discussion	Follow Up
	coalitions had a short timeframe in which to develop these products, generally less than 6 months. Additionally, the goal was for the coalitions to use local information to tailor it to their communities. • Dr. Broadbent asked if this one-time funding could be repeated in the future. Dr. de Long noted that the funding source for these projects came from the CDC CLPPP cooperative agreement, which was decreased this year across all states. The Department continues to support a dedicated field staff to provide technical support for local partnership building, including work with coalitions.	
Presentation And Discussion Of Lead Screening Topics	Dr. Patrick Parsons presented on the acceptability criteria for the determination of lead in blood. • Lab Performance Standards • Human Exposure to Lead • Newer Office-based Testing • Dr. Parsons discussed the criteria used to determine acceptable level of lead in blood. Historically, multiple biological monitoring tools have been used, including blood lead, erythrocyte protoporphyrin (EP), urine lead, plasma lead, tooth lead and bone lead. Blood lead is currently the standard of lead level analysis. EP is no longer considered sensitive enough to predict lower levels of lead exposure, but still has value for medical management of children with highly elevated blood lead levels. Urine lead is subject to fluctuations and is not recommended. Plasma lead is used in research only, and may represent the true portion of toxic lead. Tooth and bone lead levels are used only in research to measure long-term cumulative exposure. • Technologies to detect lead concentrations have changed drastically, and have allowed for detection at lower levels with smaller blood samples. The current method of analysis is based on atomic absorption spectrometry, initially developed for blood lead testing in 1970. • Anodic stripping voltimetry (ASV) technology was developed in the mid-1980's; this technology is the basis for LeadCare and LeadCare II hand-held point-of-care screening. • Today, inductively coupled plasma mass spectrometry (ICP-MS) technology is considered state-of-the-art, and can identify specific isotopes and yield information on isotope ratios to identify exposure sources.	

Topics/Speaker	Discussion	Follow Up
	Federal Certification Issues • All clinical labs must be certified under Clinical Laboratory Improvement Amendments of 1988 (CLIA '88), and must participate in an approved proficiency testing (PT) program for blood lead. • New York State laboratory certification for blood lead analysis requires that labs must be proficient in determining blood lead levels within either ± 4 mcg/dL or ± 10% of the target value, whichever error range is greater. • Occupational testing, regulated by OSHA, use different acceptability criteria for proficiency testing. Under OSHA criteria, laboratories may report on PT samples that are within ± 6 mcg/dL or ± 15% of the target range, whichever is greater. **NYS Certification Issues** • Labs that test clinical specimens originating from within NYS must have a NYS lab permit (including out-of-state labs). Permits contain specialties (including toxicology: blood lead, trace elements). Issuance of a permit requires successful participation in NYS Proficiency Testing (PT) program and a satisfactory on-site visit. New York is the only state with published standards for blood lead tests. • The New York State Proficiency Standards are as follows: a laboratory must pass at least four of five specimen samples (≥ 80%) in at least two of three consecutive test events, within ± 4 mcg/dL or 10% in order to participate in patient testing. Under this model, a lab can pass/pass/fail and continue to work. • International proficiency testing varies, but all have stricter ranges for proficiency testing (i.e., the European Union considers a test acceptable within ± 3 mcg/dL). • The National Committee for Clinical Laboratory Standards recommends that the acceptable criterion for BLL performance testing at 10 mcg/dL be reduced to ± 2 mcg/dL. **Background of NYS Proficiency Testing Program** • Program was instituted in 1973 for blood lead and erythrocyte protoporphyrin. Samples are obtained from lead-dosed goats, which provide biologically equivalent bound lead. In 2001, the PT program was expanded to include mercury, arsenic and cadmium. • Currently, 105 labs participate in the program, including 10 independent labs. These labs are certified for NYS, CLIA, OSHA, and other state purposes.	

Topics/Speaker	Discussion	Follow Up
	Current questions to address for changing the current limits for blood lead • In order to change the current limits for blood lead testing, several issues must be resolved, including the technological capability to detect smaller amounts of blood lead and/or detect blood lead more accurately; the capacity for labs to adapt their analytical techniques and detection instruments to meet the new standards, and the capacity of all labs to test additional samples if some labs do not pass stricter PT protocol. • Previous experience from the last limit change suggests an initial decrease in performance, but performance returns to high performance with initial variability, but eventual high compliance/performance. Currently, a majority of labs are performing above the current proficiency standards of ± 4 mcg/dL in their performance tests. • The federal recommendation is to support the adoption of a phased approach, starting with a ± 3 mcg/dL criterion consistent with the European Union. The next phase would revisit the impact of the short-term change to see if improvements have started and whether to adopt a stricter standard of ± 2 mcg/dL. • There are potential issues with changing the current limits for blood lead proficiency. LeadCare I devices may not meet the stricter standards, and LeadCare II users are exempt from CLIA proficiency testing. User education would be needed to reiterate the limitations of these technologies. **Comments from the Advisory Council:** • Dr. Broadbent asked about the cost of moving ahead of the standards. Dr. Parsons responded that previously, proficiency testing programs had different standards; in 1990, NYS set a tighter PT standard (± 4 mcg/dL) than was permissible under CLIA at the time (± 6 mcg/dL). Initially, there was resistance to more stringent standards, but other labs supported the stricter standards, and eventually these were adopted by CLIA. Since most labs were already operating at a more stringent level, there was no significant cost issue. A minority of laboratories either upgraded their instrumentation or modified their procedures to meet the new standards. Wadsworth Center provided guidance and technical assistance for day-to-day laboratory operations. • Dr. Broadbent asked how laboratories would or could address an intervention threshold level of 5 mcg/dL. Dr. Parsons said that this threshold would raise the question of whether laboratories or current technologies could identify children with this range (5-9 mcg/dL) of blood lead with adequate accuracy and precision.	

Topics/Speaker	Discussion	Follow Up
	Some techniques may not produce reliable data at 5 mcg/dL. Additionally, contamination errors are more likely to be significant at lower blood lead concentrations. He also questioned what interventions would be recommended for children with BLLs 5-10 mcg/dL, and how primary care providers or educators should talk with parents about BLLs for which considerable uncertainty exist in the actual number. • Ms. Migliore asked how labs reported non-integer results. Dr. Parsons responded that proficiency testing program test results must be reported in integer format only. Although it is feasible with some analytical techniques to report BLLs to the nearest 0.1 mcg/dL, most methods lack the analytical precision necessary to justify such reporting, especially when, as is the case in most commercial labs, just a single measurement is performed. • Dr. Broadbent noted that there are in-office testing schemes, and questioned what Dr. Parsons' opinion was on this. Dr. Parsons responded that currently there are ESA-developed instruments for in-office testing. These devices are not as accurate as other technologies; while point-of-care screening allows the care provider to begin intervention and education immediately, the results are not intended to be used for diagnosis. **Role of External Quality Assessment Schemes (EQAS): Detecting problems with Specific Testing** • ESA LeadCare Analyzer uses portable anodic stripping voltammetry technology. It requires a reagent treatment to decomplex the lead from red blood cells. Analysis takes 5-6 minutes to complete, for each sample. The machine is calibrated with an electronic "key" specific to each batch of test strips. • The advantages of this device are that it is moderately complex but easy to use; can be used in doctor's office; provides rapid results; is relatively low cost (approx. $2,200 per unit); and has low power requirements. • The disadvantages of the device are that accurate testing relies on fresh blood (< 24 hours old) that hasn't been refrigerated – old or refrigerated blood produces erroneously low results; glutathione levels cause interference; sensor lots vary in quality; and precision and accuracy are minimally acceptable (within 4 mcg/dL). Additional issues may occur with proficiency testing. Many testing programs (not including NYS) use "peer group means" which may mask issues with quality of testing results. PT programs generally use frozen blood. In response, NYS uses lead-dosed animal blood shipped immediately and received by the lab within 24 hours.	

Topics/Speaker	Discussion	Follow Up

	Case Study – Identifying LeadCare I Analysis Issues
	• Data analysis of New York State proficiency testing identified a negative bias of LeadCare I-tested blood samples with results ≥ 10 mcg/dL. The bias for samples < 10 mcg/dL fell within acceptable error ranges, but elevated samples were reported lower than the reference blood lead level.
	  • In order to assess this problem, Wadsworth Laboratories tested human adult blood samples poisoned through occupational exposures, to verify that the negative bias was not unique to goat blood.
	  • Wadsworth Laboratories contacted ESA, Inc (the manufacturers of LeadCare I) to notify them of the error.
	  • Wadsworth Laboratories and Wisconsin's state labs jointly conducted an investigation with human blood, again demonstrating a statistically significant negative bias.
	  • ESA, Inc. reviewed the data and requested additional studies for verification. Based on these studies, ESA, Inc. issued a recall on specific LeadCare I sensor lots. Wadsworth Laboratories temporarily placed a reporting restriction, requiring that results be reported as either < 10 mcg/dL or ≥ 10 mcg/dL. ESA, Inc. requested that all children identified with blood lead levels of ≥ 6 mcg/dL tested with faulty sensors be retested.
	  • Subsequent analysis has demonstrated that new sensor lots are more accurate. Wadsworth Laboratories has lifted the reporting restrictions.
	  • Wadsworth Laboratories issued a recommendation that laboratories use caution when using 'peer group grading' – a method of data analysis that is commonly used by proficiency testing agencies (for example, Wisconsin's PT program did not detect the negative bias because they saw all of the samples with negative bias as "true" results).
	
	LeadCare II
	• LeadCare II has been developed and is available for purchase. The device is CLIA-waived and is exempt from proficiency testing. Studies demonstrate that 98% of tests reported are within OSHA limits (± 6 mcg/dL) which leaves open the question the question of how well it performs under CLIA's more stringent criteria of ± 4 mcg/dL.	

Topics/Speaker	Discussion	Follow Up
	Comments from the Advisory Council: • Dr. Birkhead asked if the LeadCare II system was able to be used in New York. Dr. Parsons stated that physician labs can use LeadCare II without proficiency testing, but must register with the Federal physician office lab program through Wadsworth. Certified labs would have to notify Wadsworth of any methodological changes and would be required to participate in the State proficiency testing program for blood lead. Under the CLIA waiver, all LeadCare II users must follow the manufacturer's instruction regarding rest $\geq$ 10 mcg/dL. Elevated test results must be confirmed by sending the sample to a reference laboratory for confirmatory testing using a different method. Mandatory reporting to NYS under Regulations Part 67-3 is still ambiguous as regulations do not specifically cover physician office laboratories. • Dr. Birkhead asked if the CLIA 88 standard level is reduced to 3 mcg/dL, would LeadCare II meet the requirement for testing. Dr. Parsons responded that research on the level of accuracy within 4 mcg/dL has not been conducted, but believes that the machine performs adequately up to 10 mcg/dL, and is fit for screening but not as a reference technique. • Ms. Binder asked if the shipment of blood samples from Wisconsin (36 hours) could have negatively affected their study. Dr. Parsons stated that there was no indication that the extra time would have impacted the testing. Additionally, Wisconsin sent blood through an IRB-reviewed partnership/agreement. • Dr. Broadbent asked what percent of tests in New York come from in-office labs. Dr. de Long responded that there are currently 20 offices using LeadCare I. The lead program is cautiously optimistic about the role of LeadCare II, but is concerned about the limitations of reporting and appropriate use of LeadCare II as a screening tool only. The Department is establishing an internal ad-hoc committee to examine the results. • Dr. Broadbent added that losing access to data sounds like a potential draw-back. Dr. de Long stated that the Department is currently examining what authority that the Department has to require reporting. • Dr. Greenberg commented that with physicians known to be negligent in reporting, how will in-office screen testing be regulated? Physicians would/should still be good at reporting elevated blood lead levels. Would block reporting be an issue. Dr. de Long responded that these were issues that would have to be examined while developing future interventions.	

Topics/Speaker	Discussion	Follow Up
Other State Agency Update or New Business-General Advisory Council Discussion	• **Office of Temporary and Disability Assistance (OTDA)**: OTDA is currently reviewing client books; copies were provided to Council members. The books are distributed to all applicants of any temporary or emergency assistance programs. In books 2 and 3, there are potential areas to include lead messages. OTDA would like to work with DOH to suggest language changes. • **Office of Child and Family Services (OCFS)**: OCFS is currently working with DOH and SUNY Training Strategies Group to provide information and resource information to child care providers, including video information trainings. • **Department of Housing** – A new award cycle of grants was issued in October. • **All other state agencies reported no new business**.	
Additional Comments from the Advisory Council	• Dr. Greenberg requested that letters to health care providers be brief, and attachments be used to further explain information. She also mentioned that she would like to see lead testing as part of the early intervention forms. • Dr. Broadbent commented that medical association groups still view lead as a moderately low priority. Dr. Broadbent stated that there needs to be an increased demand for concern about lead. He added that school educators or administrators could assist with relaying lead poisoning prevention messages. Finally, he commented that health care provider apathy is a key challenge. • Ms. Morgan noted that rural communities are often missed in many state initiatives, primarily due to allocation of resources. Housing stock and poverty are equally detrimental in rural areas. We need to be creative in how to address screening and testing, both of which she believes are lower in rural areas. Additionally, we should analyze how to increase funds in order to support environmental initiatives.	
Public Comments	No public comments were offered. The meeting was adjourned at 2:40 p.m.	

Appendix C

2007 Advisory Council Meeting Minutes

March 15, 2007
June 15, 2007
September 10, 2007

NYS DEPARTMENT OF HEALTH
MARCH 15, 2007
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow Up
Attendees	**Council Members**: • Guthrie Birkhead, M.D., M.P.H., Director, Center for Community Health – **Council Co-chair** • Ronald Tramontano, Director, Center for Environmental Health – **Council Co-Chair** • Mary Binder, Environmental Analyst, Division of Housing and Community Renewal (Commissioner Designee) • David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) William Dorr, Assistant Director, Bureau of Early Childhood Services, NYS Office of Children and Family Services (Commissioner Designee) • Monica Kreshik, Esq., Environmental Justice Coordinator, Department of Environmental Conservation • Tom Mahar, Code Compliance Specialist III, NYS Department of State (Adjunct Designee) • Ellen Migliore, R.N., M.S., Public Health Nurse, Herkimer County Health Department (Child Health Advocate) • Deborah Nagin, Director, New York City Department of Health & Mental Hygiene- Lead Poisoning Prevention Program (Adjunct Designee) • Clifford Olin, President, EcoSpect, Inc. (Industry) • Alicia Sullivan, Assistant Counsel, NYS Office of Temporary and Disability Assistance (Commissioner Designee) **Additional Attendees**: • Michael Cambridge, Director, Bureau of Community Environmental Health and Food Protection • Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection • Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health • Eileen Franko, Dr.P.H., M.P.H., Director, Bureau of Occupational Health • Barbara Leo, M.S., F.N.P., Program Manager, Childhood Lead Poisoning Prevention Program, Bureau of Child and Adolescent Health • Barbara McTague, Director, Division of Family Health • Bruce Phillips, Counsel, NYS Department of Health • Barbara Wigzell, Director, Office of Community Development, Division of Housing and Community Renewal • Nancy Kim, Ph.D., Director, Division of Environmental Health Assessment, NYS Department of Health **Absent Members** • Rolaine Antoine, Queens Village (Parent Representative) • Thomas Ferrante, Manager of Training and Technical Services, Total Safety Consulting (Labor Union) • Kimberly Galvin, Deputy Superintendent, NYS Insurance Department (Adjunct Designee)	

Topics/Speaker	Discussion	Follow Up
	• Abby Greenberg, M.D., Director of Disease Control, Nassau County Health Department; Representative, American Academy of Pediatrics – Division II (Local Government) • Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY Buffalo (Professional Medical Organization) • Philip Landrigan, M.D., M.Sc., D.I.H., Director, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital) • Lindsay Lake Morgan, R.N., Ph.D., A.N.P., Assistant Professor, Decker School of Nursing, SUNY Binghamton (Education) • Robert Perez, Principal Industrial Hygienist, NYS Department of Labor (Commissioner Designee) • William S. Schur, Vice President of Schur Management Company, Ltd., (Real Estate)	
Welcome and Introductions: Dr. Birkhead	• The meeting was convened at 10:20 a.m. • Dr. Birkhead opened the meeting and welcomed the council members. • Dr. Birkhead initiated a roll call of the members and reviewed the meeting agenda.	
Review of minutes	• Review of minutes from the October 23, 2006 Advisory Council meeting was postponed because several council members were absent. Members were e-mailed on March 19, 2007, to provide electronic comments, and to vote on passing of the minutes.	Minutes approved by Council members.
Center for Community Health (CCH) Update: Barbara Leo, M.S., F.N.P.	Barbara Leo provided an update on CCH activities: • The continuation application was submitted for year two of the Childhood Lead Poisoning Prevention Programs Cooperative Agreement with the Centers for Disease Control and Prevention (CDC). The application includes a continued emphasis on improving surveillance, screening rates, and education, and a strong emphasis on primary prevention, and developing and strengthening strategic partnerships. CDC has notified all state programs that there is a decrease in year two funding of 2.5%; this represents the second consecutive decrease in funding for the Childhood Lead Poisoning Prevention Program (CLPPP). • Enhancements continue to be made in the electronic lead data registry, LeadWeb. Input from local health departments has been sought in the development of new reports and improvements to existing reports. A report to identify children due for their second blood lead screening test is now available, as well as a report of children due for follow-up testing. A report is under development to allow counties to produce a summary report of county-specific data by blood lead levels. • A new data analysis plan for 2004-2005 is currently under development. We have incorporated many of the recommendations suggested by Council members at the October 23, 2006 Advisory Council meeting. These recommendations include the development of algorithms to identify screening rates for children at age one year and again at age two years, and an analysis of the incidence and prevalence for blood lead levels < 5 mcg/dL and	

Topics/Speaker	Discussion	Follow Up
	5-9 mcg/dL. New geocoding software has been purchased to analyze data to the census tract level in high risk communities. • Changes to regulation Subparts 67-1 and 67-3 are under discussion. Potential changes include lowering the environmental intervention trigger to 15 mcg/dL, clarifying case management protocols for children over 6 years of age; and requiring confirmation of all finger stick blood draws ≥ 10 mcg/dL to be consistent with current CDC guidelines. • An internal work group has been convened to review the technical aspects, quality of results and the oversight of reporting for LeadCare II. Members include representatives from Medicaid, Wadsworth Laboratory, Office of Health Insurance Programs (OHIP), Bureau of Occupational Health (BOH), Division of Legal Affairs, Electronic Clinical Laboratory Reporting System (ECLRS) and Local Health Services (LHS). A working proposal for guidelines on appropriate use and testing has been drafted and shared with the work group for further development. Discussions have been held with staff from the New York State Immunization Registry to explore incorporating lead testing information into the registry. • There has been continued collaboration with the Office of Children and Family Services (OCFS) to promote lead screening of young children. A joint letter signed by OCFS and DOH has been mailed to upstate child care providers to increase awareness of their role in promoting lead testing for children. Included in the letters are samples of educational brochures, and an order form for these materials. The letter has been shared with New York City to develop a future mailing to New York City child care providers. • The program has provided a letter of support for the application of the Office of Refugee and Immigration Services' (ORIS) proposal for an Environmental Protection Agency targeted grant to reduce childhood lead poisoning. The program will continue to work with ORIS to help address the development of lead related materials. • Program has begun development of a toolkit designed to provide health care providers with resource materials to promote risk assessment of children for lead and screening of all children at age one year and again at age two years. A literature review on best practices has been completed. Collaboration with the New York State chapters of the American Academy of Pediatrics (AAP) and American Academy of Family Practitioners (AAFP) will be done to conduct focus groups and assist us in identifying learning needs and preferred educational methods of practitioners. • In December 2006, an article on childhood lead poisoning prevention and lead screening was published in the NYS Office of Medicaid Management newsletter, *Medicaid Update*. This newsletter is sent to over 42,000 medical practitioners and facilities in NYS. • Program is currently updating several educational materials: the *Lead Poisoning Prevention Guidelines for*	Provide Medicaid Update to Council Members.

Topics/Speaker	Discussion	Follow Up
	Obstetricians and Gynecologists are being updated and will be disseminated to all prenatal care providers when completed along with a joint letter signed by the Commissioner of Health and the president of the NYS Chapter of the American College of Obstetricians and Gynecologists (ACOG). The program has finalized the content for the pregnancy and childhood lead brochures, and is working with the department to approve the design. It is anticipated that these brochures will be available in spring/summer 2007. The brochures are developed at a 3rd grade reading level, and will be produced in English and Spanish. The program is also developing folders to be used by local health departments for public health detailing with health care providers. These folders will have the same design branding as the child brochures. • Program has revised the local health department (LHD) work plan template, which will realign the work of LHDs to more closely match nursing and environmental staff activities with NYS Lead Elimination Plan. The work plan is designed to obtain specific measurable activities, related to surveillance, screening, case management and primary prevention. • A Second Annual Meeting of the local health department childhood lead poisoning prevention programs is being planned for June 2007. The meeting will include national and state speakers, and includes discussions and workshops on topics such as working with community-based organizations, strategies for outreaching to health care providers, healthy housing, and GIS mapping in high-risk communities. The agenda was developed from county input and evaluations from last year's meeting. **Comments from the Advisory Council:** • Ms. Nagin asked for clarification of the comment on case management for children over six years of age. Ms. Leo responded that there has been some confusion by local health departments as to whether or not LHDs need to follow children older than six years with elevated blood lead levels. In regard to the statement of whether regulation changes are being considered for environmental case management for children with elevated blood lead levels $\geq$ 15 mcg/dL, Ms. Nagin noted that New York City's 2004 regulation change to include children with blood lead levels greater than 15 mcg/dL almost doubled their caseload, providing services to more children. • Dr. Broadbent asked if the CDC Continuation Grant application for year 2 could be distributed to the Council members. Ms. Leo replied that the application has not yet been approved by the CDC, but a copy will be provided to the Council members once it is approved. • Dr. Broadbent noted that he has heard that it is difficult to get timely data reports. Dr. de Long responded that the Department can not release any data until it has been verified. The new web-based data system, LeadWeb, will allow program to produce and release data more closely to real-time. A report is currently in development which will allow local health departments to access county-specific data. • Dr. Broadbent noted that the operational definitions for screening vary by jurisdiction (e.g., Rochester's definition	Program will provide Council members with samples of educational brochures upon publication. Program will provide Council members with copy of grant application final work plan.

Topics/Speaker	Discussion	Follow Up

	of 'at or around age one' is different from the state), which limits the ability to compare data. Dr. de Long noted that there are many considerations in developing data definitions, and also explained that the sources of data used (e.g., census data, birth cohort) may account for such variability. Program staff are available to discuss data analysis criteria with the Monroe County Health Department, if desired.
	• Dr. Broadbent provided three hand-outs for the Council members and attendees:
	  • A draft resolution to be introduced to the Medical Society of the State of New York, calling for a more proactive approach to childhood blood lead screening;
	  • A letter from the Coalition to Prevent Lead Poisoning to health care providers in the Rochester area, with an attached flyer for parents to educate them about reducing exposure risk for children with blood lead levels below 10 mcg/dL; and
	  • Two recent news articles related to lead.
	• Dr. Broadbent noted that the letter to health care providers that he provided to the Council members may be useful for the health care provider toolkit being developed. He commented that as the state moves towards the elimination of lead poisoning, the case management of children with blood lead levels below 10 mcg/dL will become more critical. He stated that the lab statement of "normal" for levels below 10 mcg/dL was a misnomer, and should be addressed. Ms. Leo responded that the program would further explore the possibility of changing that label.
	• Ms. Migliore commented that as we expand lead poisoning prevention to different populations (e.g., older children and pregnant women) there may be some nursing licensure and liability concerns. Some counties have concerns regarding any liability incurred by providing educational materials or initiating case management to certain populations (e.g., pregnant women, children with blood lead levels less than 20 mcg/dL). She added that despite this, the program must be sure that people in need are not abandoned. Ms. Leo responded that we will be discussing case management for these new populations with local health departments when the case management guidelines are approved.
	• Ms. Migliore added that it was good to see the support for local health departments, particularly with the shift toward primary prevention. She also commented professional education is very helpful as well. She recommended that the joint CCH-OCFS letter be provided to local departments of social services and child care resource referral agencies.
		The letter was sent to all county Commissioner of Social Services & Child Care Resource Referral Agencies.

NYS DEPARTMENT OF HEALTH
MARCH 15, 2007
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow Up
Center for Environmental Health (CEH) Update: Thomas Carroll	Thomas Carroll provided an update on CEH initiatives: • An additional $3 million 'aid to localities' appropriation was proposed in the 2007-2008 executive budget for primary prevention. • CEH continues to collaborate with the Office of Children and Family Services. CEH provided lead safe work practices training for fire safety representatives who inspect and permit child day care facilities. Training topics included DOH lead interventions, lead hazard identification, lead exposure, environmental hazards assessment, and the role of inspectors in primary prevention efforts. • CEH participates in periodic teleconferences with Housing and Urban Development (HUD) grantees in New York State, to provide technical assistance and support, and to promote communication between grantees. As of February 8, 2007, New York State received a total of $124.6 million in grants, projected to address 11,112 units (7,362 units have already been completed). There are 14 hazard control grants, 9 demonstration grants, and 3 outreach grants currently active in New York. A new grant announcement, SuperNOFA, was released on March 14, 2007. • CEH, in collaboration with CCH, is planning a second annual education meeting of the Local Health Department Childhood Lead Poisoning Prevention Programs in June 2007. Dr. David Jacobs has agreed to speak as the opening keynote speaker to discuss Primary prevention: Why Healthy Housing Matters. Additional topics include consumer product safety, improving health care provider screening, GIS mapping, and refugee health issues. • CEH recently performed formal reviews of the 37 full-service health departments and 8 District Offices. This process revealed timely and appropriate environmental management, and also identified the need for additional training, which will be addressed at the June LHD meeting. CEH field tests inspectors to a standardized level of performance to ensure a uniform standard of training and staff qualifications. Criteria include EPA risk assessor, completion of a radiation safety course, and a field test procedure of two joint inspections in a real scenario. Currently, there are 33 standardized inspectors in local health departments. • LeadWeb trainings for the Environmental Health components have been completed. Over half of the LHDs are using the Environmental Health LeadWeb component, and most other LHDs are beginning to use the environmental health components of LeadWeb. Only six counties have not begun to use the electronic database for recording environmental inspections. • CEH increased funds and provided a cost of living adjustment to Healthy Neighborhoods Program (HNP) sites. The HNP data collection system has been revised, and scannable forms are being designed and tested. This will allow for data entry in the field and fax or electronic collection, leading to more specific and improved data analysis.	

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	• CEH is working with New York City Department of Health and Mental Hygiene (NYC DOHMH) to ensure that the proposed revisions to Subpart 67-2 are compatible to New York City's Local Law 1. CEH is eliciting comments from other key stakeholders and interested parties on the proposed changes to Subpart 67-2. • Representatives from CEH met with the regional staff of the Consumer Product Safety Commission (CPSC), Office of the State Comptroller, and New York State Consumer Protection Board to discuss future actions related to lead-based product recalls. Over 20 consumer recalls of child-related products with lead hazards have been issued within the past six months. The current CEH protocol issues a Public Health Notice for lead-related consumer recalls. The notification system has been improved, and now provides e-mail notification of CPSC recalls to LHDs, environmental health directors, hospitals, and other interested parties. • CEH is developing an educational flyer on dust control, which includes lead in dust. This flyer is being developed at a third grade reading level, and will be available with contact information for LHDs and District Offices as appropriate. **Comments from the Advisory Council:** • Dr. Broadbent asked for clarification whether counties that had no cases in the environmental health section of LeadWeb had no cases, or if this was a result of low blood lead screening. Mr. Carroll responded that some counties, particularly rural counties, may experience cases in which environmental intervention is required (BLL $\geq$ 20 mcg/dL) very infrequently. Dr. Broadbent noted his concern that pediatricians are not screening children in these counties, and that efforts need to continue to ensure that children are being tested as per NYS regulations. • Dr. Broadbent asked for clarification on the action level for environmental interventions by LHDs. Mr. Carroll responded that current regulations require environmental interventions for children with blood lead levels $\geq$ 20 mcg/dL, although there are multiple counties performing environmental interventions for children with blood lead levels of 15-19 mcg/dL or with persistently elevated blood lead levels. He also responded that other counties may lower the action level based on the availability of resources. • Dr. Broadbent asked if Medicaid reimbursement was a possibility for people inspecting homes for multiple environmental hazards (e.g., lead and asthma). Mr. Carroll responded that HNP is looking at a pilot program that would reach out to primary care providers to identify asthma cases, and target those homes, rather than finding asthma cases in the home. HNP is examining how to address asthma more effectively, and is looking at engaging managed care. Dr. Franko added that Medicaid reimbursement has been examined in the past, but was difficult to access because Medicaid rules state that reimbursement only occurs when the examiner is from a certified home health agency or is a licensed health care professional.	

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	• Dr. Broadbent commented that he was concerned that the proposed $3 million would be spent solely on HNP projects, and suggested that some of this money should be directed to the LHDs to facilitate lowering the environmental action level to 15 mcg/dL.	
Bureau of Occupational Health Update: Eileen Franko, Dr.P.H., M.P.H.	Dr. Eileen Franko provided updates on the efforts of the Bureau of Occupational Health (BOH). • BOH provided code enforcement training to code enforcement officers and fire officials in Fulton and Montgomery Counties; 2 trainings are scheduled in April for code enforcement officers and other interested parties. BOH will be performing evaluation of code enforcement training in the near future; surveys will be sent out to 583 code enforcement officers trained by BOH, and 245 code enforcement officers who had not received training; this group will act as the control group. The evaluation will focus on the impact of training on the code officers' behavior related to the training curricula. • BOH is developing a training program for a vocational education BOCES program in Steuben County, and will include lead safe work practices training. • BOH is currently working to develop educational materials for lead exposure from firearms use. In 2006, 75 young adult and adult shooters were identified with BLL ≥ 15 mcg/dL, including 52 with levels ≥ 25 mcg/dL and 8 with levels ≥ 40 mcg/dL. The materials will focus on basic methods to reduce exposure to lead for the shooter as well as the shooter's family, and will include personal hygiene, effective housekeeping, use of low-lead or lead-free ammunition, and not making or reloading ammunition in the home. • BOH has performed 27 interviews with women of childbearing age (16 – 45 years) identified with BLL ≥ 15 mcg/dL. Nine of these women indicated they were conducting home remodeling and renovations, and received information on lead safe work practices. All of the women received information on reducing exposure and the risk of exposure to children. • Between October and December 2006, BOH monitored 134 companies with lead exposure and employees with blood lead levels ≥ 15 mcg/dL. Nineteen new companies received industrial hygiene interventions. BOH is working to develop an evaluation of these industrial interventions to determine what changes are being made, and to guide future development and improvement. • BOH provided comment and had discussion on the Environmental Protection Agency's proposed renovation and remodeling rule, expected to be published in March of 2008. BOH is considering a pilot study of the rules before they are published. **Comments from the Advisory Council:** • Dr. Broadbent asked for elaboration on the measures of effectiveness for the industrial hygiene intervention. Dr. Franko responded that BOH is developing an evaluation plan to track all of the intervention activities that are suggested to companies. The proposed plan will look at the worksite six months post-intervention to see if the	

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	suggestions have been implemented (through employee interview), and will analyze employee blood lead levels to see if they have decreased.	
New York City Department of Health and Mental Hygiene (NYC DOHMH) Update: Deborah Nagin, M.P.H.	Ms. Nagin provided an update on the New York City's Healthy Homes Hardware Store Campaign, and provided samples of brochures for the Council members as well as sample materials to view. • In 2004, NYC developed a city-wide health plan identifying ten priority health areas, including 'make your home safe and healthy'. This allows DOHMH to leverage resources for primary prevention and lead poisoning prevention. • The Healthy Homes Hardware Store campaign is one of the primary prevention initiatives in New York City that incorporates primary prevention into a holistic approach for healthy homes. • The goal of the hardware store campaign is to increase the awareness of the healthy homes concept to contractors, landlords, superintendents, do-it-yourselfers and families. This includes maintaining and repairing homes, fixing leaks and peeling paint, removing mold and pests, using household chemicals safely, making homes smoke-free, and promoting home safety, including the use of window guards. • Over three hundred hardware and paint stores were identified in high risk neighborhoods, and were asked to participate. Participants receive a logo decal, action kits (brochures, decals, palm cards, posters, and shelf signs), as well as promotional items (e.g., hats, paint stirrers); materials are available in five languages. Participating sites receive additional materials and visits from collaborative partners throughout New York City. The materials were designed using similar colors and fonts for brand identification. • Additional priorities in 2007 include expansion into other home visiting programs, including the newborn programs, nurse-family partnership, window falls prevention program, and the asthma initiative. **Comments from the Advisory Council:** • Ms. Binder asked what resources New York City residents could access for questions about housing information or inspection. Ms. Nagin said that residents could call 311 for information. NYC Department of Housing, Preservation and Development also provide information. • Dr. Broadbent asked how many children in New York City are tested for lead. Ms. Nagin responded that there were over 400,000 blood lead tests in 2006, but the exact number of individual children tested wasn't immediately available. • Dr. Broadbent asked about the funding sources for nurses performing home visiting and environmental hazard inspections. Ms. Nagin responded that some of the home visiting services are funded through NYC (newborn project, window guards), while others are grant-funded. • Dr. Broadbent asked about the educational efforts for children identified with blood lead levels < 10 mcg/dL. Ms. Nagin responded that the health department has provided information to medical providers, stating that children	

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	with BLL 5-9 should be considered potentially elevated, and that the health care provider should provide counseling on lead poisoning prevention with the parent/caregiver. DOHMH also has an active education and outreach unit which educates families about lead poisoning prevention, including tenant rights and landlord responsibilities under Local Law 1.	
Environmental Public Health Tracking Presentation: Nancy Kim, Ph.D.	Dr. Nancy Kim provided the Council with information about the Environmental Public Health Tracking Grant activities. • In 2000, the Pew Commission recommended the development of a national environmental public health tracking (EPHT) system. This system would be used to inform consumers, communities, public health practitioners, researchers, and policy makers on chronic diseases and environmental health hazards. • Beginning in 2002, New York State participated in a pilot project along with 19 other states, which tracked different diseases and exposures. The NYS pilot project examined hazardous air exposure in relation to acute myocardial infarction (AMI) and asthma, as well as trihalomethane exposure in relation to low birth weight and gestational age. • In 2006, participants of the pilot project entered into the national environmental public health tracking implementation phase with CDC guidance. Implementation is conducted in 16 states and New York City. This tracking system includes hospitalization data (asthma, AMI), birth outcomes (birth weight), birth defects, cancer (short-latency and childhood cancers), and childhood blood lead screening rates. Additionally, the system includes data regarding population exposure to hazardous air (ozone, fine particulate materials) and water (lead copper, arsenic, and microbial pathogens). • Implementation partners are working to develop indicators/measures for the hazards, exposures, and health outcomes, to be used on EPHT websites. Partners are developing 'how to' guides to ensure that indicators or measures are consistent between states and localities, and a directory of existing databases which will allow to search for information by geographical or topic area. Each state has work group leaders for each topic area. Tom Talbot, CEH, is New York State's representative for childhood lead exposure. • By September 30, 2008, tracking measures for asthma hospitalizations, AMI hospitalizations, ozone and particulate matter hazards or exposures, water contaminants, and at least two of four additional measures (birth defects, cancer, child blood lead screening, and vital statistics) must be available; all measures are to be developed and available by September 30, 2010. • Each indicator must meet specific requirements which include: being measurable, able to be tracked over time, action oriented, based on demonstrated links between environment and health, and informative to the public and other agencies. Exposure indicators (blood lead levels), intervention indicators (blood lead testing rates), and health effect indicators (rates of lead poisoning in children) are under development.	

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	• The EPHT system information is developed in a three-tiered system.
	  • Tier 1 includes local area network (LAN) access to databases for BEOE/CEH staff working on environmental health surveillance.
	  • Tier 2 data will be available through the New York State Health Commerce Network.
	  • Tier 3 data will be available through the DOH public website.
	• The Tier 1 data system is menu-driven, to facilitate use. It allows for cross-database analysis, as well as interpolation of expected outcomes. This data system can be used to investigate why an outcome did not occur as expected.
	Comments from the Advisory Council:
	• Ms. Nagin commented that New York City was also involved in EPHT, as well as the Environmental Data Exchange Network (EDEN) for sampling data. She asked whether EPHT was initially developed to support routine public health functions, or was it also intended for use during emergencies. Dr. Kim responded that, as a national program, it is difficult for EPHT to be used for emergency or disaster preparedness, because there are currently many 'holes' in the environmental health and exposure data. The program is currently more suitable for public health and public queries. Mr. Tramontano added that the recognition of limitations has led to additional grants and systems, including biomonitoring. He added that New York State and New York City had more environmental data than most states. Dr. Kim added that the grant program is designed to build a national infrastructure that states and localities will be able to use.
	• Dr. Broadbent asked about the connections between CEH and the national representatives from Centers for Disease Control and Prevention. Dr. Kim responded that the Division of Environmental Health Assessment has routine contact with other state and CDC representatives at the national workgroups.
	• Dr. Broadbent asked if the tracking would be able to identify a variety of incidence rates (e.g. 5-9 mcg/dL). Dr. Kim responded that the goal of the CDC is to develop a national system, so states that have minimal environmental health can add to the system. New York State is doing more than the minimum of measures for the system because we have the ability and data to do so.	

Lead Control in Housing Presentation: Barbara Wigzell	Barbara Wigzell provided a background of the Division of Housing and Community Renewal (DHCR) and an overview of the Lead Control in Affordable Housing initiative: • DHCR's new commissioner, Deborah VanAmerongen, has expressed interest in expanding the current focus on lead control.	

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	• DHCR is responsible for the supervision, maintentance and development of affordable, low, and moderate income housing. Programs are housed within four offices: Office of Fair Housing and Equal Opportunity, Office of Housing Operations, Office of Rent Administration, and Office of Community Development (OCD). Programs include the Public Housing Modernization Program, Section 8 Housing, New York State Low Income Housing Trust Fund, HOME Investment Partnership Program, and others. Additional information on DHCR is available online at http://dhcr.state.ny.us.
	The Office of Community Development (OCD)
	• A responsibility of the OCD's Environmental Analysis Unit (EAU) is to conduct environmental quality reviews of OCD projects and programs to ensure state and federal requirements are met. The EAU also reviews projects and provides recommendations for handling lead-based paint contamination and remediation. EAU works to ensure that both family and senior housing sites are assessed for lead contamination, are properly abated, and works to remediate lead soil contamination at brownfield sites.
	• EAU's lead policy is carried out in accordance with Housing and Urban Development's "*Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing*". OCD funds five distinct programs under this lead policy: HOME Investment Partnership Program – Local Program Administrator (LPA) Program, New York State Homes for Working Families Program, New York State Housing Development Fund, New York Main Street Program, and Access to Home Program.
	• OCD funds three programs with different lead-based paint policies, including the New York State Weatherization Assistance Program, Low-Income Housing Credit Program, and the State Low-Income Housing Tax Credit Program. Each of these programs follows different federal guidelines regarding lead-based paint remediation.
	New York State Consolidated Plan for 2006-2010
	• Within the New York State Consolidated Plan, 2006-2010, a lead-based paint hazard assessment was conducted.
	• According to U.S. Census data, 323,410 households in New York State are at highest risk for exposing persons to lead because they:
	  ◦ include one or more children under 6 years of age;
	  ◦ have incomes at or below 50% of the area median income; and
	  ◦ live in units constructed before 1980.
	• New York State will continue to implement lead hazard identification and control protocols, provide technical assistance to localities and community-based organizations, and support local applications for lead hazard control program grants.	

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	New York State Action Plan – 2007
	• DHCR, in coordination with Office of Temporary and Disability Assistance, and Governor's Office for Small Cities developed the "*New York State Annual Action Plan*" for 2007. In relation to lead, DHCR will:
	  • Consider providing funds for lead hazard work in units assisted by the Weatherization Program in areas where no additional lead abatement assistance is available.
	  • Consider priority status for HOME LPA applicants for single family rehabilitation and tenant-based rental assistance, if they target lead hazard control.
	  • Work with DOH to develop a referral process for free testing when a sub-recipient of DHCR funds becomes aware of a child who has a need for, but has not been tested for lead poisoning.
	  • Continue to pursue the goal of eliminating childhood lead poisoning by 2010, through continued work of the New York State Advisory Council on Lead Poisoning Prevention.
	  • Work with DOH to develop and implement strategies to eliminate childhood lead poisoning in New York State.
	  • Implement sophisticated lead hazard identification and reduction protocols, and provide technical assistance to localities.
	  • Make lead hazard control a requirement of all DHCR housing rehabilitation programs.
	• Mary Binder, Environmental Analyst and Council member for DHCR, presented on two examples of projects recently completed:
	1. A five unit senior housing site in Saratoga, NY was rehabilitated between 2001 and 2004. The unit was built in 1835, and historical site requirements for rehabilitation were followed. The building's interior was completely gutted during the process. Lead was found on the exterior siding, with evidence of dry scraping. In order to assess soil contamination, samples were taken from 20 points on the lot. All samples came back within acceptable ranges. The site was reopened as a four unit senior housing site.
	2. A three block long by one block wide site in Poughkeepsie, NY was rehabilitated and developed in coordination with the Department of Environmental Conservation (DEC); this represents the first brownfield participant with the DEC. The site was the location of a former brass foundry, gas station, and oil burner service provider, and was contaminated with petrolium, mercury, lead and PCBs. Over 800 tons of contaminated soil, including 80 tons of lead-contaminated soil was removed. DEC developed mitigation measures to provide barriers to all contaminated surfaces, including buildings, pavement, or two feet of clean fill, and a system to protect against volatile organic chemical off-gassing was installed. The site continues to receive groundwater monitoring from DEC. Eight retail units and 54 family housing units are located at the site.	

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	Comments from the Advisory Council: • A member of the audience asked what funds were available for lead abatement besides DHCR project funds. Ms. Binder responded that additional funds came from state and federal (HUD) sources, as well as private funds through loans. • Dr. Broadbent asked if problems identified through inspections were referred to another agency or if they were fixed by the project. Ms. Wigzell replied that the plan is to identify the problems and then refer the families to the LHD. Follow-up for remediation is performed by DHCR for weatherization projects, or referred to a local not-for-profit agency for hazards identified in other programs. Since programs work with families living onsite, DHCR is currently looking to identify contingent funding to better serve the families through alternate housing or remediating hazards not related to weatherization. • Dr. Birkhead asked for clarification on the identification of high risk housing sites, and whether there was a plan to prioritize these houses first. Ms. Wigzel responded that DHCR does not currently target these addresses. The goals and target areas of each program within DHCR vary; DHCR is looking to further develop interagency communication to develop a program approach and philosophy. Dr. Birkhead commented that the DOH approach is to identify neighborhoods at high risk and work with them proactively, and asked if this was similar to DHCR's efforts. Ms. Wigzell noted that the local program administrator (HOME LPA) programs perform more work on the local level to identify and administer the DHCR program needs. At the local level, housing authorities and community development agencies are the key components of local efforts. • Dr. Broadbent commented that there was interest in developing healthy housing registries, and asked if DHCR would organize this, and what challenges would this concept pose. Ms. Wigzell replied that DHCR is involved in the oversight and funding of projects. A housing registry would be difficult to initiate, as well as maintain. • Ms. Nagin commented that the knowledge of DHCR and DOH were different, but necessary for collaboration. She noted that one particular problem, especially in New York City, is for smaller one- and two-unit homes to obtain funds and loans. Ms. Binder noted that the HOME LPA programs could provide funds to local not-for-profit organizations interested in identifying single unit homes for rehabilitation. She directed the Council to the DHCR website's interactive mapping page to identify local CBOs participating in DHCR funding programs. (http://www.dhcr.state.ny.us/ahd/frames.htm) • Dr. de Long asked whether project funding targeted specific areas within the state. Ms. Wigzell replied that DHCR tries to distribute the funds as evenly as possible. Dr. de Long commented that DOH often hears about lack of resouces for owner-occupied housing, especially in rural areas. Mr. Olin replied that funding distribution is dependent on the local not-for-profit agencies that apply for funding. Ms. Binder added that lead is one component of many that DHCR works on. Ms. Wigzell noted that current DHCR local programs include both large and small	

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	projects and counties.	
Agency Updates	Mr. Tramontano asked for agency updates from Council Members. ▪ Tom Mahar, Department of State, provided a handout and described recent activity regarding the International Property Maintenance Code (IPMC). In September 2006, Mr. Mahar submitted a proposal to amend the IPMC code section 305.3, Interior Surfaces, to add the following sentence: *Deteriorated lead-based paint shall be repaired or removed using approved lead-safe working practices.* The proposal was disapproved at the International Code Council hearing, but a public comment was made on the action, requiring the proposal to be discussed at the Final Action Hearing, scheduled for May 23, 2007 in Rochester, NY. • Mr. Mahar asked for support by way of qualified individuals who could attend and be prepared to support the code change proposal. Each speaker is limited to two minutes and a one minute rebuttal; speakers must have different and new material from other speakers. • This code change proposal impacts New York State codes as they are generally based on the IPMC. • Mr. Mahar added that he would provide assistance in developing a plan with potential speakers. • Mr. Dorr, Office of Children and Family Services, commented that the Department's additional initiatives were underway to increase child care provider awareness of lead poisoning prevention. OCFS and DOH are working with SUNY Training Group to improve the training sessions provided via videoconference through SUNY. SUNY has committed to an hour-long training on environmental hazards, and is available to provide lead prevention information and brochures at monthly video conferences. • No further updates were received from other agencies.	
Additional Comments from the Advisory Council	• Dr. Broadbent requested comment on the handouts that he provided for the Medical Society of the State of New York. He added that he remains concerned with the question about testing at or around age 2, and called for suggestions to deal with testing at age 2, as well as working with children with BLL <10 mcg/dL. He noted that the actions in Vermont (reducing the action level to 5 mcg/dL) and Governor Spitzer's inclusion of lead poisoning prevention and primary prevention were encouraging. • Mr. Tramontano added that, so far, members of the State legislature have not contested the additional proposed funds for primary prevention in the Executive Budget. • Dr. Birkhead requested that future advisory council meetings start at 10:30, to better accommodate Council members arriving via Amtrak.	Program will schedule future meetings to begin at 10:30.
Public Comments	• A comment was received asking if legislation had been proposed to make some of the abatement costs the responsibility of tenants in New York City. Ms. Nagin responded that this was proposed, but failed to be passed into law. • No further comments were received. Mr. Tramontano adjourned the meeting at 2:30 pm.	

NYS DEPARTMENT OF HEALTH
JUNE 15, 2007
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow Up
Attendees	**Council Members**: • Guthrie Birkhead, M.D., M.P.H., Director, Center for Community Health – **Council Co-chair** • Nancy Kim, Ph.D., Interim Director, Center for Environmental Health – **Acting Council Co-chair** • David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) • William Dorr, Assistant Director, Bureau of Early Childhood Services, NYS Office of Children and Family Services (Commissioner Designee) • Abby Greenberg, M.D., Acting Commissioner, Nassau County Health Department; Representative, American Academy of Pediatrics – Division II (Local Government) • Monica Kreshik, Esq., Environmental Justice Coordinator, Department of Environmental Conservation (Commissioner Designee) • Tom Mahar, Code Compliance Specialist III, NYS Department of State (Adjunct Designee) • Ellen Migliore, R.N., M.S., Public Health Nurse, Herkimer County Health Department (Child Health Advocate) • Tanya Ross, Associate Industrial Hygienist, NYS Department of Labor (Labor) • Alicia Sullivan, Senior Attorney, NYS Office of Temporary and Disability Assistance (Commissioner Designee) **Additional Attendees**: • Michael Cambridge, Director, Bureau of Community Environmental Health and Food Protection • Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection • Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health • Eileen Franko, Dr.P.H., M.P.H., Director, Bureau of Occupational Health • Barbara Leo, M.S., F.N.P., Program Manager, Childhood Lead Poisoning Prevention Program, Bureau of Child and Adolescent Health • Barbara McTague, Director, Division of Family Health • Bruce Phillips, Counsel, NYS Department of Health • Richard Svenson, Director, Division of Environmental Health Protection **Absent Members** • Rolaine Antoine, Queens Village (Parent Representative) • Mary Binder, Environmental Analyst, Division of Housing and Community Renewal (Commissioner Designee) • Thomas Ferrante, Manager of Training and Technical Services, Total Safety Consulting (Labor Union) • Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY Buffalo (Professional Medical Organization) • Lindsay Lake Morgan, R.N., Ph.D., A.N.P., Assistant Professor, Decker School of Nursing, SUNY Binghamton	

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	(Education) • Philip Landrigan, M.D., M.Sc., D.I.H., Director, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital) • Deborah Nagin, Director, New York City Department of Health & Mental Hygiene- Lead Poisoning Prevention Program (Adjunct Designee) • Clifford Olin, President, EcoSpect, Inc. (Industry) • Stacy Rowland, Deputy Superintendant, Legislative Affairs, State Insurance Program (Adjunct Designee) • William S. Schur, Vice President of Schur Management Company, Ltd., (Real Estate)	
Welcome and Introductions: Dr. Birkhead	• The meeting was convened at 10:40 a.m. • Dr. Birkhead opened the meeting and welcomed the council members. • Dr. Birkhead initiated a roll call of the members and reviewed the meeting agenda.	
Review of minutes	• Review of minutes from the March 15, 2007 Advisory Council meeting was postponed because several council members were absent. Following the meeting, members were sent a copy of the March 15th minutes and asked to provide any comments electronically and to vote on passing of the minutes.	Minutes approved by Council members.
Center for Environmental Health (CEH) Update: Tom Carroll	Mr. Carroll presented an update of activities from the Center for Environmental Health (CEH). Topics and discussion include: • **New Primary Prevention Initiative**: • The Article VII bill included in the enacted SFY 2007-2008 state budget includes an amendment to Section 1370-a of Title X, NYCRR, which requires the implementation of a pilot project to work with local health departments in targeted counties to develop and implement primary prevention plans for identified high incidence zip codes. The pilot programs will address high-risk housing and will promote collaboration between local health departments and other local government agencies, and programs performing remediation work. Three million dollars ($3 million) of new funding allocated in the executive budget for primary prevention of childhood lead poisoning will be used to support this pilot program. The program will be administered by the Bureau of Community Environmental Health and Food Protection in the Center for Environmental Health, in collaboration with the Bureau of Child and Adolescent Health Childhood Lead Poisoning Prevention Program in the Center for Community Health (CCH). • Data analysis has been completed to identify target counties and zip codes for the first year of this initiative. Zip codes were ranked by annual incident number of cases of lead poisoning (BLL $\geq$ 10 ug/dl) among children	

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	under age six in 2005. In parallel to this zip code ranking, counties were rank ordered by annual incident number of lead poisoning among children under the age of six in 2005. The top eight counties/localities (counting New York City as a single locality), which accounted for 80% of the statewide total of incident cases of lead poisoning, were classified as "target" high incidence counties consistent with identifying counties with significant concentrations of children with elevated blood lead levels. Counties were deemed eligible for funding for the first year of the pilot program if they both met the target high-incidence criteria at the county level. In these counties, the zip code identified with the highest ranking would be the designated area for pilot program activities, although surrounding areas or other zip codes could also be considered for the pilot program. Based on this analysis, the following counties were deemed eligible: Erie, Monroe, Onondaga, Westchester, Orange, Oneida, Albany, and New York City. The Department will provide grant funding to these target localities to support the program. Targeting available resources to this subset of specific high-incidence zip codes and high-incidence counties/city within specific neighborhoods is critical to achieving elimination of lead poisoning in New York State. • In cooperation with the target localities, Department staff will further refine the target area(s) using GIS mapping and/or historical data. Staff will provide technical support to develop a primary prevention plan relevant to the local area. LHD staff will examine what currently exists in the locality, and develop a plan to incorporate new initiatives as part of the plan. Examples of primary prevention initiatives to be examined include: developing formal collaborative partnerships, identification of geographic areas within high incidence zip codes that have high prevalence of lead paint hazards, development of a housing inspection program, utilizing the area of high risk designation, developing and utilizing effective enforcement policies and activities, coordinating local resources, increasing lead-safe work practices capacity, collection and reporting of data for evaluation, and referring children under age six for lead screening, if not yet done. The local health commissioner, in consultation with the Department, will determine the appropriate methods depending on the current assets and needs of the community. • CEH is also developing a proposal with a national not-for-profit organization to consult with the Department and all pilot program localities in the development, implementation and evaluation of the pilot programs. • **Interagency Partnerships**: • CEH and CCH have provided comments to the Office of Children and Family Services (OCFS) on a script for a training video production for child care providers. CEH and CCH will continue to work in collaboration with OCFS and the SUNY Research Center to provide training opportunities. CEH has begun discussion with	

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	OCFS to develop a new educational video segment for the OCFS monthly training for child care providers. • NYSDOH is a member of the NYS Division of Housing and Community Renewal (DHCR) National Affordable Housing Act (NAHA) Task Force and Partnership Advisory Committee. The committee is currently reviewing the 2008 Action Plan covering housing programs, including projects related to lead paint hazards. • CEH continues to foster relationships with HUD grant recipients, as well as encourage partnerships between HUD grantees and local health departments. CEH hosts periodic teleconferences with HUD-funded lead hazard contractors, providing networking and technical assistance. • CEH and the Center for Community Health (CCH) are working, with the New York State Association of County Health Officials (NYSACHO) on a 2-day lead education meeting in June. Topics include developing effective primary prevention strategies and the environmental health lead web system. Keynote speakers include Dave Jacobs, PhD, CIH; Director of Research at the National Center for Healthy Housing. • **Local Health Department Work Plan Trainings**: CEH and CCH staff completed four regional trainings for all local health departments, providing training on the recently revised lead program work plans. Changes to the work plan were made to improve reporting and accountability, and place greater emphasis on primary prevention activities. • **Environmental Health Electronic Case Management**: As of June 2007, 95% of local health departments are using the environmental health component of LeadWeb, the lead data registry with 58% of local health departments fully utilizing the key components of the registry. CEH continues to work with local health departments to provide technical assistance and identify new functions. • **Healthy Neighborhoods Program (HNP) Update**: HNP staff are working to roll out a revised data collection system for HNP encounters. The revised form is being tested, and involves a scannable fax form that will electronically record the encounter report. A rollout of the form is anticipated in July 2007. • **Revision of Part 67-2: Environmental Assessment and Abatement**: CEH is working with New York City Department of Health and Mental Hygiene (NYC DOHMH) to address their concerns due to differences between state regulations and Local Law 1, NYC.	

Topics/Speaker	Discussion	Follow Up
	Advisory Council Discussion: • Ms. Migliore asked if partial service local health departments can use district offices for primary prevention initiatives. Mr. Carroll responded that currently, this depends on the district office's availability of resources, and that these counties should discuss their primary prevention needs with their district office. Eileen Franko added that the Bureau of Occupational Health (BOH) assists in providing training for lead-safe work practices. • Dr. Broadbent asked whether the targeted approach for the primary prevention pilot program would be more precise if census tract analysis was used. Mr. Carroll responded that the amendment to Public Health Law specifies zip code-level analysis. Dr. de Long added that the law allows flexibility for targeting, and does not exclude further targeting within those zip codes or providing primary prevention services in adjacent non-high risk zip codes. • Dr. Broadbent asked for clarification on the definition of an "area of high risk". Mr. Carroll responded that the designation of an area of high risk is defined in Public Health Law, in which a Commissioner of Health can designate an area with one or more dwellings in which a condition conducive to lead poisoning of children exists as high risk. This allows for department staff to treat the dwellings as if there was a lead poisoned child. For example, an apartment building can be designated an area of high risk, and every apartment can be inspected as if there was a child with lead poisoning residing in that unit. Additionally, an area of high risk designation allows the Commissioner to issue a Notice and Demand, and pursue appropriate enforcement. • Dr. Broadbent asked whether there was reluctance for local health departments to declare an area as "high risk". Mr. Carroll replied that many counties use the area of high risk declaration on a case-by-case basis for different reasons, including inspecting adjacent apartments/buildings, entering dwellings with children with elevated blood lead levels of 15-19 mcg/dL, currently below the level of environmental intervention. It is anticipated that this will be used more frequently for primary prevention activities. Dr. Birkhead added that, when funding is available, this type of activity should be encouraged. • Dr. Greenberg asked what the legal implications and responsibilities were for counties designating an area of high risk. Mr. Carroll noted that the local health department, following PHL and DOH guidance, could designate an area of high risk if it was built before 1960**,** had a child with an elevated blood lead level, or was in disrepair. Dr. Greenberg asked for clarification whether the designation of an area of high risk would establish a special relationship. Mr. Phillips, Counsel to the Advisory Council responded that a special relationship was established if the local health department acknowledges a duty to assist the public, and fails to uphold that duty. In order to find	

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	the county liable, the individual would need to show that they were directly offered assistance but were denied duty, and as a result, were negatively affected. Dr. de Long noted that the Department will work with Counsel to develop clear guidance for local health departments. • Dr. Broadbent asked for clarification on how the $3 million allocation was going to be spent, and how this would relate to the multiple topics covered by the Healthy Neighborhoods Programs. Mr. Carroll responded that the recipient counties will be developing a primary prevention plan. The main emphasis of this plan is for the counties to inspect more houses. Counties may choose to increase funding for their HNP, purchase additional materials to conduct inspections (i.e. x-ray fluorescence analyzers), conduct needs assessments, or perform remediation. • Dr. Broadbent asked for clarification regarding the changes to 67.2 in relation to one- and two-family dwellings. Current NYC Local Law 1 does not cover one- and two- families. Mr. Carroll replied that CEH will continue to discuss how they may be able to address one- and two- family housing in their primary prevention plan. He added that each county has the ability to increase their primary prevention activities specific to the needs identified in each county.	

Bureau of Occupational Health (BOH) Update: Eileen Franko, Dr.P.H., M.P.H	Dr. Franko provided the Council with an update of recent activities by BOH. Topics include:
	
	• **Code Enforcement Trainings**: Between March 15, 2007 and June 15, 2007, BOH conducted three code enforcement training sessions. Currently, there are 876 code enforcement officers that have received training through BOH June 2006. BOH performs evaluations for the training session, and currently maintains a database of over 1,000 code enforcement officers (876 training recipients and 147 controls). Evaluations were sent out in May of 2007, and included information on learning, behavioral change and referrals. As of June 8, 2007 responses were received. A second mailing to non-respondents is planned in the near future. Preliminary findings of interest include:
	  • 98% of respondents noted that the training increased their knowledge of lead in housing in NYS;
	  • 94% of respondents noted that the course improved their ability to identify lead hazards;
	  • 80% of respondents noted that the training course changed how they addressed lead during housing inspections;
	  • 75% of respondents currently address chipping or peeling paint during a housing inspection;
	  • 99.3% of respondents found the training relevant to their work;
	  • 96% of respondents would recommend the course to coworkers or colleagues; and
	  • 96.3% of respondents rated the training as “good” or “excellent”.	

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	• Participants were asked to identify what type of code enforcement officer they were (i.e., architect, building inspector, fire inspector). • **Additional Training**: BOH staff provided training to employees of Curtis Lumber, covering the importance of products they sell and the information that they provide. BOH staff also provided training to the Association of Home Building Inspectors on the current lead regulations. • **Follow-up Activities for Pregnant Women**: BOH continues to perform interviews of all women of childbearing age (16 – 45) with BLL $\geq$ 15 mcg/dL. Between January and May, 2007, 155 women were identified with BLLs $\geq$ 10 mcg/dL, and 57 women had BLLs $\geq$ 15 mcg/dL; 42 women (74%) with BLL $\geq$ 15 mcg/dL were pregnant. These women received information on exposure sources, methods to reduce or eliminate exposure, and received a letter to give to their obstetrician to have the newborn tested. • **Industry Evaluations and Study**: BOH is working on the metal recycling industry project to assess lead exposure among metal recyclers. BOH has interviewed workers from the recycling industry, and has surveyed 101 metal recycling workers throughout New York State. The survey assesses exposures associated with routine tasks (e.g., sorting, shearing, torch cutting). Information obtained through the survey has guided BOH in developing a fact sheet, provided to the Council in draft format, with recommendations to reduce workers' lead exposure. Council members were asked to provide comment on the fact sheet by June 30th, 2007. The survey found that significant exposure comes from torch cutting of various metals, including unpainted metals and new steel. Additionally, the survey found lead contamination occurs in employee restrooms and break rooms, leading to potential transfer to home. Metal recycling facilities that received a site visit improved their lead protection programs after receiving advice and technical assistance. BOH will post survey results on the DOH website, and will issue a press release on these results. BOH will continue to work with the Institute of Scrap Recycling Industry to develop educational activities for metal recycling workers, and is currently writing an article for submission to a peer reviewed journal. • **Industrial Hygiene Interventions**: In the first quarter of 2007, BOH monitored 112 companies for lead exposure, provided 23 interventions including education, and conducted 2 site visits. BOH sent 500 outreach letters to contractors working on NYS DOT and Thruway bridges. DOH has also developed a fact sheet, provided in draft format to the Council, for target practice and firing ranges. Council members were asked to provide comment on the fact sheet by June 30th, 2007. This fact sheet focuses on educating how to minimize exposure at work and reduce contamination at home.	

Topics/Speaker	Discussion	Follow Up
	Advisory Council Discussion: • Dr. Broadbent commented that people encouraged to expand the scope of their job may not be happy about adding inspection components. Dr. Franko responded that the purpose of the code enforcement officer training was to reinforce their current job per NYS codes. Currently the Property Maintenance Code requires that all surfaces on the interior and exterior of building be maintained in intact condition. Although the code currently does not address lead-safe work practices, the training included these methods. Dr. Franko added that lead safe work practices are considered as an ideal model to follow, regardless of the presence or absence of lead. • Ms. Migliore asked if firing ranges were licensed or registered. Nicholas Pavelchak, Industrial Hygiene Section Chief, BOH, commented that firing ranges are not licensed, and that BOH works with associations and organizations, rod and gun clubs, and private ranges. Dr. Franko added that BOH could use feedback from local health departments about ranges in each county. • Dr. Broadbent asked about issues associated with the use of lead sinkers for fishing. Nicholas Pavelchak noted that the risk associated with lead sinkers primarily depends on hand-to-mouth behaviors, but noted that some fishermen would bite on the sinker to close it around the line. Ms. Migliore added that people still scavenge auto repair shops for lead to be melted and made into sinkers. • Dr. Greenberg asked if BOH worked in collaboration with law enforcement shooting ranges to provide education. Dr. Franko replied that BOH is planning to provide education at law enforcement ranges. • Dr. Broadbent asked for a description of the ongoing activities for pregnant women. Dr. Franko responded that BOH looks at all women of childbearing age with elevated blood lead levels. For those women with a blood lead level of $\geq$ 15 mcg/dL, BOH conducts an interview to identify potential sources and provide education on sources of lead and risk reduction to decrease exposure. If an exposure source is identified within the work place, BOH contacts the company to address these issues. Dr. Franko added that in New York City, a home visit and environmental evaluation is also conducted. Dr. de Long added that CCH works to educate the general public, health care providers, and prenatal care providers. Efforts targeting prenatal care providers and pregnant women are emphasized in the revised work plan. • Dr. Greenberg asked whether BOH directly contacts the health care provider(s) of a pregnant woman with elevated blood lead levels. Dr. Franko commented that a letter was given to the pregnant women, to give to her obstetrician. Dr. Greenberg commented that a more direct, proactive approach may ensure more thorough follow-	

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	up services for the mother and newborn. • Ms. Migliore asked whether BOH reached out to participants of the Prenatal Care Assistance Program (PCAP) and MOMS program to assess for lead exposure. Dr. de Long responded that lead is part of the intake and assessment tool. Ms. Migliore commented that Herkimer County screens all PCAP enrollees and found that many of them were lead poisoned as children.	
Center for Community Health (CCH) Update: Barbara Leo, M.S., F.N.P.	Ms. Leo provided an update to the Council on CCH activities. Topics include: • **Centers for Disease Control and Prevention (CDC) Cooperative Agreement**: The Childhood Lead Poisoning Prevention Program (CLPPP) received approval for Year 2 of the CDC Cooperative Agreement continuing application, and is completing a technical review response. (Copy of grant application was provided to the Council members). The technical review noted several strengths, including the comprehensive nature of the childhood lead poisoning elimination plan, the additional funding of $3 million for primary prevention, the comprehensive surveillance reports, and strong collaboration with state and local agencies, particularly with Medicaid providers. Recommendations included CLPPP discussing with the Advisory Council how to broaden the scope of the program to include other housing-related health hazards; clarifying the percent of lab reports that are received electronically; reporting on the Healthy Neighborhoods Program's activities (number of homes remediated, number of women and children living in remediated homes, and whether BLL indicated that the children were not yet exposed), and expanding the marketing of lead-safe work practices. • **Data Analysis Report**: CLPPP has developed several new analyses based on prior discussion with the Advisory Council and other stakeholders. Statewide data for 2004-2005 will initially be posted on the DOH website following Departmental approval. The final comprehensive written report is anticipated to be available by the end of the year. New data analyses include children with a screening test at age one year and age two years ;incidence for BLL <5 mcg/dL, 5-9 mcg/dL, 10-14 mcg/dL, 15-19 mcg/dL, 20-44 mcg/dL, and $\geq$ 45 mcg/dL; and incidence by age and gender. (See notes on presentation of data below for additional detail). • **Local Health Department Work Plan**: The LHD work plan was revised to meet updated recommendations from the CDC, the Case Management Guidelines, and to better align activities with the NYS Lead Elimination Plan. The work plan has twelve objectives within five goals, including program administration, education, screening, case management, and primary prevention. The new work plan format requires LHDs to propose specific	

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	measurable activities related to each objective. • **LHD Work Plan Training**: Four regional work plan trainings were provided for LHD nursing and environmental staff and state district office staff in the month of April. LHDs received county-specific 2005 preliminary data (incidence, prevalence and screening rates) and demographic information (poverty rates, % pre-1960 housing stock) to assist in writing work plans. Technical assistance was provided in the development of work plans. • **Second Annual LHD Meeting**: CLPPP is finalizing plans for the upcoming two-day meeting for local health departments. National, state and local presenters have been invited to discuss nursing and education topics, including strategies for outreach to health care providers, working with community-based organizations, primary prevention, health literacy, and non-lead paint sources. • **Educational Efforts:** CLPPP has completed several educational initiatives, including a joint letter from DOH and OCFS mailed to all child care providers to increase awareness of their role in promoting lead testing, the revised brochures on lead poisoning prevention for pregnant women and for infants and children, and a folder for education efforts to health care providers by LHDs. **Advisory Council Discussion:** • Dr. Broadbent commented that the distribution method of information to health care providers was crucial, and inquired about the distribution plan, as well as the status of the development of the health care provider toolkit. Ms. Leo responded that the brochures will be distributed directly to the local health departments for use with community and public groups as well as health care providers. The folders will be provided, in conjunction with materials for the health care provider toolkit, to the local health departments to provide education to the health care providers in their community. These toolkits will be provided in-person with a brief discussion, as well as in mailings to providers. The toolkit is being developed in two phases. The first phase will include key peer-reviewed journal articles, anticipatory guidance information, risk assessment questions, and a physician's desk reference card. Providers will also receive an order form for additional educational materials, including the revised brochures. Dr. Broadbent requested that copies of materials be sent to the Advisory Council members when they are sent to other interested parties. • Dr. Broadbent asked if the 2006 lead data was available for analysis. Ms. Leo responded that the data for 2006 still needs to be cleaned for data entry errors, duplicate records, etc. Additionally, staff are working with some counties that utilize data collection methods other than LeadWeb. While LeadWeb provides real-time data, the	

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	process of data cleaning and analysis still takes time. The goal is for future data reports to be produced annually and with progressively shorter turn-around time between the end of the calendar year and publication. • Dr. Broadbent asked for a status update on changing the language that laboratories use for reporting blood lead levels below 10 mcg/dL. Currently many labs report out a BLL < 10 mcg/dL as a "normal" result. Ms. Leo replied that CCH has begun discussions with Wadsworth Laboratories to identify the process to change this information. She added that laboratory reports vary greatly between labs. Dr. Broadbent added that, in Rochester, there is a preliminary agreement with the laboratories to change the language for reporting results below 10 mcg/dL; he will provide an update to the Council on the success of this initiative at a future Council meeting. • Mr. Dorr commented that he would provide additional organizations that CCH can use as resources for work with child care providers.	

Data Analysis 2004-2005 Preliminary Report: Rachel de Long, MD, MPH	Dr. de Long provided the Council with an update on the status of the 2004-2005 Data Report.
	
	• Through prior meetings, the Advisory Council provided a great deal of feedback on what types of analyses should be included in future data reports. As a result, CLPPP has developed or is developing analyses to update trend data on incidence and screening, age-specific screening rates at 1 and 2 years of age, lead poisoning incidence data by blood lead level categories including information on children with BLL below 10 mcg/dL, additional demographic details about children with EBLL, expanded geographic analysis at multiple levels, and expanded information on environmental investigations and follow-up.
	
	• The plan for publication of the data report is to share the data that we have through a series of internet data releases on the DOH website. These will include core indicators, and 'chapters' of additional analyses, including more extensive demographic analysis and geographic analysis.
	
	• Dr. de Long presented several slides of examples of new data analyses, including:
	  • Total count and proportion of children screened at or around age 1 and at or around age 2[1,2,3,4]
	  • Proportion of children receiving at least one lead screening test by age 24 months and by age 36 months[1,2,4]
	  • Number and rates of children under age six newly identified with lead poisoning by BLL categories: 10 mcg/dL, 10-14 mcg/dL, 15-19 mcg/dL , ≥ 20 mcg/dL , 20-44 mcg/dL , ≥ 45 mcg/dL [2,5]
	  • Trends in blood lead levels at incident case classification among children less than six of age [2,5]
	  • Number and percent of children under age six identified with blood lead levels less than 5 mcg/dL and
		Staff will provide Council members with hard copies of the data presentation handouts (one

Topics/Speaker	Discussion	Follow Up
	between 5 and 9 mcg/dL [2,5] • Comparison of proportion of children screened, by age group category and birth year cohort [2,4] • Comparison of children under age six newly identified with blood lead levels ≥ 10 mcg/dL by age category at case classification [2,5] • Comparison of age-specific incidence rates for children under age six with blood lead levels ≥ 10 mcg/dL [2,5] • Proportion of children screened at or around age one and at or around age two, by gender [2,5] • Comparison of gender-specific incidence rates for children under age six newly identified with blood lead levels ≥ 10 mcg/dL [2,5] Notes: 1: This analysis was used to operationalize the definition of "at or around age one year" and "at or around age two years" 2: Data is from New York State excluding New York City. 3: Birth Cohort 2002; tested between 2002 and 2005 4: Birth Cohorts 1998 – 2992; tested through 2005 5: Tests performed 1998 – 2005 **Advisory Council Discussion** • Dr. de Long noted that CCH will continue discussions with Wadsworth Laboratory staff to develop language to describe blood lead levels below 10 mcg/dL, in order to appropriately characterize the accuracy of these reported results • Dr. Broadbent asked for input on the use of this data to work toward lowering the trigger level for environmental investigations from its' current level at 20 mcg/dL. Dr. de Long replied that the analyses of incidence rates of blood lead levels 10-14 mcg/dL and 15-19 mcg/dL help us to estimate the impact of any changes that the department would consider, and provide a more current estimate of the additional caseload that goes into consideration when we evaluate potential regulation changes. • Dr. Broadbent asked about the ability of LeadWeb and data analysis to move towards faster publication of data. Dr. de Long noted that while the LeadWeb data is more readily available, there still is a great deal of data cleaning and analysis that needs to be done. She noted that publication of data within one year is the ideal goal that the program is working to achieve. • Dr. de Long requested that Council members e-mail additional comments and ideas for data analysis to the program staff.	**slide per page) at the next meeting.**

Topics/Speaker	Discussion	Follow Up
Presentation: New York State Department of Agriculture and Markets, Division of Food Safety and Inspection: Lead Surveillance **Mr. Curtis Vincent**	Mr. Curtis Vincent, Assistant Director of the Division of Food Safety and Inspection, NYS Department of Agriculture and Markets was invited to present on the lead surveillance activities in food products conducted in the Department. • The Department of Agriculture and Markets (Ag&Mkts) has a memorandum of understanding with the Department of Health (DOH) to divide the regulatory and inspection responsibilities of food in New York State. Ag&Mkts is responsible for regulating approximately 28,000 food establishments, including food manufacturers, bakeries, processing plants, retail stores, home processors, beverage plants, and feed mills. Over 42,000 inspections are conducted annually, with a staff of approximately 105 inspectors. • Ag&Mkts initiates over 350 food recalls annually, resulting from labeling inspections, food samples, and consumer complaints. Over 1.5 million pounds of recalled food is destroyed annually. • Ag&Mkts is responsible for both domestic and imported food in New York State. Several federal agencies are responsible for imported food entering the country, including U.S. Customs, the Food and Drug Administration (FDA) and the Department of Agriculture. Over 25,000 shipments of FDA-regulated foods arrive daily into the US from more than 100 countries. A small portion of imported food is inspected per year by the FDA and the Department of Agriculture. 32% of imports come through New York State, representing over 3.7 million shipments per year. • **Import Alerts**: Import alerts are issued by the FDA, to identify problem commodities and shippers, and provide guidance for import coverage. Examples include products with unapproved additives, banned additives, or products that pose a choking hazard. • **Ag&Mkts Lead in Foods Surveillance Programs**: Ag&Mkts has four surveillance programs, including import warehouse surveillance~~,~~ Mexican candy surveillance, canned foods from Eastern Europe and Russia, and domestically produced maple syrup surveillance. • **Mexican Candy**: The FDA guidance for maximum allowable lead in candy is 0.1 parts per million (ppm). This level was changed from the previous guideline of 0.5 ppm. Between 2004 and 2006, 35% of sampled Mexican candies were tested above the allowable lead content. Despite the stricter lead levels effective in 2006, there is a decreasing trend in the number of candy samples with elevated lead levels. Candies that tested positive for elevated lead levels include “super rebanaditas” (0.70 ppm), gusano (0.15 ppm), and palerindas (0.11 ppm, with a lead-painted stick that tested at 430 ppm). Contamination sources may include lead-contaminated weights used to	

Topics/Speaker	Discussion	Follow Up
	increase profits from chilies (farmers are paid by weight), harvesting methods, chilies not washed before drying, ceramic storage vessels, and ink on the candy wrappers. • **Lead in Canned Foods**: In June 1995, the FDA published a final rule in the Federal Register, prohibiting the use of lead solder in manufacturing cans. This rule affected both domestic and imported foods; a majority of domestic and Canadian manufacturers had stopped using lead previous to this rule; 17 other countries report that they do not import food into the U.S. in lead solder cans, but approximately 10% of imported canned foods contain lead solder. Inspectors use LeadCheck swab kits to identify the presence of lead. The swab turns red in the presence of lead. Any positive results are sent to the Department's Food Laboratories for confirmation. Examples of imported canned foods include Danube herring, salmon fillets, and imported dairy products from Russia and Eastern Europe. • **Chapulines (grasshoppers)**: Chapulines are a Mexican delicacy, fried with chilies, garlic and lemons. An outbreak of lead poisoning in Monterey County, California among pregnant women and children was associated with chapulines imported from Oaxaca, Mexico. A difficulty in sampling chapulines is that they are sold from behind the counter, and may not be noticed by inspectors. • **Maple Syrup**: Ag&Mkts samples approximately 50 maple syrup producers every year in New York State. Syrup can become contaminated with lead from several sources, including roadside dust and equipment. The majority of lead comes from the equipment, including old evaporators, tanks and buckets made before 1955, galvanized equipment made before 1994, brass and bronze pump fittings, old metal spouts and old tin buckets. The level of contamination increases if the sap or syrup remains for long periods of time. Results $\geq$ 500 parts per billion (ppb) are considered acceptable. Maple syrup producers whose samples test between 501 and 750 ppb for lead, receive education and advisement that the lab results exceeded the guideline of $\leq$ 500 ppb, and products are re-sampled during the next calendar season. Maple syrup producers whose samples test greater than 750 ppb for lead are visited by an inspector, and Ag&Mkts requests that the manufacturer ceases any sales of the syrup. These manufacturers receive a follow-up sampling the next calendar season. In 2007, 14% of samples were identified with lead levels greater than 500 ppb. • **Vassilaros Coffee**: In 2007, a domestically produced product, manufactured in Flushing, New York, was identified by an inspector. The company had found old coffee cans and packed new product in them. The seam contained 100% lead, and the coffee was contaminated with 0.35 ppm of lead. As a result, all of the coffee was	

Topics/Speaker	Discussion	Follow Up
	recalled and destroyed, and the company was assessed a civil penalty. **Comments from the Advisory Council:** • Ms. Kreshik inquired if Ag&Mkts played a role in testing immigrants for exposure sources. Mr. Svenson, Director, Division of Environmental Health Protection, responded that several federal agencies played a role in testing potential sources of lead exposure to immigrant families. The FDA examines tableware, while Consumer Product Safety Commission examines other products. At the state level, the Bureau of Community Environmental Health and Food Protection coordinate with CPSC to test interstate commerce, such as jewelry testing, lead recalls, etc. • Dr. Broadbent asked whether there was a need for locality or state legislation. Mr. Svenson noted that CEH was still analyzing. He added that there needs to be standardized levels of concern for different classes of products, and that test results need to be shared with the proper regulatory entity.	
Agency Updates	Monica Kreshik, Esq., reported on recent activities with the Department of Environmental Conservation (DEC): • In 2006, DEC awarded 10 grants for an Environmental Justice Program, to address disparities in environmental health exposures. The 2007 cycle was modified to broaden the eligibility criteria for applicants. Additionally, DEC is looking to work with DOH to include lead-safe work practices and efforts targeted toward pregnant women. Applications involving lead poisoning will be reviewed with DOH as appropriate. DEC hopes to increase the award amount in 2008. Tom Mahar provided a report on the Department of State's recent lead-related activities: • In 2006, the Department of State submitted a proposal to the International Code Council (ICC) to add the statement that "deteriorating lead-based paint shall be repaired or removed, using lead-safe work practices" to the property maintenance codes, in order to address older building stock, and have the ability to issue a violation. At the Code Development Hearing in Florida, written and public comments were heard, but the proposal was disapproved by the ICC. A public comment was received, placing the topic on the Final Action Hearing in May of 2007. Staff from DOS, DOH, and several other agencies provided testimony, but the proposal was ultimately disapproved. • DOS will propose a similar change during the next cycle of meetings, scheduled to start Spring of 2008. • Additionally, New York State has adopted the ICC 2003 Codes as its' Property Maintenance Codes. • No other updates from agencies were received.	

NYS DEPARTMENT OF HEALTH
JUNE 15, 2007
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow Up
Public Comment	No public comments were received. The meeting was adjourned at 3:30 pm	

NYS DEPARTMENT OF HEALTH
SEPTEMBER 10, 2007
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow Up
Attendees	**Council Members:** • Guthrie S. Birkhead, M.D., M.P.H., Deputy Commissioner, Office of Public Health (**Council Co-Chair)** • Rolaine Antoine, Queens Village, NY (Parent Representative) • David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) • William Dorr, Assistant Director, Bureau of Early Childhood Services, NYS Office of Children and Family Services (Commissioner Designee) • Abby Greenberg, M.D., Acting Commissioner, Nassau County Health Department; Representative, American Academy of Pediatrics – Division II (Local Government) • Lindsay Lake Morgan, R.N., Ph.D., A.N.P.; Assistant Professor, Decker School of Nursing, SUNY Binghamton (Education) • Thomas Mahar, Code Compliance Specialist III, NYS Department of State (Adjunct Designee) • Ellen Migliore, R.N., M.S., Public Health Nurse, Herkimer County Health Department. (Child Health Advocate) • Doug Morrison (representing Monica Kreshik), NYS Department of Environmental Conservation (Commissioner Designee) • Deborah Nagin, M.P.H., Director, NYC Department of Health and Mental Hygiene – Lead Poisoning Prevention Program (Adjunct Designee) • Clifford Olin, President, EcoSpect (Industry) • Tanya Ross, Associate Industrial Hygienist, NYS Department of Labor (Labor) • Alicia Sullivan, Associate Counsel, NYS Office of Temporary and Disability Assistance (Commissioner Designee) **Additional Attendees:** • Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection, NYSDOH • Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health, NYSDOH • Eileen Franko, Dr.P.H., M.P.H., Director, Bureau of Occupational Health, NYSDOH • David Jacobs, Ph.D., C.I.H., Research Director, National Center for Healthy Housing • Barbara Leo, M.S., F.N.P., Program Manager, Childhood Lead Poisoning Prevention Program, Bureau of Child and Adolescent Health, NYSDOH • Bruce Phillips, Counsel, NYSDOH • Richard Svenson, Director, Division of Environmental Health Protection, NYSDOH	

Topics/Speaker	Discussion	Follow Up
	Absent Council Members: • Mary Binder, Environmental Analyst, Division of Housing and Community Renewal (Commissioner Designee) • Thomas Ferrante, Manager of Training and Technical Services, Total Safety Consulting (Labor Union) • Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY Buffalo (Professional Medical Organization) • Nancy Kim, Ph.D., Interim Director, Center for Environmental Health (Council Co-Chair) • Philip J. Landrigan, M.D., M.Sc., FAAP, Director and Professor of Pediatrics, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital) • Stacy Rowland, Deputy Superintendent, Legislative Affairs, State Insurance Program (Adjunct Designee) • William Schur, Vice President, Schur Management Company, Ltd. (Real Estate)	
Welcome and Introductions	• The meeting was convened at 10:10 a.m. • Dr. Birkhead opened the meeting and welcomed the council members. • Dr. Birkhead provided opening remarks regarding the webcasting of the meeting, in accordance with Governor Spitzer's Executive Order #3 and the Open Meetings Law. The meeting notice and links to the webcast are at http://www.nyhealth.gov/events. (Note: this webcast was archived until October 10, 2007 and all future webcasts are anticipated to be announced at this website and will be archived for one month following the meetings.) • Dr. Birkhead provided opening remarks. In accordance with Executive Law, section 166, members of the public who appear before the Council and represent any agency regulated by the Department of Health must fill out a record of attendance, provided at the registration table. • Dr. Birkhead provided an overview of the meeting agenda.	
Lead in Consumer Products: **T. Carroll** **B. Leo** Interagency canvassing of	Richard Svenson provided a summary of recent Departmental activities surrounding lead in consumer products. He briefly discussed the collaborative effort between the Department's Center for Community Health (CCH), Center for Environmental Health (CEH), the New York State Consumer Protection Board (CPB), New York State Department of Agriculture and Markets (Ag&Mkts), and local health departments (LHDs) in developing and implementing a plan of action regarding the August 2007 recalls of approximately 1.2 million toys due to lead-based hazards, including efforts initiated by the New York State Commissioner of Health Richard F. Daines and Governor Eliot Spitzer to enact a mandatory recall of the toys in New York State, and to issue a press release on the toy recalls. Thomas Carroll and Barbara Leo provided the council with an update on the recent actions concerning lead in consumer products following the August 2007 recalls, and an update on addressing lead in jewelry. Mr. Carroll provided a description of the lead recall activities that NYSDOH, CPB, Ag&Mkts, and LHDs conducted regarding	

Topics/Speaker	Discussion	Follow Up
retail stores	recall education for retailers, wholesalers and distribution centers, and canvassing activities at retail stores statewide to identify recalled items that were still on retail shelves. Council members positively noted the comprehensive and rapid response of the Department to the August recalls. Additional council discussion took place on several issues, including: • Similar activities conducted by New York City Department of Health and Mental Hygiene (NYCDOHMH), including canvassing and inspecting toy stores and drug stores, and contacting retail regional offices, wholesalers and distribution centers; • Sinterest expressed by the Toy Industry Association and major toy manufacturers in increased regulation by federal agencies; and • A news article in the New York Times on lead in consumer products, which raised questions about whether states would develop individual standards for the amount of lead in consumer products.	
Public and Professional Education Efforts	Ms. Leo described the educational outreach efforts by the Department in response to the toy recalls. • Education materials were developed and distributed to 27,000 health care providers and 20,000 child care providers. Health care providers also received a Health Advisory via the NYS Health Alert Network. • Educational materials developed for parents were provided electronically to LHDs for outreach and education activities, and were posted on the public NYSDOH website. • In consultation with experts at the DOH-funded Regional Lead Resource Centers (RLRCs), blood lead screening recommendations were developed for children potentially exposed to lead through affected toys. • The Department worked with the Office of Children and Family Services (OCFS), CPB, the RLRCs, and professional medical organizations, including the American Academy of Pediatrics, American Academy of Family Practitioners and the Medical Society of the State of New York to disseminate materials to health care providers, child care providers and parents. Council discussion took place on several issues, including: • Lead levels associated with the recalled toys, which had not been provided by the federal Consumer Product Safety Commission (CPSC) or the manufacturers. It was noted that the recalls were based on the federal standard of 600 parts per million (0.06%), which is below the detection limits of field test kits and XRF testing. • Children identified with lead poisoning due to exposure from recalled toys. It was noted that no individuals had been identified as poisoned attributed to toy exposure.	The Department will evaluate the effectiveness of education by analyzing trends in blood lead screening following toy recalls and outreach activities.

Topics/Speaker	Discussion	Follow Up
Lead in Jewelry; NYS Bill 8077 Veto	• Inclusion of nursing associations in materials distribution. It was noted that Nurse Practitioners were included in the mailing distribution. Mr. Carroll provided an update on the status of NYS Assembly Bill #8077 – an act to amend the environmental conservation law in relation to jewelry containing lead. On August 28, 2007, Governor Spitzer vetoed this bill, citing that the lead levels established in the bill were not sufficiently protective, concerns that penalties imposed under the bill would only be imposed for intentional violations, and the lack of lead content disclosure by the manufacturers to the distributors, wholesalers or retailers. Ms. Nagin noted that NYCDOHMH would be willing to lend its experience in jewelry testing to any further technical discussions regarding lead in jewelry.	Nursing associations will be included in relevant educational outreach efforts in the future

Update on Proposed Regulatory Changes: R. de Long T. Carroll	Dr. Rachel de Long and Thomas Carroll presented an update on proposed regulatory changes to Title 10, NYCRR, Part 67 that are under development.
	• Proposed changes to Subpart 67-1 include:
	  • Requiring confirmation of all capillary (fingerstick) samples with blood lead levels (BLLs) $\geq$ 10 mcg/dL (currently at 15 mcg/dL);
	  • Lowering the blood lead level threshold requiring a complete diagnostic evaluation and environmental management services to BLLs $\geq$ 15 mcg/dL (currently at 20 mcg/dL);
	  • Clarifying follow-up services required for children ages 6 – 18 years with elevated blood lead levels; and
	  • Authorizing health care providers to utilize point of care blood lead analysis devices that are waived from federal Clinical Laboratory Improvement Amendment requirements (CLIA-waived), and requiring reporting of results of such point of care analysis to the Department.
	• The Department is currently developing a formal regulatory proposal to accomplish these changes.
	
	Mr. Carroll provided the Council with a summary of current regulations and summary of proposed changes to Subpart 67-2.
	• Subpart 67-2 covers environmental investigations, regulations for environmental sampling of lead, environmental testing and reporting, issuance of Notice and Demands, environmental interventions and abatement, and enforcement.	

Topics/Speaker	Discussion	Follow Up

	• Proposed revisions include:
	  • Correcting definitions and language to align with federal regulations;
	  • Requiring all investigations be performed by certified personnel;
	  • Clarifying the authority to issue a Notice and Demand;
	  • Updating methodology for XRF sampling; and
	  • Lowering the definition of lead in paint by XRF.
	• Many of these changes are already in guidance provided to LHDs and district offices, but inclusion into the regulations will increase the enforceability of the proposed regulations.
	• Mr. Carroll added that the proposed regulations will exempt NYC, to avoid conflict with Local Law 1.
	
	Council discussion took place on several issues, including:
	• The importance of recognizing follow up services other than chelation treatment as part of 'medical interventions' for children with BLLs $\leq$ 45 mcg/dL;
	• The importance of clarifying the terms 'screening', 'testing' and 'risk assessment', which are frequently confused in practice by health care providers;
	• The potential for further lowering the blood lead level threshold requiring environmental management to $\geq$ 10 mcg/dL. The Department is developing educational materials for health care providers and parents of children with BLLs $\leq$ 10 mcg/dL, to be covered later in the meeting agenda;
	• Steps to address BLLs of concern for pregnant women. It was noted that the Department is currently updating the guidance documents for prenatal care providers, and the Bureau of Occupation Health (BOH) is considering lowering the intervention level to 10 mcg/dL for women of childbearing age, from the current level of 15 mcg/dL.
	• Parental compliance with blood lead screening or follow-up tests. It was noted that the Department takes an educational approach for promoting parental compliance with blood lead screening and follow-up, and works with LHDs, other state and local government agencies and health care providers to remove barriers to timely blood lead screening and follow-up.
	• How proposed regulations relate to local legislation in various municipalities. It was noted that municipalities have the ability to adopt more stringent local requirements, but more stringent state law would supersede local laws. It was also clarified that the Department can only adopt regulations under appropriate statutory authority.
	• The Governor's authority to declare an area hazardous and require remediation of lead hazards in declared high risk areas.
		Further comments from Council members will be sought on proposed regulation changes as they are completed.

Topics/Speaker	Discussion	Follow Up
	• The use of dust wipe clearance testing. It was noted that the proposed regulatory changes include use of dust wipe clearance, allowing more effective regulation.	

Primary Prevention Pilot Project: T. Carroll	Dr. Birkhead provided introductory comments and background information on the new primary prevention pilot project. Mr. Carroll then provided an update on the status of the project.
	• In the 2007-2008 NYS Executive Budget, $3 million of new funding was proposed for the development of a primary prevention pilot project, to aid localities in developing primary prevention pilot projects in counties with high risk ZIP codes.
	• The Department identified eight jurisdictions (seven upstate counties plus New York City) with the highest annual incidences of elevated blood lead levels (EBLLs) among children 0 – 6 years of age as targets for the first year of the pilot project. Each of the eight local health departments (LHDs) will target at least one ZIP code with the highest incidence of EBLLs, with the flexibility to target additional high risk areas in the county. The eight jurisdictions include Albany, Erie, Monroe, Oneida, Onondaga, Orange and Westchester counties, as well as the five boroughs of New York City.
	• The eight local health departments that are part of the pilot projects are expected to develop local primary prevention plans extending to 2010. Each plan must include five key components:
	  • Identifying the scope of the problem of childhood lead poisoning on a local level;
	  • Developing local strategic partnerships and community outreach;
	  • Developing feasible approaches to targeting, inspection, hazard control and enforcement in high risk housing;
	  • Building local capacity; and
	  • Improving funding capacity for hazard control projects.
	• The current year's plan will focus on refining the target areas within each ZIP code and within the counties and developing local partnerships within the communities and counties. The plans will lay the groundwork for addressing the additional key components described above.
	• CEH is contracting with the National Center for Healthy Housing, a national not-for-profit housing agency to act as a center of excellence. This agency will provide technical assistance to the eight LHDs in the planning, implementation and evaluation of the primary prevention pilot projects.	

Topics/Speaker	Discussion	Follow Up
	Discussion took place on several issues, including: • Consideration of targeting areas with low screening rates. It was noted that low screening rates within a county may underestimate the incidence of elevated blood lead levels; • Availability of geocoded maps for partner agencies; • Analysis of incidence data at the census tract level. It was noted that the Department will offer assistance to LHDs to conduct further analysis for targeting activities, and is geocoding data to support census tract level analysis; • Allowable uses of primary prevention pilot project funds. It was clarified that funds from this project are primarily directed to develop the infrastructure and ability to conduct primary prevention activities, including capacity to leverage additional funding. The funds are not intended to support direct lead hazard remediation costs. It was also noted that the primary prevention projects can be integrated with other local programs and grants, such as HUD funded projects, Healthy Neighborhoods Programs, and local Division of Housing and Community Renewal (DHCR) funded projects; • The availability of EPA-certified housing inspectors. NYCDOHMH has identified a lack of available EPA-certified housing inspectors as a challenge. Some of the eight pilot project municipalities have included plans to build capacity for EPA-certified inspectors. • Comparison of environmental and child level blood lead data. It was noted that the new LeadWeb data system incorporates both blood lead, nursing case management and environmental case management data; • The relationship of the pilot project to DHCR's annual action plans. It was noted that the Department has provided comments to DHCR on their current action plan, and provides representation on the task force that develops these action plans.	The Department will share geocoded maps of high risk ZIP codes with partner agencies. Further updates on the primary prevention pilot project will be included in upcoming Council meetings.
Recent Developments in Housing and Lead Poisoning Prevention: Making Primary Prevention a Reality:	Dr. David Jacobs, Research Director at the National Center for Healthy Housing provided a historical overview of lead poisoning and the historical development of healthy housing in the past 150 years, and compared poor housing conditions across the world, noting the correlations between poor housing and infectious diseases and environmental illnesses. Other topics discussed included: • Development of dust and soil standards by HUD and EPA; • Effectiveness of housing-based interventions, including cleaning, paint stabilization, window treatment and window replacement; • Recommendations for updating lead in dust standards; • Dust suppression techniques during demolition;	

Topics/Speaker	Discussion	Follow Up
D. Jacobs	• Healthy homes approaches; • Low income housing tax credits for rehabilitation or construction of new housing; • Healthy housing and positive health outcomes; • Developing standards for lead in children's toys; and • Lead and crime rates in multiple international studies. Council discussion took place on several issues, including: • The rationale for not lowering the level of concern to 5 mcg/dL. It was noted that development of environmental standards takes into account scientific evidence as well as attainability and measurability of standards; • Current occupational BLL standards. It was noted that the current OSHA standard is 50 mcg/dL; • Standards for lead in water. It was noted that while water-based exposure is a source that needs to be addressed, it accounts for a small proportion of environmental lead exposure. Additionally, addressing lead-contaminated water systems is very expensive. • The preference between abatement controls and interim controls. It was noted that in practice, most housing rehabilitation projects use a combination of abatement and interim controls.	
Screening and Education Updates: R. de Long	Dr. de Long provided a brief update on screening and education initiatives, including point-of-care lead testing and outreach and education for children with BLLs below 10 10 mcg/dL. She began by reviewing the historical and current availability of point-of-care lead screening and the recent federal FDA-classification of new point of care technology as Clinical Laboratory Improvement Amendment (CLIA)-waived. She also discussed current regulations regarding blood lead testing, and proposed regulations to address barriers to use of point of care blood lead analysis devices in provider settings in New York State. Council discussion took place on several issues, including: • Quality assurance and control with health care provider offices using CLIA-waived devices. It was noted that NYCDOHMH works with Medicaid providers on quality assurance and control, and that at least one other state reportedly requires satisfactory completion of proficiency testing as a condition for receiving Medicaid reimbursement for point-of-care blood lead testing; • The importance of provider reporting of results obtained through point of care testing;	

Topics/Speaker	Discussion	Follow Up
Educational Interventions for Children with BLLs <10 mcg/dL	• Other settings for point of care blood lead analysis. It was noted that the proposed regulations would allow use of CLIA-waived point of care testing in limited service laboratory settings (e.g., public health clinics, school-based health centers), in addition to physician office settings. Dr. de Long described a new initiative planned to develop educational materials for parents and health care providers of children with BLLs < 10 mcg/dL, in light of the evidence BLLs < 10 mcg/dL are associated with decreased IQ scores. In NYS, approximately 22,000 children are identified with BLLs 5-9 mcg/dL each year. Topics under consideration include: • Educational messages and materials for parents and health care providers; • Appropriate dissemination methods; and • Logistics for implementation of various approaches. The Department is interested in receiving input from Council members and others on the development and distribution of messages and materials. A work group will be formed to help develop the project. Council discussion took place on this issue, including: • NYCDOHMH recommends that physicians start education on risk reduction for families of children with BLLs of 5 – 9 mcg/dL. • Strengthening education to health care providers indicating that BLLs of 5 – 9 mcg/dL are not "normal" lead levels; • Information developed by the Rochester Coalition to End Lead Poisoning on this topic; • An update on the efforts in Rochester to work with local blood lead testing laboratories to change their reporting forms indication of blood lead levels < 10 mcg/dL. As a result of these efforts, one of the three major laboratories in Rochester has agreed to change the wording of laboratory reports for BLLs 0-9 mcg/dL, pending final approval from laboratory directors.	The Department will convene a workgroup to develop educational interventions for children with BLLs < 10 mcg/dL. Interested council members are invited to participate in this workgroup. Dr. Broadbent will share copies of the materials developed by the Rochester coalition. The workgroup will review these as part of the new initiative described. CLPPP staff will work with staff from the Department's Wadsworth Laboratory to pursue changes to laboratory reports with BLL results < 10 mcg/dL. An update will be included at the next Council meeting.
State Agency Updates	Representatives from state agencies provided the following updates on lead-related activities: • Tom Mahar, Department of State (DOS), commented that the next series of hearings for the International Code Council's (ICC) National Code Change Proposal are scheduled for February 2008 in California. DOS	

Topics/Speaker	Discussion	Follow Up
	will again propose the lead-based paint initiative as previously described. NYS has reactivated its' technical subcommittees to compare NYS Codes to the ICC 2006 National Codes. Mr. Mahar is the chair of the Property Maintenance Codes technical subcommittee. • Doug Morrison, Department of Environmental Conservation, commented that the Office of Environmental Justice has completed a request for applications for the Environmental Justice Community Impact Grants, which now include projects that deal with childhood lead poisoning and lead contamination in communities. Currently, one project in Syracuse is being funded which is examining the effectiveness of various education methods in reducing blood lead levels in children. A new round of solicitations is anticipated by October 2007 for additional grants; approximately $1,000,000 total is available. Currently, each grant is for up to $25,000. Organizations must represent smaller organizations no larger than towns. Each applicant must focus on environmental health issues, must include a research component (can be social, educational, biological or chemical research), and must include a community education component. • Alicia Sullivan, Office of Temporary and Disability Assistance, stated that the Bureau of Refugee and Immigrant Assistance has been awarded a grant from EPA to translate lead poisoning prevention materials into five languages (Chinese Cantonese, Mandarin, Italian, Hindi and Haitian-Creole) and conduct education, outreach and translation of lead poisoning prevention materials to cities within the leading high incidence counties (NYC, Rochester, Buffalo, Albany, Syracuse, Utica). This is a 2-year contract, anticipated to begin in October 2007.	
Public Comment	No comments were received.	
Adjournment	Meeting adjourned at 2:48 pm.	

Appendix D

2008 Advisory Council Meeting Minutes

March 6, 2008
June 19, 2008

NYS DEPARTMENT OF HEALTH
MARCH 6, 2008
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow Up
Attendees	**Council Members:** • Guthrie S. Birkhead, M.D., M.P.H., Deputy Commissioner, Office of Public Health (**Council Co-Chair)** • Mary Binder, Environmental Analyst, Division of Housing and Community Renewal (Commissioner Designee) • David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) • Abby Greenberg, M.D., Acting Commissioner, Nassau County Health Department; Representative, American Academy of Pediatrics – Division II (Local Government) • Nancy Kim, Ph.D., Interim Director, Center for Environmental Health **(Council Co-Chair)** • Monica Kreshik, NYS Department of Environmental Conservation (Commissioner Designee) • Thomas Mahar, Code Compliance Specialist III, NYS Department of State (Adjunct Designee) • Ellen Migliore, R.N., M.S., Public Health Nurse, Herkimer County Health Department. (Child Health Advocate) • Deborah Nagin, M.P.H., Director, NYC Department of Health and Mental Hygiene – Lead Poisoning Prevention Program (Adjunct Designee) • Kathleen Pickel representing William Dorr, Assistant Director, Division of Child Care Services, NYS Office of Children and Family Services (Commissioner Designee) • Tanya Ross, Associate Industrial Hygienist, NYS Department of Labor (Labor) • Alicia Sullivan, Associate Counsel, NYS Office of Temporary and Disability Assistance (Commissioner Designee) **Additional Attendees:** • Michael Cambridge, R.S., Bureau of Community Environmental Health and Food Protection, NYSDOH • Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health, NYSDOH • Eileen Franko, Dr.P.H., M.P.H., Director, Bureau of Occupational Health, NYSDOH • Valerie Grey, Assistant Commissioner, Office of Governmental and External Affairs, NYSDOH • Richard Jenny, M.D., Wadsworth Center, NYSDOH • Barbara Leo, M.S., F.N.P., Manager, Childhood Lead Poisoning Prevention Program, Bureau of Child and Adolescent Health, NYSDOH • Barbara McTague, Director, Division of Family Health, NYSDOH • Bruce Phillips, Counsel, NYSDOH • Richard Svenson, Director, Division of Environmental Health Protection, NYSDOH	

NYS DEPARTMENT OF HEALTH
MARCH 6, 2008
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow Up
	Absent Council Members: • Rolaine Antoine, Queens Village, NY (Parent Representative) • Thomas Ferrante, Manager of Training and Technical Services, Total Safety Consulting (Labor Union) • Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY Buffalo (Professional Medical Organization) • Lindsay Lake Morgan, R.N., Ph.D., A.N.P.; Assistant Professor, Decker School of Nursing, SUNY Binghamton (Education) • Philip J. Landrigan, M.D., M.Sc., FAAP, Director and Professor of Pediatrics, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital) • Clifford Olin, President, EcoSpect (Industry) • Stacy Rowland, Deputy Superintendent, Legislative Affairs, State Insurance Program (Adjunct Designee) • William Schur, Vice President, Schur Management Company, Ltd. (Real Estate)	

Welcome and Introductions; Review of Minutes
 	
Dr. Birkhead
	• The meeting was convened at 10:15 a.m.
	• Dr. Birkhead opened the meeting and welcomed the Council members.
	• Dr. Birkhead provided an overview of the full day meeting agenda addressing major activities currently in progress and identified by Council members as priorities for discussion. Dr. Birkhead presented brief highlights of progress since the last Council meeting in September 2007, including:
	  • Implementation of a new Primary Prevention Pilot Initiative;
	  • Analysis of lead surveillance data;
	  • Support for local Childhood Lead Poisoning Prevention Programs (CLPPPs) in all LHDs across the state;
	  • Completion of a competitive application process to fund three Regional Lead Resource Centers (RLRCs) for a five-year period;
	  • Provided input on the advanced notice of proposed rulemaking for the U.S. Environmental Protection Agency National Ambient Air Quality Standards;
	  • Use of new portable blood lead analysis devices; and
	  • Proposed changes to lead poisoning prevention regulations.
	• Draft minutes of the September 10, 2007 Advisory Council meeting were reviewed and accepted.	

Department of Health Office of Governmental Affairs – 2008	Valerie Grey, Assistant Commissioner, Office of Governmental and External Affairs gave an overview of the 2008 State Budget. • Ms. Grey described the process for the Governor's 21-day amendments to the state budget. • The next step is for the Legislature to begin negotiations and conferencing to approve the state budget.	

Topics/Speaker	Discussion	Follow Up
State Budget Overview **Valerie Grey**	In addition to the budget, the Legislature will be reviewing program bills (submitted by the Governor by April 1, 2008) and Departmental bills (submitted by state agencies by March 1, 2008). These include a Department of Health legislative proposal related to childhood lead screening.	
Department of Health Legislative Proposal (Department Bill) Childhood Lead Screening **Rachel de Long**	Dr. de Long discussed the purpose of a proposed Departmental Bill to increase childhood lead screening/testing rates by expanding the statewide immunization registry, (New York State Immunization Information System (NYSIIS)), to include childhood lead screening/testing data. The Bill amends current Public Health Law (PHL) to: • Authorize disclosure of blood lead results to NYSIIS; and • Grant health care providers access to NYSIIS for additional specific purposes, including required submission of results from portable blood lead analysis, determination of blood lead screening status, review of practice coverage, generation of reminder notices and quality improvement. • If enacted the bill, would become effective September 1, 2008. Council discussion took place on several issues, including: • Collection and processing of immunization and lead data within NYSIIS. The immunization registry is being implemented throughout the state in 2008-2009, with regional trainings for health care providers scheduled; • Availability of data from NYSIIS for academic and research purposes. It was clarified that lead and immunization data specific to individual children will not be available to the general public and researchers as stipulated by PHL. • The need for proposing legislation to exchange data between LeadWeb and NYSIIS. It was clarified that current statute does not allow for the sharing of data between the two registries without statutory change; • New York City Department of Health and Mental Hygiene (NYCDOHMH) has developed a joint registry, the "Master Child Index," which is populated by vital records, but maintains individual immunization and lead registries. • The practical nature of the linked registries will allow for better assurance of complete lead testing and immunization for children who move, or present at an emergency room or urgent care setting.	
Primary Prevention of Childhood Lead Poisoning **Mike Cambridge**	Mike Cambridge gave a brief update on the implementation of the $3 million in the 2007-2008 budget to support a lead primary prevention pilot project. Eight local health departments (LHDs) were identified for the first year of the pilot project, based on high incidence zip codes, and have received funding to develop primary prevention plans and other associated contract requirements. Mr. Cambridge further described the role of the National Center for Healthy Housing in providing technical guidance to the Department and the eight identified LHDs funded under this initiative. He also gave a brief summary on each LHDs approach to primary prevention, and how evaluations of the various approaches used by LHDs are in progress.	

Topics/Speaker	Discussion	Follow Up
	Mr. Cambridge noted the proposed $5.5 million funding for the primary prevention pilot project in the 2008-2009 executive budget, and requested comments and recommendations from the Council on implementation of the additional funds, including expansion of the existing eight LHD contracts, funding additional LHDs with high risk ZIP codes or a combination of these two approaches. Mr. Cambridge asked Council members to provide input on other ideas. Mr. Cambridge discussed some considerations for determining the next steps for use of the increased funding, including: • Number of children with elevated lead levels; • Number of housing units built before 1978; • Availability of other programs/services to enhance the effectiveness, such as Healthy Neighborhood Programs (HNP) and, U.S. Department of Housing and Urban Development (HUD) funds for property owners; • Full or partial service health departments; • Effectiveness of the local program design; and • LHDs with multiple high risk zip codes. Council discussion took place on several issues, including: • Use of evaluation measures and plans implemented by the eight current pilot programs, including guidance from the National Center for Healthy Housing; • Consistency between each pilot project LHD in regards to the role and responsibilities of the landlord, the locality's building codes, and strength of local regulations; • Methodology to determine ZIP codes designated as high-risk, and flexibility of each pilot project implementation plan to adjust to changing incidence of EBLLs and to designate additional ZIP codes at high risk; and • Use of the OCFS day care registry website to identify day care facilities located in high-risk ZIP codes.	Comments on the next steps were requested to be sent to Michael Cambridge (mjc03@health.state.ny.us) or Tom Carroll (tjc03@health.state.ny.us) by April 1, 2008. DOH staff will follow up with OCFS about a registry of day care facilities in target communities.

Childhood Lead Poisoning Surveillance Reports
 	
Rachel de Long
	Rachel de Long provided an update on the 2004-05 surveillance data report.
	• Analysis of 2004-05 lead surveillance data has been completed. A comprehensive data report has been developed, and is under Departmental review. New analyses include:
	  • screening rates by age category;
	  • incidence numbers and rates by BLL category;
	  • analysis of children with BLL < 10 mcg/dL;
	  • demographic analysis by age and gender;
	  • maps of screening and incidence measures; and	

Topics/Speaker	Discussion	Follow Up
	• ZIP code level analysis of incidence numbers; • A poster was developed and presented at the recent DOH poster day on February 13, 2008. Dr. de Long explained the dissemination process of the 2004-2005 data report, included posting the report to the DOH website; printed copies to be distributed to LHDs, Regional Lead Resource Centers and others upon request. Dr. de Long requested Council member input regarding the development of a shorter companion 2004-2005 data document for the general public. Council members were asked to provide suggestions on what key messages should be included, how these messages should be graphically represented (e.g., tables, charts, maps), and to whom the companion document, as well as the comprehensive data report, should be distributed. Dr. de Long also discussed plans for the 2006-07 data analysis report and requested comments and recommendations from the Council on additional analyses to be considered for the 2006-2007 data report. Council discussion took place on several issues, including: • Whether the ZIP code analysis conducted was based on the child's address or the physician's address. The addresses in the ZIP code analysis are the child's address, and the Department conducts routine quality assurance to identify and correct or remove records when a health care provider or laboratory address is listed as the child's address prior to analysis. • Why ZIP codes were analyzed, versus census tract for the data analysis. ZIP code analysis was used to determine areas of high risk because the primary prevention pilot project budget bill language passed in 2007 specifically required ZIP code analysis. The Department is also currently working to complete geocoding of addresses in LeadWeb, to allow for further analysis at the census tract level in future reports. • Recommendations for future data analysis, including further detail on demographic and geographic characteristics of children with BLLs between 5-9 mcg/dL; • The role of the newly funded Regional Lead Resource Centers, including an expanded emphasis on health care provider education to increase screening of children at age one year and again at age two years; • Concerns were expressed on how to increase the percentage of children who either (a) did not receive a screening test at two years of age, or (b) were tested and were identified with elevated blood lead levels. Discussion revolved around various ways to improve testing at age two years and effective methods of health care provider education; and • The importance of data reports for the general public when reaching out to providers and working with families.	Comments can be provided by e-mail to Dr. de Long (rmd07@health.state.ny.us) or Barbara Leo (bjl03@health.state.ny.us) Further discussion of 2006-2007 data analysis will be scheduled for the next Council meeting.

Topics/Speaker	Discussion	Follow Up
NYC Update **Deb Nagin**	Deborah Nagin gave an update on progress at NYCDOHMH. Efforts include improving the lead risk assessment among children and pregnant women, and analyzing characteristics of lead-poisoned children born in US and refugee/immigrant children. Ms. Nagin also discussed the influence that these analyses may have on policy and procedures. Ms. Nagin provided a brief overview of the NYC Lead Elimination Plan, related to reducing exposure to non-paint lead sources. NYCDOHMH works to increase the understanding of non-paint exposures, build new community partnerships, educate immigrant communities, and reduce exposure through community outreach, education and enforcement, as needed. NYCDOHMH has developed a new Child Risk Assessment (CRA), designed to improve risk assessment, improve the quality and consistency of surveillance data, and increase the knowledge gained of the characteristics of children receiving an environmental investigation. This form was implemented in June 2006, and included staff training on implementation of the form and interviewing techniques. Quality assurance reviews are conducted by program supervisors. New questions include: • Mother and father's country of origin; • Child's country of birth, and region (for foreign-born children); and • Foreign travel. The CRA form addresses several key areas, including prenatal exposures, foreign exposures (e.g., child's country of birth, length of stay, family background), foreign travel patterns, use of imported products, non-food items that the child may have eaten, chewed or mouthed, occupational exposure of household members, paint hazards and dust sampling, lead in soil and lead in water. Ms. Nagin provided an overview of lead poisoning in NYC in 2006. 800 children were identified with BLLs $\geq$15 mcg/dL. Of these, foreign-born children were over-represented compared to the overall proportion of foreign-born children in NYC. Data collected identified that the average age of a lead poisoned child born in the US was 27 months (2.25 years); the average age of a foreign-born child with lead poisoning was 65 months (5.4 years), with wide variance between countries. Disparities were also identified with the age of first blood lead test; foreign-born children were first tested on average at age 75 months; US-born children were first tested on average at 18 months of age. Foreign-born children were also less likely to have an identified lead-based paint hazard found in the environmental inspection, despite living in the same or similar neighborhoods.	Copies of NYC's CRA form and Risk Assessment for Pregnant Women will be provided to Council members.

Topics/Speaker	Discussion	Follow Up
	Ms. Nagin discussed the implications of these data in regards to policy and initiatives. Education and outreach to health care providers, particularly those who care for immigrant children, should encourage testing of older immigrant children. Outreach and education efforts for high-risk immigrant communities should continue, focusing on reducing current and future lead exposures, using effective, clear and culturally appropriate messages. Council discussion took place on several issues, including: • Status of BLLs of siblings in immigrant families with an older child with an EBLL, and identifying common sources of lead exposure in the U.S.; • Lowering the environmental intervention level below 15 mcg/dL. Resources currently don't allow for environmental investigations for all children with BLLs of 10-14 mcg/dL, but educational interventions are conducted for children with BLLs of 10-14 mcg/dL, and are being developed for children with BLLs 5-9 mcg/dL; • Trends and information on older children with EBLLs born in the U.S. In U.S.-born children with elevated blood lead levels, the proportion of older children compared to young children (age 0-5 years) is small. NYCDOHMH does assess all older children identified with EBLLs up to 18 years of age; and • Using the risk assessment form to identify additional non-lead paint sources of exposure.	
Renovation and Remodeling **Eileen Franko**	Eileen Franko gave an overview on the current project "Renovation and Remodeling (R&R) Study for 2006-07". In 1993-1994, NYSDOH conducted a survey, published in MMWR, on Renovation and Remodeling. It found that of the 4,608 children referred for environmental investigations, 320 children most likely were exposed to lead due to renovation and remodeling, in 258 homes. This accounted for 7% of all children identified with EBLLs in NYS, excluding NYC. As a result, an R&R Campaign was implemented beginning in 1995, including videos on safe methods for lead removal and development of public service announcements. In 2006-2007, the Bureau of Occupational Health conducted a similar survey of local health department environmental inspections to assess the impact of R&R as a potential source of lead poisoning. 153 households that received environmental investigation were found to have R&R as a potential exposure source; this represents 13.3% of all dwellings referred for environmental investigations in NYS, excluding NYC. Further analysis was conducted on who performed the R&R (e.g., owner/tenant, non-resident owner, contractor), the location of the house, type of work conducted, and age of house. The housing markets during both survey periods (1993/1994 and 2006/2007) exhibited similar characteristics, in that houses were difficult to sell, so homeowners were conducting more R&R activities to either increase the marketability of the house or to repair it for continued occupancy. Dr. Franko requested Council input on the next steps as a result of this study, including educational messages, message delivery, target audience(s), and developing a sustaining message.	

Topics/Speaker	Discussion	Follow Up
	Initial feedback from Council members included: • Developing "consumer data sheets" similar to material safety data sheets (MSDS), to be provided at the point-of-sale to the consumer; • Prohibiting dry scraping and sanding of paint of unknown lead content, similar to NYC's regulation; providing education in stores (e.g., wet method); • Reinforcing education about lead dust as the predominant exposure source; • Methods on educating homeowners; • Adding on to existing trainings (e.g., Home Depot "Do-It-Yourself " trainings; manufacturer-sponsored contractor trainings); • Prenatal outreach (e.g., painting the baby's room safely) as a mechanism to outreach to families; • Outreach and education to new property owners (may be different than outreach to families); • Working with county clerk for all applications for mortgage tax and deeds; • Rotating or scattering the educational messages to maintain the educational initiatives; and • Establishing lead safe work practices as an educational standard in trade schools and other vocational training settings	Additional Council comments should be E-mailed to Eileen Franko at emf03@health.state.ny.us
Update on Proposed Regulation Changes to SubPart 67. **Rachel de Long** **Mike Cambridge**	Dr. de Long and Mr. Cambridge provided an update on the status of the proposed regulatory changes to Subpart 67 of Title X, NYCRR. The Department is finalizing the text of the regulatory proposals, and is seeking input on the benefits, need, and impact of the proposed regulatory changes, through outreach to stakeholder groups including the Council. Dr. de Long summarized proposed changes to Subparts 67-1 and 67-3, regarding screening and case management/follow-up of children. The discussion focused on changing the level of environmental intervention from $\geq$ 20 mcg/dL to $\geq$ 15 mcg/dL, authorizing the use of CLIA-waived portable blood lead analyzers in provider office laboratories (POLs) and limited service laboratories (LSLs), and requiring reporting of screening results from these devices. The proposed changes to regulations for expanded comprehensive case management services would require diagnostic evaluation, medical treatment and referral for environmental management for all children with BLLs $\geq$ 15 mcg/dL compared to the current BLL threshold of $\geq$ 20 mcg/dL. The rationale for expanding these services include: • Reducing environmental lead hazards for affected children as well as other children (e.g., siblings, future children residing in dwelling); • Number of children (NYS, excluding NYC) with BLLs $\geq$ 20 mcg/dL has declined from 1,113 children in 1996 to 326 children with BLLs $\geq$ 20 mcg/dL in 2005. In 2005, the total number of children with BLLs $\geq$ 15 mcg/dL was 786; and • Currently, several LHDs are providing comprehensive case management to children with BLLs $\geq$ 15 mcg/dL.	Provide Council with proposed regulations for comment when available

Topics/Speaker	Discussion	Follow Up
	Council discussion took place on several issues, including: • Clarification of the age at which comprehensive case management would be conducted. Public Health Law and regulations are only age-specific for universal blood lead screening (at age one year and again at age two years) and risk assessment-based screening (age six months to six years). Requirements for follow-up services for children with EBLLs are not age specific; and • The capacity of LHDs and the health care workforce to respond to the increased caseload. The second major proposed change to regulation would allow the use of CLIA-waived portable blood lead analyzers in POLs and LSLs as a blood lead screening test. Current regulations predate the existence of such technology, and only permit lead testing in certified toxicology laboratories. In recognizing new technologies, the proposed changes will authorize the use of CLIA-waived portable blood lead analysis devices in appropriate settings (POLs and LSLs), and require reporting of screening lead test results from CLIA-waived portable blood lead analysis devices to the Department within five (5) business days. The rationale for these changes include: • Reduction of barriers for parents obtaining blood lead screening tests for children; and • Assuring a complete surveillance system of all blood lead screening tests, as well as to assure appropriate follow-up. Council discussion took place on several issues, including: • Additional reimbursement to health care providers for blood drawing and testing with CLIA-waived portable blood lead analysis devices. This is recognized as an important question, and discussion has been initiated within the Department. • Quality assurance and control, regarding CLIA-waived portable blood lead analyzers. Dr. Jenny, from the Wadsworth Center, summarized the monitoring and quality assurance practices for LSLs and POLs. Mr. Cambridge described the proposed regulatory changes for Subpart 67-2. These changes include updates or revisions to requirements for environmental investigations for lead hazards, sampling, the Notice and Demand process, abatement and enforcement. The proposed updates to regulations will bring the regulations in alignment with current federal guidelines and technology. Proposed changes will also clarify the process to issue a Notice and Demand, update the definition of lead in paint by XRF sampling to be consistent with federal guidelines, and will specify training requirements by hazard control workers. Changes will not restrict or supersede NYC authority and duties of Local Law 1.	

Topics/Speaker	Discussion	Follow Up
	Council discussion took place on several issues, including: • Requirement of education and training for interim control activity and abatement activities. More extensive repairs will be required to be conducted by an EPA-certified firm, whereas minor repairs will be required to be conducted by contractors with lead-safe work practices (HUD training). The LHDs are required to approve any remediation plans, and have the authority to require an EPA-certified firm; and • Environmental regulations in Subpart 67-2 do not have specifications toward age of child. The Department is working to clarify the flexibility for LHDs to address the potential sources of lead exposure for older children that may differ from those of young children.	
Blood Lead Levels < 10 mcg/dL **Dr. Richard Jenny, Ph.D.** **Barbara Leo**	Dr. Jenny and Ms. Leo presented information on initiatives related to children with blood lead levels < 10 mcg/dL. Dr. Jenny discussed an initiative undertaken by Wadsworth Center, the State Public Health Laboratory, related to changing the language on laboratory requisitions for BLLs < 10 mcg/dL. Currently, blood lead analysis results < 10 mcg/dL are typically reported as "normal" by most laboratories. Following a standard process for modifying laboratory requirements, Wadsworth Center sent a letter to all certified laboratories proposing a change in language on laboratory requisitions for blood lead levels < 10 mcg/dL. It was proposed that a comment be added to the test report for all BLLs that are < 10 mcg/dL, but that are above the level of detection limit. If implemented, the proposed language would read, "Blood lead levels < 10 mcg/dL have been associated with adverse health effects in young children." The laboratories were provided an opportunity to comment on the proposed change. Eleven laboratories responded, out of approximately 60 certified laboratories. Comments received by certified laboratories, in general, included: • Interest on the part of the laboratory to maintain consistency with CDC guidance, which considers BLLs $\geq$ 10 mcg/dL as a level of concern in children; • The need to provide physicians and families with information to complement the proposed changes on lab reports; • questions concerning the varying capacity of laboratory technology to accurately detect lower lead concentrations; and • All of the commenting laboratories agreed that something needs to be done in reference to a BLL <10 mcg/dL as not being "normal". Wadsworth will continue to review comments received from laboratory directors on the proposed amendment to NYS Department of Health Clinical Laboratory Reference System Lead Testing Standards that addresses interpretation of blood lead levels below 10 mcg/dL. If implemented, the proposed change would be designated as Blood Lead Standard 11 (BL 11) and required of all laboratories holding a permit in the "Toxicology – Blood Lead" category	

Topics/Speaker	Discussion	Follow Up
	Council discussion took place on several issues, including: • The standard statement of a reference interval on laboratory reports, and the compromise that is being developed to include a statement of concern related to blood lead levels < 10 mcg/dL. Laboratories would have to include the proposed language, if implemented. This change would reiterate to health care providers that there is concern for BLLs < 10 mcg/dL. • Strong Memorial Hospital and ACM Laboratories of Rochester, NY, have changed the wording on laboratory reports for BLLs < 10 mcg/dL; Rochester General Hospital is considering similar changes. Council members discussed the processes in which Rochester-area hospitals worked with the Coalition to End Lead Poisoning to accomplish these changes. • New York City provides guidance to all physicians on providing risk reduction education and anticipatory guidance to parents of children with BLLs of 5-9 mcg/dL. Ms. Leo briefly described the Department's initiative to develop and distribute anticipatory guidance to health care providers and parents of children with BLLs < 10 mcg/dL. The CLPPP has convened a work group to assist with the development of the education materials including LHD staff, Council members, Regional Lead Resource Centers, DOH staff from Central and Regional Office staff, and staff from OCFS. In 2005, 190,956 (98.8%) of children under the age of six years who were tested for lead had BLLs < 10 mcg/dL. Of these, 22,096 (11.4%) had BLL 5-9 mcg/dL; 168,860 (87.4%) had BLL $\leq$ 4 mcg/dL. The new educational initiative will be developed with the target audience of parents and health care providers. The goal of the initiative is to develop education materials that provide information on how to prevent further increases in BLLs through the prevention of further exposure. Specific objectives include: • To increase parental knowledge and awareness on methods for preventing or reducing further exposure to lead; • To increase parental risk reduction behaviors; • To increase health care provider knowledge, awareness and efficacy to provide risk reduction and anticipatory guidance to parents of children with BLLs 5-9 mcg/dL; and • To increase parental and health care provider knowledge of blood lead testing requirements in accordance with NYS screening requirements.	CLPP staff will continue to work with Wadsworth Center on this issue. Updates will be provided at future meetings.

Topics/Speaker	Discussion	Follow Up
	The work group is currently working to identify key messages for parents and health care providers, content and format of the new materials, and methods for disseminating the new materials. The initial proposed materials include: • An educational handout for parents of children with BLLs under 10 mcg/dL that includes information about lead poisoning and risk reduction messages; and • A statewide mailing to pediatric health care providers, including a Commissioner's letter, new parent education materials, and a summary of recommendations in MMWR, November 2007. Materials will likely be posted on the DOH website and may be mailed directly to parents. Council discussion took place on several issues, including: • Inclusion of NHANES levels in the parent education initiatives; and • Developing a "long form" for more detailed information, in addition to a "short form" for basic information.	
Council Member Updates and State Agency Updates	Council members and representatives from state agencies provided the following updates on lead-related activities: • The Division of Housing and Community Renewal is actively participating in the Governor's housing initiative, which will provide $400 million for low-income housing across NYS. Low-income housing (Section 8 housing) is required to be lead-safe. • The Department of Environmental Conservation's Office of Environmental Justice recently announced its' third round of grants to community-based organizations addressing issues in communities traditionally burdened by environmentally-associated health impacts. Over $1 million in grants are available in total, with each applicant able to request up to $50,000. Applications are due April 23, 2008. The current round of grants is open to applicants working on projects in many areas of environmental concern, including lead. New language was included in the RFA to include those projects which "identify lead hazards for children and pregnant women, prevent lead-related housing risks, and/or promote lead safe work practices by homeowners and contractors in residential remodeling and renovation". Council members were provided with information to distribute to constituents. Funding cycles are up to 3 years. • On April 1 and 2, 2008, the Rochester Pediatrics Society Annual Bevin Lecture is hosting Dr. Bruce Lanphear, who will give a lecture on Rochester's role on the ongoing elimination of lead toxicity. • Since revising the WIC form to include lead testing requirements, Rochester is now looking at making changes to the Medical Report for a Child in Daycare form. In Monroe County the daycare health form is based on a state form. (The Daycare form is a social service form.) The Screening Committee of the Lead Coalition would like to propose that the Daycare form include information about lead testing at ages one and two with date and result listed on the form and a statement "Per NYS law, a blood lead test is required at one and two years of age and whenever risk of lead poisoning is likely."	Request for updated Advisory Council roster. CLPPP staff will follow up with OCFS to explore potential changes to the day care form.

Topics/Speaker	Discussion	Follow Up
Public Comment	Matthew Chachere, Counsel for the NYC Coalition to End Lead Poisoning, and member of NYS Coalition to End Lead Poisoning, provided concerns on the Subpart 67-2 proposed regulatory change, including: • Permitting interim controls in secondary interventions (when a child is identified with an EBLL), to match federal regulations. Mr. Chachere noted that since New York State has the highest number of pre-1960 houses, and ranks second in the number of lead poisoned children, performing interim controls may not be enough. • The federal guidelines, with which the proposed regulations will align, categorize interventions as either "abatement" or "interim control," regardless of the potential lead exposure produced if unsafe work practices are used (e.g., an interim control of scraping paint may produce more lead dust than the abatement act of replacing a door).	
Adjournment	The next meeting is scheduled for June 19, 2008. One Council member requested to reschedule the June meeting. The Department will follow up with Council members to assess other potential dates. Meeting adjourned at 3:30 PM.	The Department could not secure a webcasting-accessible venue for other potential dates. The next meeting is scheduled for June 19, 2008. An agenda and other relevant material will be forthcoming.

NYS DEPARTMENT OF HEALTH
JUNE 19, 2008
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow Up
Attendees	**Council Members:** • Guthrie S. Birkhead, M.D., M.P.H., Deputy Commissioner, Office of Public Health (Council Co-Chair) • Nancy Kim, Ph.D., Interim Director, Center for Environmental Health (Council Co-Chair) • Mary Binder, Environmental Analyst, Division of Housing and Community Renewal (Commissioner Designee) • Abby Greenberg, M.D., Acting Commissioner, Nassau County Health Department; Representative, American Academy of Pediatrics – Division II (Local Government) • Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY Buffalo (Professional Medical Organization) • Thomas Keenan, Temporary Assistance Specialist, NYS Office of Temporary Disability Assistance (OTDA), Bureau of Refugee and Immigrant Assistance (BRIA) (Adjunct Member) • Monica Kreshik, EJ Coordinator, NYS Department of Environmental Conservation (Commissioner Designee) • Lindsay Lake Morgan, R.N., Ph.D., A.N.P.; Assistant Professor, Decker School of Nursing, SUNY Binghamton (Education) • Thomas Mahar, Code Compliance Specialist III, Assistant Director, Regional Services NYS Department of State Code Division (Adjunct Designee) • Ellen Migliore, R.N., M.S., Public Health Nurse, Herkimer County Health Department. (Child Health Advocate) • Deborah Nagin, M.P.H., Director, NYC Department of Health and Mental Hygiene (NYCDOHMH) – Lead Poisoning Prevention Program (Adjunct Designee) • Clifford Olin, President, EcoSpect, Inc. (Industry) • Kathleen Pickel, Child and Family Services Specialist 2, Division of Child Care Services, NYS Office of Children and Family Services, (Commissioner Designee) • Tanya Ross, Associate Industrial Hygienist, NYS Department of Labor (Commissioner Designee) **Additional Attendees**: • Richard F. Daines, M.D., NYS Commissioner of Health • Michael Cambridge, R.S., Director, Bureau of Community Environmental Health and Food Protection, Center for Environmental Health • Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection, NYSDOH • Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health, NYSDOH • Todd A. Gold, Director of Policy Research, NYS Consumer Protection Board • Lisa R. Harris-Eglin, Deputy Executive Director and General Counsel, NYS Consumer Protection Board	

Topics/Speaker	Discussion	Follow Up
	• Barbara Leo, M.S., F.N.P., Program Manager, Childhood Lead Poisoning Prevention Program (CLPPP), Bureau of Child and Adolescent Health, NYSDOH • Bruce Phillips, Counsel, NYSDOH • Richard Svenson, Director, Division of Environmental Health Protection, NYSDOH **Absent Council Members:** • Rolaine Antoine, Queens Village, NY (Parent Representative) • David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) • Thomas Ferrante, Manager of Training and Technical Services, Total Safety Consulting (Labor Union) • Philip J. Landrigan, M.D., M.Sc., FAAP, Director and Professor of Pediatrics, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital) • Stacy Rowland, Deputy Superintendent, Legislative Affairs, State Insurance Program (Adjunct Designee) • William Schur, Vice President, Schur Management Company, Ltd. (Real Estate)	

NYS DEPARTMENT OF HEALTH
JUNE 19, 2008
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow Up

Welcome and Introductions	• The meeting was convened at 10:08 a.m.
	• Dr. Birkhead opened the meeting and welcomed the council members.
	• Dr. Birkhead provided opening remarks regarding compliance with relevant executive orders:
	  ◦ In accordance with Executive Order #3 and the Open Meeting Law, this meeting is being made available on the internet. The meeting notice and links to the webcast are at http://www.nyhealth.gov/events. (Note: this webcast is archived until July 19, 2008 and all future webcasts are anticipated to be announced at this website and will be archived for one month following the meeting.);
	  ◦ In accordance with Executive Law, section 166, members of the public who appear before the Council and represent any agency regulated by the Department of Health must fill out a record of attendance, provided at the registration table.	

Overview of Agenda	• Dr. Birkhead provided an overview of the meeting. He indicated that additional time has been incorporated within the agenda for council discussion on key topics.
	• Dr. Birkhead highlighted progress made by the NYS Department of Health (DOH) in lead poisoning prevention, including:
	  ◦ Expansion of primary prevention initiatives;
	  ◦ Funding to support local health departments (LHDs) and Regional Lead Resource Centers (RLRCs);
	  ◦ Completion of updated surveillance data analysis;
	  ◦ Progress in proposed regulation changes.	

Review and Approval of Minutes	Dr. Birkhead asked members if there were additions or edits to the minutes of the last meeting. No comments or edits were made. Motion to accept minutes made by Ellen Migliore, seconded by Thomas Mahar. Motion passed.	
Commissioner's Welcome: Richard F. Daines, M.D., Commissioner of Health	The Commissioner reviewed progress to date, ongoing activities, and thanked the council for its contributions. He noted that lead poisoning remains an environmental health threat of great concern for children. Between 1998 and 2005, childhood lead poisoning decreased by 60%. About 5,000 children are still identified with lead poisoning each year throughout the state, concentrated in seven upstate counties and New York City. The Commissioner lauded DOH's strong partnerships with other agencies and community groups. Increasingly, DOH is focusing on primary prevention strategies, with the goal of preventing all childhood lead poisoning. DOH has seen	

Topics/Speaker	Discussion	Follow Up
	improvements in screening rates for children ages 1 and 2, and will continue strategies to promote screening in accordance with current regulations. The Department this session introduced new legislation to integrate the lead registry with the immunization registry in order to identify children in need of testing , to support clinical and state-level quality improvement activities, and to facilitate reporting of office-based lead screening results from physician offices. Dr. Daines noted his appreciation for the role the council plays and the time members have contributed. Input from this council has been very useful and he looks forward to their continuing feedback.	
Legislative Update: Dr. de Long standing in for Valerie Grey, Office of Governmental and External Affairs	Dr. de Long provided an update on the proposed departmental bill that would link the immunization and lead registries. The bill has been introduced in the Assembly and Senate. At the time of the meeting, the bill was in the Health Committee in the Senate and the Rules Committee in the Assembly. The bill would reinforce lead screening requirements and facilitate clinical quality improvement activities by integrating information at the point of care. Doctors would be able to run quality assurance reports for their practices and receive prompts for lead testing. The combined registry would also be a vehicle for providers to submit reports of blood lead screening test results obtained through portable analyzers in their offices.	
Analysis of 2006-2007 Childhood Lead Data: Dr. Rachel de Long Preliminary analysis results	Dr. de Long presented preliminary results of analysis of state-level childhood lead data from 2006 and 2007, and asked the council for input on additional analysis and how the data could be used to improve public health efforts. She noted the significance of having 2007 data available in 2008, as well as the positive trends identified in the preliminary analysis. Additional analysis and final reports are planned to be released by the end of the calendar year. Dr. de Long reviewed preliminary screening and incidence measures for NY State, excluding New York City (NYC data are analyzed and published separately by NYCDOHMH). The number and percent of children screened for lead is increasing, while the number and rate of children with new cases of lead poisoning is declining. Key findings include: • **Screening rates for children at or around age one year are improving.** 63.7% of children born in 2005 were tested for lead at or around age one year, compared to 49.4% of children born in 1998. • **Screening rates for children at or around age two years are also improving.** 51.6% of children born in 2002 were tested for lead at or around age two, compared to 38.6% of children born in 1998. Although screening rates for two year old children are improving, the percentage of children screened at age two	

Topics/Speaker	Discussion	Follow Up

Considerations for additional analysis
 	
Council Discussion
	years is lower than the percentage screened at age one year, making this an important target for screening promotion efforts.
	• **A high percent of children receive at least one lead screening test by age three years, but fewer receive two tests by age three consistent with NYS screening requirements.** Of children born in New York State in 2004, 82.8% received at least one lead screening test by age 36 months. Although the percent of children receiving at least two tests by age three years is significantly lower than the percent of children receiving one test by age three years, trend data indicate this measure is improving. The percent of children who received at least **two** screening tests by age three years increased from 26.8% of children born in 1998 to 40.8% of children born in 2004.
	• **The number of children with elevated blood lead levels (EBLLs) is steadily declining.** Trend data show the dramatic improvement in the number of children identified with confirmed BLLs $\geq$ 10 mcg/dL, the current definition of lead poisoning established by the federal Centers for Disease Control and Prevention (CDC). In 2007, approximately 1,900 children under age six years newly identified with BLLs $\geq$ 10 mcg/dL in New York State (excluding NYC), compared to 5,198 children in 1998.
	• **The rate of incidence of lead poisoning among young children is also steadily declining**. Between 1998 and 2007, a nearly 70% decline in the rate of incidence of lead poisoning was observed, from 29.8 per 1,000 children (2.98%) under age six years tested in 1998 to 9.2 per 1,000 (0.92%) of children under age six years tested for lead in 2007. Declines were observed across all blood lead level categories (10-14 mcg/dL, 15-19 mcg/dL, 20-44 mcg/dL).
	
	Next steps include:
	• Completion of additional analysis, including:
	  • Geographic analysis, including geocoding and mapping of key screening and incidence measures at county and sub-county (e.g. ZIP code, census tract) levels;
	  • Demographic descriptive analysis of children who have elevated blood lead levels; and
	  • Analysis of serial screening results, for example to assess the frequency of results $\geq$ 10 mcg/dL among children whose first screening result was below 10 mcg/dL
	• Publication of final data reports; and
	• Continued work with the Department's Environmental Public Health Tracking Grant program on a CDC initiative to create a new public portal to provide lead-related data and information on the DOH web site.
	
	Discussion took place on several issues, including:	

Topics/Speaker	Discussion	Follow Up
	• **Geographic analysis of data**. It was noted that once geocoded, screening and incidence results can be analyzed and presented at any geographic level, including county or sub-county (such as ZIP code or census tract). Urban/rural differences can also be analyzed. Dr. Lake-Morgan noted that there is a program offered through the internet that can look at influences of urban areas on rural areas. There is also interest in assessing the geographic or demographic distribution of blood lead levels 5-9 mcg/dL to assess whether it is similar to blood lead levels $\geq$ 10 mcg/dL. • **Effective use of data with physicians and other target groups**. Showing local data to physicians could be an effective way to convince them that lead is still a problem, and the importance of screening. The importance of analyzing serial lead screening results to help demonstrate the need for repeat screenings was noted, for example to demonstrate the frequency of blood lead levels 5-9 mcg/dL increasing to $\geq$ 10 mcg/dL on subsequent screening test. Because there are so many children with blood lead levels in the 5-9 mcg/dL range, NYCDOHMH has focused some analysis and targeted follow-up efforts on children with blood lead levels of 8-9 mcg/dL. • **Factors contributing to elevated blood lead levels**. It was noted that the ability to identify the potential source(s) of lead exposure for children based on available data is limited, as information on suspected sources is only collected for children who receive environmental investigations (currently mandated for children with results $\geq$ 20 mcg/dL). In addition, until recently this information has been kept at the local level, but with the implementation of environmental modules in the new statewide web-based system, it will be available for statewide analysis. Environmental investigations may include soil sampling as indicated. Interest in matching childhood lead test results with adult blood lead levels to assess the potential contribution of parent occupational exposures was also noted. Dr. Greenberg noted that Nassau County conducted an analysis of contributing environmental factors to lead poisoning over a 10-year period that found the predominant risk factor is still lead paint and dust, with no observable change due to contamination of toys or cosmetics. • **Tracking of housing level data**. When the environmental components of the new LeadWeb system are fully implemented, housing-level information, such as the number of times a specific dwelling has been identified as having lead hazards, can be identified and tracked. Through the new primary prevention initiative, some counties are tracking high-risk houses electronically. It was noted that even when a child with an elevated blood lead level moves, LHDs have the authority to require the property owner from the previous residence to carry out remediation activities to reduce lead hazards.	Dr. Lindsay Lake-Morgan will send information on the program to Dr. de Long.

Topics/Speaker	Discussion	Follow Up
Primary Prevention of Childhood Lead Poisoning: Michael Cambridge, Update on Year One of pilot project in target communities. Update on proposed funding for SFY08. Council Discussion	Michael Cambridge reviewed progress in implementing the primary prevention pilot initiative (PPPI) in the first group of eight target counties: Erie, Monroe, Onondaga, Oneida, Albany, Orange, Westchester, and NYC. The 2007-08 state budget included $3 million for a targeted pilot program that began 10/1/07. The eight localities targeted for Year 1 of this project accounted for 80% of all new cases of lead poisoning among children under age six years in 2005, with projects focusing on the highest incidence ZIP codes within these counties. All counties include lead-safe training and notifying property owners of hazards. Additional common elements include media awareness, working with Healthy Neighborhoods Programs, and code enforcement. Next steps: • **Expand the pilot program**. For 2008-09, funding is increasing to over $5 million. Up to six new primary prevention counties will be added, targeting ZIP codes with the highest number of children with EBLLs. Additional target counties identified for 2008 include: Broome, Chautauqua, Dutchess, Fulton, Montgomery, and Schenectady. The target start date is October 1, 2008. • **Evaluate the pilot program**. The National Center for Healthy Housing, a renowned national organization with expertise in primary prevention, has been funded to provide evaluation and consultation/technical support for the pilot program. Year 1 findings from the pilot projects in eight counties will be evaluated and shared with all LHDs. Developing recommendations for primary prevention strategies in lower incidence counties is an area of special interest. Discussion took place on several issues, including: • **The importance of working through local institutions and organizations**. Working through local institutions, such as refugee resettlement agencies, Section 8 housing, and others can increase the impact on housing. DOH will analyze this experience to generate recommendations to identify how to reach different groups. DOH is planning to engage other state agencies for this initiative. Each state agency at the table was requested to help mobilize their offices at the local level. Counties are also working with faith-based groups and many other groups. Working with community groups was a required part of the application. • **Specific collaboration with refugee resettlement programs**. Tom Keenan from OTDA Bureau of Refugee and Immigration Assistance (BRIA) noted the potential positive impact of collaboration with local refugee resettlement agencies, noting that about 85% of refugee resettlement in NYS is in upstate counties. Counties in the primary prevention project have flexibility to choose areas and partners for intervention. At least one pilot project in Oneida County has selected to work on this target area. DOH will be looking to	Tom Keenan will provide Dr. Birkhead with a list of local refugee resettlement

Topics/Speaker	Discussion	Follow Up
	see that other counties with high refugee resettlement make appropriate linkages. In addition to the primary prevention pilot program, the lead program has been doing work with nursing staff of LHDs, in collaboration with BRIA and the Department's Refugee Health Program, to make sure refugee children get appropriate blood lead testing. • **Details of environmental inspections**. Projects are using different approaches. For example, in some counties code enforcement officers do visual assessments, with referrals to sanitarians for technical assistance on remediation if lead hazards are suspected. Counties are using XRF testing as needed, using a tiered approach. They are following existing regulations. • **Multi-dwelling apartment buildings**. When a child with an EBL lives in a multidwelling apartment building, the entire building can be declared an area of high risk, and an inspection is done of the entire building. DOH has encouraged this approach, which has been adopted by several of the PPPI counties.	offices.
Product Safety: Todd Gold, Lisa Harris-Eglin, NYS Consumer Protection Board	Ms. Harris-Eglin and Mr. Gold presented an overview of the NYS Consumer Protection Board (CPB) and current initiatives related to children's product safety. Key information presented included: • Overview of NYS CPB. The Board was established in 1970. There are 32 staff members, with headquarters in Albany, and a field office in NYC. The Board mediates consumer complaints, utility rate issues, develops legislation, and issues policy papers. • Collaboration with the federal Consumer Product Safety Commission (CPSC). In 2003, the Board began a collaboration with CPSC. The CPSC invited the Board to become a state designee, to carry out recalls in NYS. The Board found that many products were not recalled when notices were issued. Most retailers did not know there was a recall, but retailers are generally compliant when they know. The Board is collaborating with the NYS Dept. of Agriculture and Markets and DOH to make sure consumers and retailers are aware of recall notices. The Board has educational materials and speakers available. • Involvement in recent lead hazard product recalls. Following a series of high volume major national recalls of children's products due to lead contamination in 2007, CPB surveyed 2,800 stores and found that many recalled products were still on the shelves. Working with the Dept. of Agriculture and Markets and DOH, CPB got products off the shelves. CPB then did another sweep of retailers and randomly chose over 40 products for testing. They found three products with lead hazards, all from "Dollar" stores. DOH did a statewide recall of these items, then CPSC issued nationwide recalls. A key challenge noted during this process was the inadequate labeling on some products. For example, a toy truck that was found to have high levels of lead prompting a state recall had no information on its package to identify the manufacturer or distributor, which made it very difficult to track. CPB is continuing store sweeps to monitor recall	

Topics/Speaker	Discussion	Follow Up
Council Discussion	implementation in the state, and is working with second-hand stores to display recall notices. • Development of new proposed state legislation. This year, CPB has helped the Governor draft legislation to increase product safety warning information. The proposed legislation would require manufacturers to insert a product safety owner's card for durable children's products (e.g. car seats, mattresses, cribs). Consumers who fill out and mail back the cards can then be informed if the products are recalled. The legislation also requires three types of warning labels: 1) Warning if lead paint is used; 2) Warning for all toys using magnets about danger of ingestion; 3) Warning if liquid or gel is used in a product, with a requirement that the liquid is identified. The bill also requires labeling of the manufacturer and importer, and includes display of recall notices for retailers and internet stores. • Additional ongoing consumer product safety programs. An ongoing CPB initiative is the Recall Awareness Promotion Program (RAPP). Store partners, including restaurants and hotels, agree to stay current with recall notices. CPB has a Children's Initiative, with a mascot dog named "Champ." CPB has a toy inventory check-list to help parents list all their toys in case there is a recall. CPB is also partnering with local papers to post information on where to go for recall information. CPB has information and presentations that can be shared with other organizations. Discussion took place on several issues, including: • Clarification of several points within the proposed legislation, including: • Detection limit for the proposed lead warning sign on toys. There is no specific proposed limit for notification of lead content in toys specified at this point in the current bill. It was noted that testing equipment cannot certify any product is "lead-free," but only that a product is under a certain detection limit. • Enforcement. Part of CPB's mission is to test products, conduct blind sweeps, and issue consumer tips. It is trying to work cooperatively with industry. • Applicability of legislation to lead within plastic. The current legislation is limited to lead in painted products. • Owner safety cards. The owner safety cards are sent to the original manufacturer. • Potential for industry resistance about requiring labeling of manufacturer or importer. None has been experienced to date.	

Topics/Speaker	Discussion	Follow Up
	• Impact of toy recalls on public awareness. There appears to be more general public awareness of the problem of lead poisoning and lead hazards, attributable in part to the toy recall notice work described. A preliminary analysis of lead screening rates suggests that screening went up after the August 2007 recalls, and that increases were at least partially sustained over time. • How manufacturers determine whether lead is in a product. It was noted that many manufacturers thought they were using non-lead paint, but they were not. Industry representatives say they are creating stronger oversight over their products. • Other CPB resources. OCFS distributed about 20,000 inventory check-lists to day care providers. The check-lists are on the CPB web site (www.consumer.state.ny.us). To request a speaker from CPB, visit the web site for the phone number and call.	
NYCDOHMH Childhood Lead Poisoning Prevention Update: Deborah Nagin	Deborah Nagin presented an overview of New York City lead poisoning surveillance data and current NYCDOHMH lead prevention activities. Highlights included: • Significant declines in the prevalence and severity of childhood lead poisoning between 1995 and 2007 in New York City, including an 89% decline in the number of lead-poisoned children, 0-18 years of age; a reduction in cases of severe lead poisoning (> 45 mcg/dL) from 82 cases to 19 cases; and a decline in the number of children with BLLs >20 mcg/dL from 1,709 to 287. • Lead paint remains the most common hazard identified for children with environmental investigations. Seventy-six percent of lead-poisoned children with a test result greater than or equal to 15 mcg/dL had a lead paint hazard identified. Most severe cases are attributed to serious lead paint hazards in homes. • Lead screening has improved between 2002 - 2007. About 90% of children are tested at least once by age three, and 44% are tested at both ages 1 and 2 years. Improvement is attributed to NYCDOHMH collaboration with 17 managed care programs, extensive educational efforts with providers and families, and other strategies. Standard forms for WIC and child care are also helpful for promoting lead testing. Through the NYC online registry, physicians can see patients' immunization status and lead test history. • Future directions and challenges include an expansion in primary prevention efforts. NYCDOHMH's lead program is working with their department's newborn home visiting programs, using HUD and other loan programs to reduce lead hazards. Consistent with evolving CDC guidance, NYC is also transitioning to a Healthy Homes approach, which addresses multiple hazards, e.g. CO, fire detectors, pests, mold, lead, window guards. • Another challenge is developing an approach for addressing the large number of children with blood lead levels 5-9 mcg/dL. Currently children with BLLs in this range do not receive case management services.	

Topics/Speaker	Discussion	Follow Up
Council discussion	Determining whether BLLs under 10 mcg/dL fit within primary vs. secondary prevention activities is a challenge. Discussion took place on several issues, including: • Collaborating with home visiting programs on healthy homes/primary prevention activities. NYCDOHMH trains home visiting staff to look for lead and other environmental hazards, using standardized assessment forms. Prioritizing and handling multiple issues that may be identified and successfully utilizing available funding sources are ongoing challenges. It is hoped that an upcoming CDC invitational conference will provide additional tools and guidance. • Follow-up services for children with EBLLs. NYCDOHMH follows children up to age 18 years with BLLs of 10 mcg/dL or higher, with environmental investigations beginning at 15 mcg/dL.	
Update: Public health approach to children with blood lead levels less than 10 mcg/dL: Barbara Leo **Report of work group** **Council discussion**	Barbara Leo provided an update on this initiative, the purpose of which is to address research, including the November 2007 MMWR report from CDC, that demonstrates the harmful effects of BLLs below the current CDC "level of concern" of 10 mcg/dL and recommendations for health care providers. Updates included: • Preliminary analysis of 2007 data showed that 99% of all children tested for lead had blood lead levels under 10 mcg/dL. Ten percent of all children tested had BLLs 5-9 mcg/dL, and 89% had BLLs less than 5 mcg/dL. • A letter was sent by Wadsworth to lab directors in NYS that proposed a language change to add a new required comment addressing BLL results below 10 mcg/dL on laboratory reports. This letter generated a large volume of comments in response from laboratories, which are being reviewed to inform the final development of this new requirement. • Progress of the work group convened to provide input on the development and dissemination of new educational materials for parents and health care providers of children with BLL results below 10 mcg/dL was reviewed. To date, three conference calls and multiple drafts of materials have been developed and discussed. The work group emphasized the importance of low literacy level for materials and consistency with lab report language. The goal is to have materials ready to disseminate by the end of 2008. Discussion took place on several issues, including: • Translation. Materials will be translated at a minimum into Spanish and Chinese. • Distribution. A suggestion was made that refugee centers could pilot test and distribute materials. It was	

Topics/Speaker	Discussion	Follow Up
	clarified that this material is designed for use in a health care provider's office, because it focuses specifically on results of laboratory tests. However, refugee centers could be very helpful in distributing other more general materials. It was suggested that NGOs or other community groups could be involved in the initiative as well.	
Council Member Updates	Council members provided the following updates on lead-related activities: • Dr. Greenberg noted that the NYS Chapter of the American Academy of Pediatrics (AAP) is concerned about a recent CDC announcement about lead in artificial turf. Ms. Nagin noted that NYCDOHMH has done a lot of research on turf, and has a literature review on its web site. The Department of Conservation is also doing a study of leaching with artificial turf. It was noted that not all turf is the same, and that older turf is more likely to contain lead. Other issues have been raised about turf, including heat stress, injuries, chemicals other than lead, gasses, latex allergies, infections. Dr. Kim noted that DOH will release a fact sheet on this issue in the near future. • Thomas Keenan, announced that the Bureau of Refugee and Immigrant Assistance received a 2-year grant from EPA to conduct outreach, and translate materials. The Bureau has worked with Onondaga and Oneida County local health departments, and can assist other LHDs with translation of materials. • Monica Kreshik announced that the NYS Department of Environmental Conservation (DEC) is in the process of a grants award process for environmental justice pursuant to an April 2008 RFA. Out of 80 applications, seven dealt with lead. All applications involve education among low-income, communities of color. NYSDOH lead program staff will participate in the review process, with awards anticipated to be announced in July. • Mary Binder noted that the Division of Housing and Community Renewal fared well in the new budget. The Division is going to have another funding round and will have additional housing rehabilitation activities. • Dr. de Long requested input from council members on topics for future meetings.	The NYC report on lead in artificial turf is available on-line at: http://home2.nyc.gov/html/doh/downloads/pdf/eode/turf_report_05-08.pdf
Public Comment	No comments were received	
Adjournment	Meeting adjourned at 2:52 p.m.	

New York State Department of Health

Advisory Council on Lead Poisoning Prevention

Report for
July 1, 2008 – December 31, 2008

Addendum to report for January 1, 2006 – June 30, 2008

David A. Paterson
Governor

Richard F. Daines, M.D.
Commissioner of Health

Note: This report covers the period from July 1, 2008 – December 31, 2008. It is an addendum to a previous report that covers the period from January 1, 2006 – June 30, 2008. The next planned report will cover the entire calendar year from January 1, 2009 – December 31, 2009.

NEW YORK STATE ADVISORY COUNCIL ON LEAD POISONING PREVENTION [1]

State Agency Designee Members

Council Chair

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Deputy Commissioner, Office of Public Health
NYS Department of Health

Division of Housing and Community Renewal
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Associate Industrial Hygienist
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Public Members

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Community Group Representative
Co-chair, Coalition to End Lead Poisoning in New York State

Thomas Ferrante
Labor Union Representative
Manager of Training and Technical Services
Total Safety Consulting

Abby Greenberg, M.D., F.A.A.P.
Local Government Representative
Director, Center for Public Health
Nassau County Health Department
Representative, American Academy of Pediatrics, Division II

Juanita Hunter, Ed.D.
Professional Medical Organization Representative
Professor Emeritus, School of Nursing
State University of New York at Buffalo

[1] Members as of December 2008.

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Assistant Professor, Decker School of Nursing
State University of New York at Binghamton

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Professor and Chairman, Department of
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Ellen Migliore, R.N., M.S.
Child Health Advocate Representative
Public Health Nurse
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Clifford Olin
Industry Representative
President
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Assistance
Bureau of Refugee and Immigrant Assistance

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INTRODUCTION

Lead poisoning continues to be a major preventable environmental health problem impacting young children in New York State (NYS). Over the last decade, blood lead levels among children have steadily declined in NYS and nationwide. This decline in the incidence and severity of lead poisoning among children has been noted as one of the greatest public health successes of the last century. While significant progress has been made, substantial exposure to lead still exists and continued efforts are needed to address the problem of childhood lead poisoning in NYS. The State is committed to achieving the goal of eliminating childhood lead poisoning. Elimination of childhood lead poisoning is essential to improving the lives of New York's children, especially socio-economically disadvantaged children who are disproportionately affected by lead poisoning.

Exposure to lead is associated with a range of serious health effects on young children. Lead is a systemic toxin that affects virtually all body systems. Lead exposure is an important cause of preventable brain injury and neurodevelopmental dysfunction and associated detrimental effects on children's cognitive and behavioral development, including measurable declines in IQ. Lead exposure also has been associated with anemia, hearing loss, diminished skeletal growth, delayed pubertal development, dental caries, hypertension, osteoporosis, pregnancy complications and low birth weight. Although there is no established threshold at which lead causes harmful effects, the federal Centers for Disease Control and Prevention (CDC) has defined lead poisoning as a blood lead level (BLL) of $\geq$ 10 micrograms per deciliter (mcg/dL). At this level, clinical and public health intervention is indicated.

The majority of children with lead poisoning are exposed to lead from deteriorating lead paint and lead dust in their homes. Prior to being banned in New York City (NYC) in 1960 and nationally in 1978, lead paint was used in homes, and was widely used prior to 1950. NYS has the largest number and percent of pre-1950 housing of all states in the nation. Lead exposure in older homes may occur as a result of deteriorating paint, as well as contamination during repairs and renovations if lead-safe work practices are not followed. Additional sources of lead exposure may include lead-contaminated soil and water and imported food, pottery, cosmetics, traditional medicines, toys and jewelry. Children and pregnant women in certain immigrant communities who use traditional medications, foods, cosmetics and cooking utensils containing lead may be at especially high risk for exposure to lead from these sources. Children may also be exposed to lead if their parents or guardians have occupations or hobbies that expose them to lead. Infants whose mothers have high blood lead levels may be exposed to lead during pregnancy or through breast milk. Because medical treatment options for lead poisoning are limited, primary prevention strategies that identify and reduce lead hazards in children's environments are critical to protect children from lead exposure before they become lead poisoned. A growing body of research indicates that children's development can be adversely affected at BLLs below the CDC-defined action level of 10 mcg/dL, further highlighting the need for primary prevention efforts.

Secondary prevention strategies also remain important components of lead prevention efforts. Early identification of children with elevated blood lead levels (EBLLs) through routine blood lead testing is essential to assure coordination of follow-up services to minimize harmful effects and prevent further exposure to lead. Under current NYS regulations adopted pursuant to NYS Public Health Law, health care providers are required to test all children using blood lead tests at or around age one year and again at or around age two years. Health care providers are also required to assess all children age six months to six years at least once annually for lead exposure using a risk assessment tool, with blood lead testing for all children found to be at risk based on those assessments. Additionally, health care providers are required

to assess each pregnant woman at the initial prenatal visit for lead exposure using a risk assessment tool, and test or refer for testing those pregnant women found to be at risk for lead exposure.

Children with EBLLs receive follow-up services to minimize the adverse effects of lead and to reduce further exposure to lead in their environments. Health care providers, families, local health departments (LHDs) and the State Department of Health (DOH) work together to assure that children with EBLLs receive these services. Specific follow-up services vary by blood lead level category. All children with blood lead levels greater than or equal to 10 mcg/dL require risk reduction education, nutritional counseling and follow-up testing to monitor blood lead levels. Beginning at 15 mcg/dL, children also require detailed lead exposure assessments, nutritional and developmental assessments and environmental management that includes inspections of their homes and other places where they spend significant amounts of time, with remediation of lead hazards identified.[1] Children with BLLs greater than or equal to 45 mcg/dL may benefit from specialized medical treatment called chelation therapy that helps remove lead from the body. At very high BLLs children require hospitalization for treatment.

The CDC, along with the President's Task Force on Environmental Health Risks and Safety Risks for Children, have called for the elimination of childhood lead poisoning (defined as blood lead levels at or above 10 mcg/dL among children age six years and younger). This goal is consistent with the long-standing work done in NYS and serves as a call to action to strengthen current lead poisoning prevention activities. In response to the CDC's charge, DOH has taken a leadership role in developing and implementing a strategic plan for the elimination of childhood lead poisoning in NYS. This plan, *Eliminating Childhood Lead Poisoning in New York State by 2010,* was published in 2004.[2] This state plan is a companion to the strategic plan developed by NYC Department of Health and Mental Hygiene (NYCDOHMH) that specifically covers NYC.[3] The plan is intended to serve as a roadmap to guide the work of DOH and partner organizations' statewide in efforts to eliminate childhood lead poisoning. At the same time, it is a living document that may be refined in response to changing needs and opportunities in NYS. This report serves to update and further define progress and priorities for achieving elimination of childhood lead poisoning.

DOH implements a comprehensive public health approach to prevent and eliminate childhood lead poisoning that includes: laboratory reporting, surveillance and data analysis; education for families, health care providers, professionals and the public; promotion of lead testing of children and pregnant women; assurance of timely, comprehensive medical and environmental management for children with lead poisoning; policy and program activities to advance both primary and secondary prevention of lead poisoning; and response to emerging lead-related public health issues, such as lead poisoning among immigrant and refugee children and recalls of lead-contaminated consumer products. Across all of these areas, universal population-based strategies are balanced with more intensive strategies targeted to the communities and populations at highest risk, and emphasis is placed on establishing and maintaining strong partnerships with a range of federal, state and local agencies, organizations and other stakeholder groups. Additional detail on key progress in these areas during the reporting period is presented in subsequent sections of this report.

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[1] State regulations were revised effective June 20, 2009 to require the comprehensive follow-up services listed for all children with BLLs $\geq$ 15 mcg/dL. Prior to this revision, these specific follow-up services were required for children with BLLs $\geq$ 20 mcg/dL.

[2] New York State Department of Health. (2004). Eliminating *Childhood Lead Poisoning in New York State by 2010*. Available online at: www.nyhealth.gov/environmental/lead/exposure/childhood/finalplantoc.htm.

[3] New York City Department of Health and Mental Hygiene (2005). *NewYork City Plan to Eliminate Childhood Lead Poisoning.* Available online at: www.nyc.gov/html/doh/downloads/pdf/lead/lead-plan.pdf.

New York State's Advisory Council on Lead Poisoning Prevention meets regularly to discuss issues relevant to the development and implementation of the statewide plan for lead poisoning elimination and to advise DOH regarding recommendations it deems necessary. This council is charged with reporting to the Governor and the Legislature annually about the progress made in the elimination of lead poisoning in NYS. This report serves to describe the progress made during the period from July 1, 2008, to December 31, 2008. It is an addendum to a previous report that covers the period from January 1, 2006 – June 30, 2008.

NEW YORK STATE ADVISORY COUNCIL ON LEAD POISONING PREVENTION

The Lead Poisoning Prevention Act of 1992 (NYS Public Health Law, Title10, Section 1370-b) established the New York State Advisory Council on Lead Poisoning Prevention within the DOH. Council members include the Commissioners, or their designees, of: the DOH; the former Department of Social Services, subsequently fulfilled by the Office of Children and Family Services (OCFS); the Department of Environmental Conservation (DEC); the Division of Housing and Community Renewal (DHCR); and the Department of Labor (DOL). In addition, the Council includes fifteen public members appointed by the Governor, with at least one public member representative of each of the following: local government; community groups; labor unions; real estate; industry; parents; educators; local housing authorities; child health advocates; environmental groups; professional medical organizations and hospitals. In recognition of the importance of participation from other essential partners, the DOH has reached out to additional key agencies to assist with Council deliberations as adjunct members. Adjunct members in 2008 included representatives of the NYS Department of State (DOS), NYS Department of Insurance (DOI), NYS Office of Temporary and Disability Assistance (OTDA) and NYCDOHMH.[1]

The authorizing Public Health Law (Section 1370 of Title 10) charges the Council with the following roles and duties:

- To develop a comprehensive statewide plan to prevent lead poisoning and to minimize lead exposure;
- To coordinate the activities of its member agencies with respect to environmental lead policy and the statewide plan;
- To recommend adoption of policies with regard to the detection and elimination of lead hazards in the environment;
- To recommend the adoption of policies with regard to the identification and management of children with elevated lead levels;
- To recommend the adoption of policies with regard to education and outreach strategies related to lead exposure, detection and risk reduction;
- To comment on regulations of the DOH under this title when the Council deems appropriate;
- To make recommendations to ensure the qualifications of persons performing inspection and abatement of lead through a system of licensure and certification;
- To recommend strategies for funding the lead poisoning prevention program, including but not limited to ways to enhance the funding of screening through insurance coverage and other means and ways to financially assist property owners in abating environmental lead, such as tax credits, loan funds and other approaches; and
- To report on or before December 1 of each year to the Governor and the Legislature concerning the previous year's development and implementation of the statewide plan and operation of the program, together with recommendations it deems necessary and the

[1] Effective April 2009, Public Health Law Section 1370-b was amended to include the Office of Temporary and Disability Assistance, the Department of State and the Department of Insurance as official members of the Advisory Council, and to clarify timeframe requirements for the Council's annual report.

most currently available lead surveillance measures. Such report shall be made available on the DOH website: www.nyhealth.gov/environmental/lead/adviory_council/index.htm.

The New York State Advisory Council on Lead Poisoning Prevention meets regularly to discuss issues and strategies relevant to the prevention and elimination of childhood lead poisoning in NYS. During the time period corresponding to this report, the Council met one time on October 21, 2008. Two previous meetings in 2008, held on March 6 and June 19, were included in a previous Council report. Meetings took place in Albany, New York. All meetings are open to the public, and since September 10, 2007, have been Webcast pursuant to Executive Order #3. The Council meeting during this period included updates and Council discussion on several key priority topics related to the elimination of lead poisoning, including:

- Specific commitments made by Governor Paterson in his veto message of a childhood lead poisoning prevention bill (A6399), including: expanding criteria for comprehensive follow-up services from 20 mcg/dL to 15 mcg/dL; charging the DOH to assess if the blood lead level criterion for these comprehensive interventions should be further lowered to 10 mcg/dL; assessing whether additional elements of the primary prevention pilot program should be written into law; and advancing a legislative proposal that was previously introduced as a departmental bill to link the state immunization and childhood lead registries to improve lead testing;
- The DOH's public health approach to address emerging concerns about the harmful effects of blood lead levels below the current action level of 10 mcg/dL, including: expanded surveillance measures and tracking; new professional and parent education messages and materials; and changes to blood lead laboratory reports;
- The DOH's Primary Prevention Pilot initiative, including expansion of funding and target communities in Year 2 (2008);
- A presentation from the CDC on CDC's vision and steps taken to transition state and federal lead poisoning prevention programs to a more comprehensive "healthy housing" approach;
- The outline and steps to complete the next annual report of the Council; and
- Updates and open discussion from Council members, including:
    - Ongoing work within the OTDA Bureau of Refugee and Immigration Assistance (BRIA) to translate and disseminate lead prevention materials to refugee communities;
    - Ongoing work within the DHCR to provide funds for low-income housing development and rehabilitation, including assurance of lead safe work practices and clearance;
    - Ongoing work within the DOL Division of Safety and Health to provide training and consultation to employers and contractors;
    - An announcement from the DEC about a new Environmental Justice Task Force convened by the Governor, with discussion on strategies for enhancing outreach and engagement of diverse communities;
    - Discussion of opportunities for DOH to further collaborate with the OCFS to update and distribute relevant educational materials for child care providers related to lead poisoning;

- An overview of the current property maintenance standard contained within the uniform code, as well as annual training and certification of local code officials provided by the DOS;
- Expansion of follow-up activities for children with elevated blood lead levels by the NYCDOHMH Lead Poisoning Prevention program, including educational letters to families of children with BLLs 5-9 mcg/dL, environmental inspections for children under age three years with confirmed BLLs 10-14 mcg/dL as part of their primary prevention pilot project, and collaboration with BRIA to identify and address non-paint sources of lead exposure among immigrant communities; and
- Ongoing work within the Nassau County Department of Health to conduct home inspections for infants with BLLs 5-9 mcg/dL and other children with persistently elevated BLLs below 15 mcg/dL.

With Council feedback and input, and building on the work completed in the first half of the year, significant additional progress was made during the period covered by this report toward implementing the statewide elimination plan and achieving the goal of elimination of childhood lead poisoning in New York State. More specific information about the topics addressed by the Council at its October 2008 meeting, along with other priorities and actions from the period of July 1 – December 31, 2008, are described in subsequent sections of this report. Minutes of the October 2008 meeting are included as Appendix B of this report.

LEAD POISONING IN NEW YORK STATE: PROGRESS TOWARD ELIMINATION

The analysis and application of data are important tools used by the DOH to assess the extent of the childhood lead poisoning problem, to identify high-risk communities and populations with the highest need for interventions and to monitor and evaluate the effectiveness of interventions. In 2008, the DOH completed and published a comprehensive report of childhood lead surveillance data for 2004 and 2005 for NYS, excluding NYC, and in early 2009 a comprehensive report of 2006 and 2007 data was completed and published. These reports demonstrate that NYS has made significant progress during the last decade toward the elimination of childhood lead poisoning, while highlighting areas for further action. Council members provided extensive input on the development, modification and prioritization of key data elements for these surveillance reports and continue to provide recommendations for future data reports.

As of the time this Council report was prepared, final analysis of surveillance data from 2008 was in progress. Preliminary analysis of 2008 data indicates that the positive trends demonstrated in the 2004-05 and 2006-07 reports continued in 2008. Key surveillance indicators from the preliminary analysis of 2008 data are presented and described below to provide a snapshot of lead testing and progress toward elimination of lead poisoning in NYS. A major change reflected in these preliminary results for 2008 is the incorporation of NYC lead surveillance data, which for the first time provides a single comprehensive statewide picture of lead poisoning and lead testing. The creation of a statewide data report that includes NYC data has been a longstanding priority of both the DOH and the NYCDOHMH, as well as the Council. The DOH and NYCDOHMH collaborated extensively to accomplish this data integration and will continue to work together to finalize the statewide data report for 2008 as well as future analyses and reports.

Previous detailed analyses of 2004-2005 and 2006-2007 data for NYS excluding NYC, including many tables, figures and maps, can be found in the complete surveillance reports published on the DOH Web site at: www.nyhealth.gov/environmental/lead/exposure/. In addition, the NYCDOHMH Lead Poisoning Prevention Program has released annual reports, including local blood lead surveillance data for NYC, through 2008. These reports may be accessed online at: www.nyc.gov/html/doh/html/pub/pub.shtml?t=lead.

Progress in Testing Young Children for Lead Poisoning

Under current NYS regulations adopted pursuant to NYS Public Health Law, health care providers are required to test all children using blood lead tests at or around age one and again at or around age two, and to assess all children age six months to six years at least once annually for risk of lead exposure using a risk assessment tool, with blood lead testing for all children found to be at risk.

Blood lead testing rates are described for groups of children born in a given year (i.e., birth cohorts) because this is the most accurate way to estimate the number of children in a given age group who require blood lead screening tests. Testing rates for a group of children born in a

given year are based on blood lead testing data from subsequent years. For example, testing rates at ages one and two for children born in 2005 are based on blood lead tests that occurred from 2005 through 2008. Birth cohorts beyond 2005 are not included in the analysis because those children had not yet reached 36 months of age by 2008.

Data Highlights

- **Lead testing rates for children at or around age one are improving.** Preliminary analysis of lead testing data through 2008 demonstrate that in NYS (including NYC), blood lead testing rates for children at or around age one have increased by 48 percent over the last eight years. Sixty-six percent of children born in 2005 were tested for lead at or around age one, compared with 44.8 percent of children born in 1998 and 63.3 percent of children born in 2004 (refer to Figure 1).

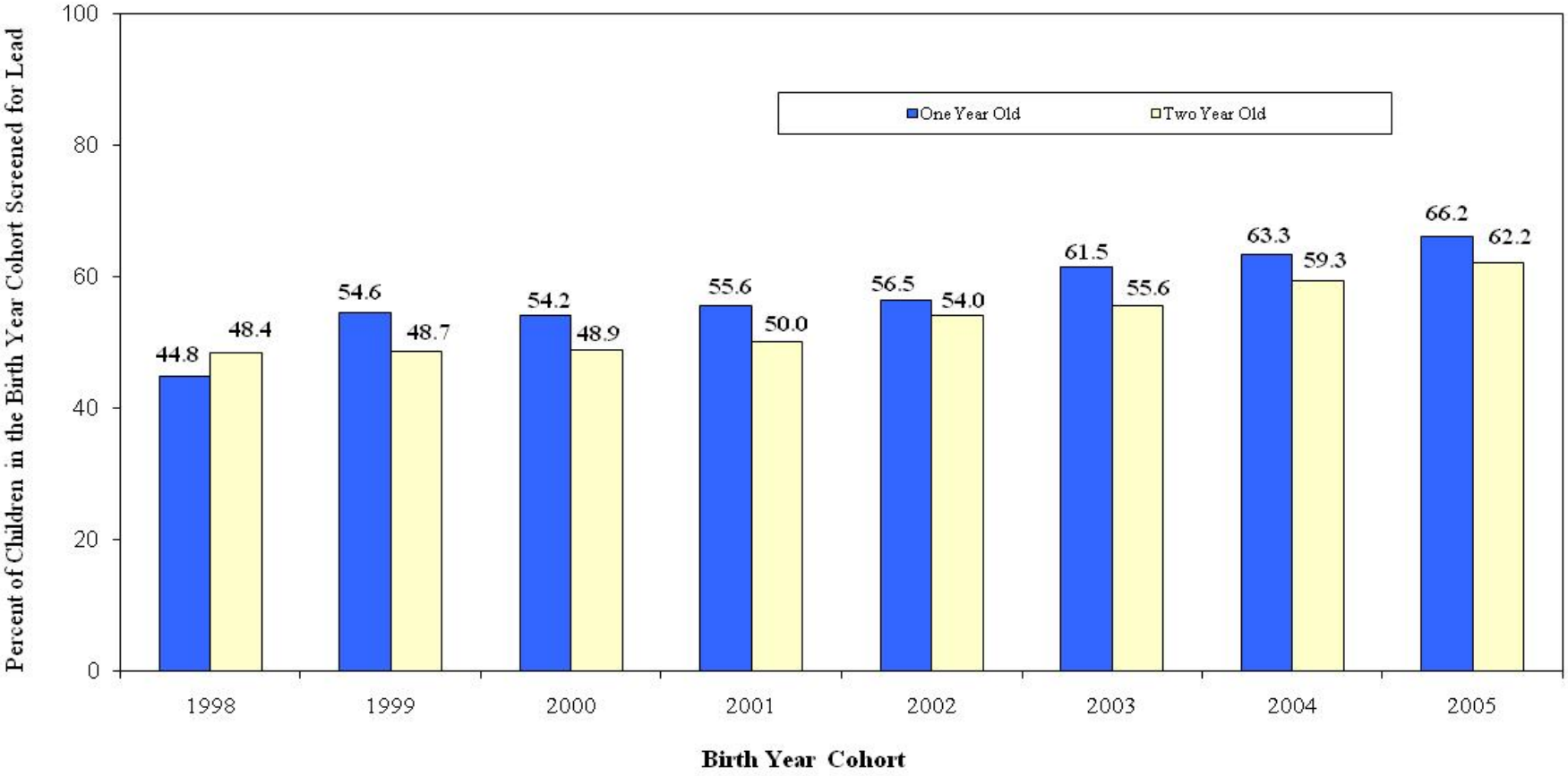
- **Lead testing rates for children at or around age two are also improving.** Preliminary analysis of lead testing data through 2008 demonstrate that in NYS (including NYC), blood lead testing rates for children at or around age two have increased by 29 percent over the last eight years. Sixty-two percent of children born in 2005 were tested for lead at or around age two, compared with 48.4 percent of children born in 1998 and 59.3 percent of children born in 2004 (refer to Figure 1). Although testing rates for two year-old children are improving, the percent of children tested at age two is lower than the percent tested at age one, making this an important target for blood lead testing interventions.

- **More children are being tested two or more times by age three.** Preliminary results of an expanded analysis of testing patterns among children up to age three, using data through 2008, show several related positive trends. The percent of NYS children who have no lead tests by age three has steadily declined, from 22.7 percent of children born in 1998 to 12.1 percent of children born in 2005, a 47 percent decline. At the same time, the percent of NYS children who have been tested two or more times by age three has increased from 29.4 percent for children born in 1998 to 47.5 percent for children born in 2005, a 61 percent increase. The percent of NYS children who have been tested only one time (for example, at age one but not at age two) has declined by 15 percent from 47.8 percent of children born in 1998 to 40.5 percent of children born in 2005 (refer to Figure 2). This expanded analysis, new for the 2008 data report, provides a more complete picture of the testing patterns among children under age three.

  While the 2008 Lead Surveillance Report is under executive review, the data cited here will be considered preliminary until the report is approved.

Figure 1: Percent of Children Tested for Lead At or Around Age One Year and At or Around Age Two Years[1]

New York State, 1998 - 2005 Birth Cohorts (1998 to 2008 Blood Lead Test Data)[2]

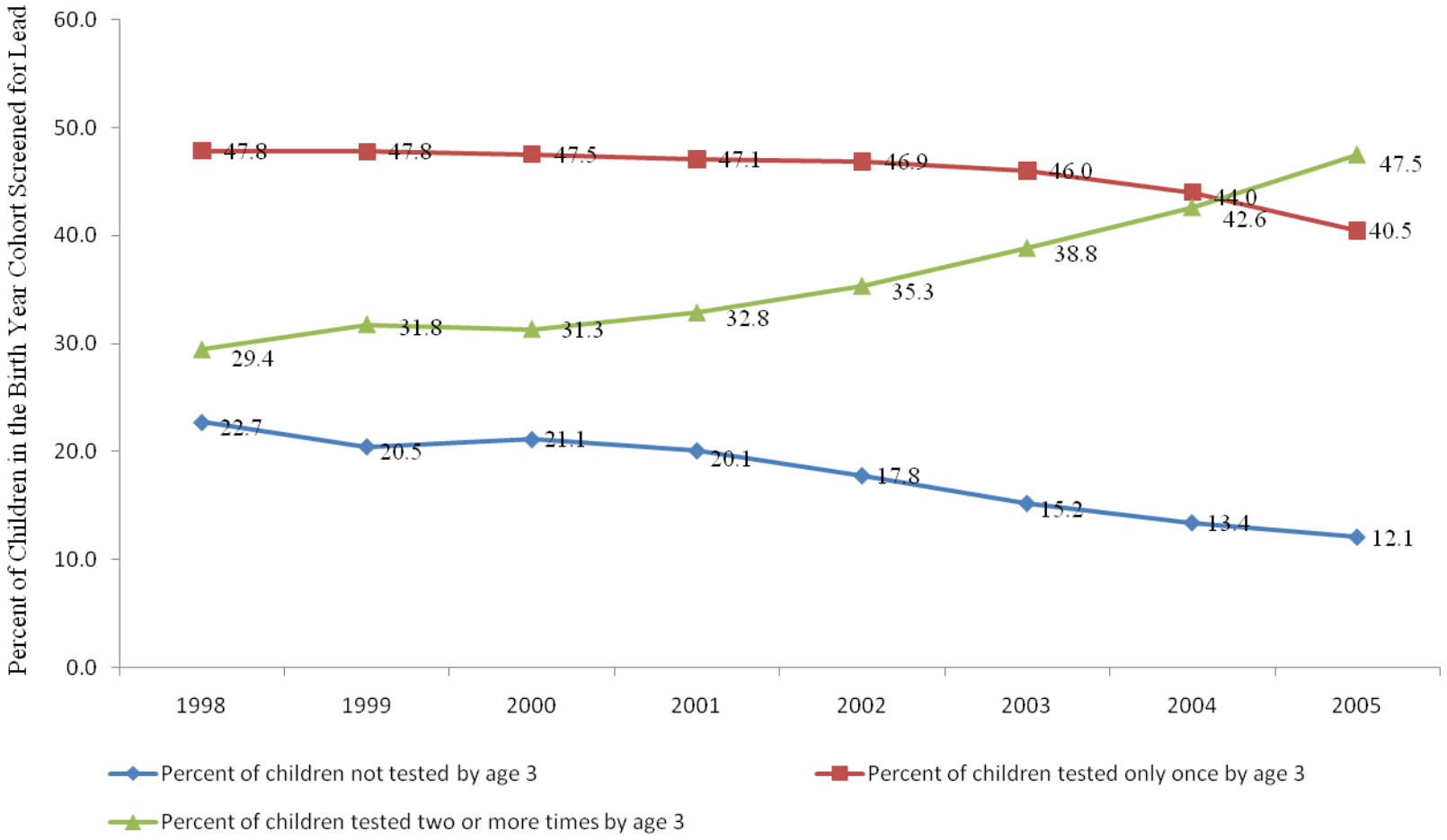


[1] At or around age one year is defined as nine months to < 18 months and at or around age two years is defined as 18 months to < 36 months.
[2] Birth Cohorts beyond 2005 are not included in this analysis because those children had not yet reached 36 months of age by 2008.

[4] Birth Cohorts beyond 2005 are not included in this analysis because those children had not yet reached 36 months of age by 2008.

Figure 2: Lead Testing Patterns Among Children Under Age 3 Years

New York State, 1998 - 2005 Birth Cohorts, (1998 to 2008 Blood Lead Test Data)[1]



[1] Birth Cohorts beyond 2005 are not included in this analysis because those children had not yet reached 36 months of age by 2008.

Preliminary data – do not cite or publish as final

Progress in Reducing the Incidence of Childhood Lead Poisoning

Incidence is the measure of the number of children identified for the first time within a specified time period with confirmed BLLs ≥ 10 mcg/dL, (the current definition of lead poisoning). Although there is no established threshold at which lead causes harmful effects, the CDC has defined a BLL of ≥ 10 mcg/dL as the action level for clinical and public health intervention. Incidence is described both in terms of the total number of new cases of childhood lead poisoning as well as the rate, or proportion, of children tested for lead who are newly identified with lead poisoning.

Children with EBLLs receive follow-up services to minimize the adverse effects of lead and to reduce further exposure to lead in their environments. Health care providers, families, LHDs and the DOH work together to assure that children with EBLLs receive these services. The specific services required vary by BLL category.

Data Highlights

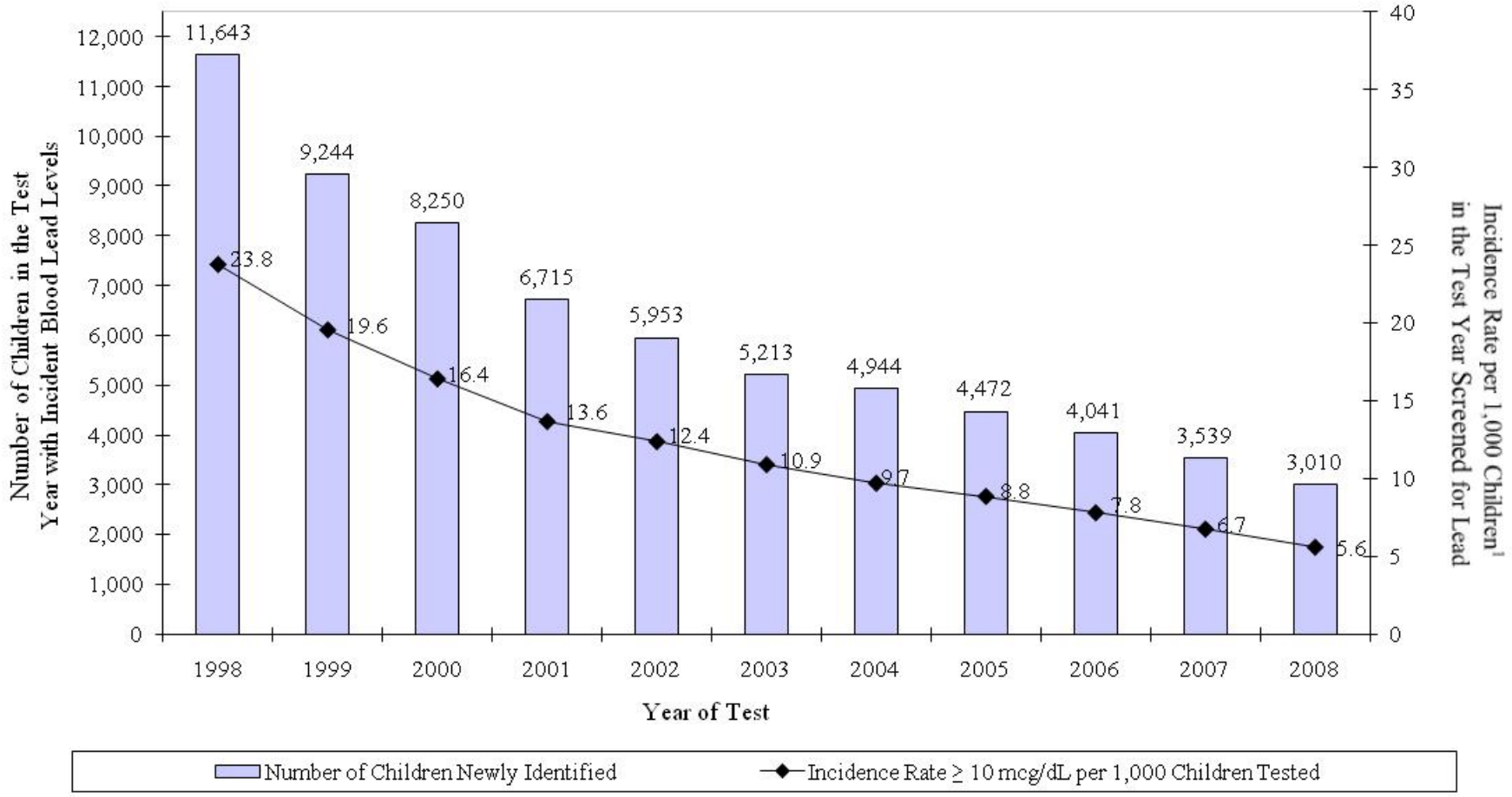
- **The number of children with EBLLs is steadily declining across all BLL categories.** Trend data for NYS (including NYC) show a dramatic reduction in the number of children identified with confirmed BLLs ≥ 10 mcg/dL, the current definition of lead poisoning established by the CDC. In 2008, 3,010 children less than six years old were newly identified with BLLs ≥ 10mcg/dL, compared with 11,643 children in 1998. This represents a striking 74.1 percent decline in the number of children with EBLLs since 1998 (refer to Figure 3).

- **The rate of incidence of lead poisoning among young children is also steadily declining**. Between 1998 and 2008 for NYS (including NYC), a striking 76.5 percent decline in the rate of incidence of lead poisoning was observed, from 23.8 per 1,000 children (2.38 percent) under age six tested in 1998 to 5.6 per 1,000 children (0.56 percent) under age six tested in 2008 (refer to Figure 3).

The incidence of childhood lead poisoning varies greatly across the state. From 2006-2008, the majority of children newly identified with BLLs ≥ 10 mcg/dL (approximately 90 percent of incident cases statewide) resided in 24 counties (listed in descending order of incidence): Bronx, Erie, Kings, Monroe, Queens, New York, Onondaga, Westchester, Oneida, Orange, Nassau, Albany, Richmond, Suffolk, Rensselaer, Dutchess, Niagara, Ulster, Rockland, Fulton, Broome, Montgomery, Chautauqua and Schenectady. Eighty percent of incident cases were in children residing in the following 12 counties (listed in descending order of incidence): Bronx, Erie, Kings, Monroe, Queens, New York, Onondaga, Westchester, Oneida, Orange, Nassau and Albany.

Figure 3: Incidence of Blood Lead Levels ≥ 10 mcg/dL Among Children Under Age Six Years[1]

New York State, 1998 to 2008 Blood Lead Test Data



[1] Incidence Rate: Total number of children under age six years identified for the first time with confirmed BLLs ≥ 10 mcg/dL divided by the total number of children under age six that had lead tests in that given year, multiplied by 1,000.

Preliminary data – do not cite or publish as final

Children with Blood Lead Levels Below 10 mcg/dL

A growing body of scientific research highlights concerns about the effects on children's development of BLLs below 10 mcg/dL, the blood lead level established by the CDC as the definition of lead poisoning and the level requiring medical and public health intervention. In light of these emerging concerns, beginning with the 2004-05 data report, annual data reports have included a new indicator measuring the number and percent of children with BLLs in the range of 5–9 mcg/dL.

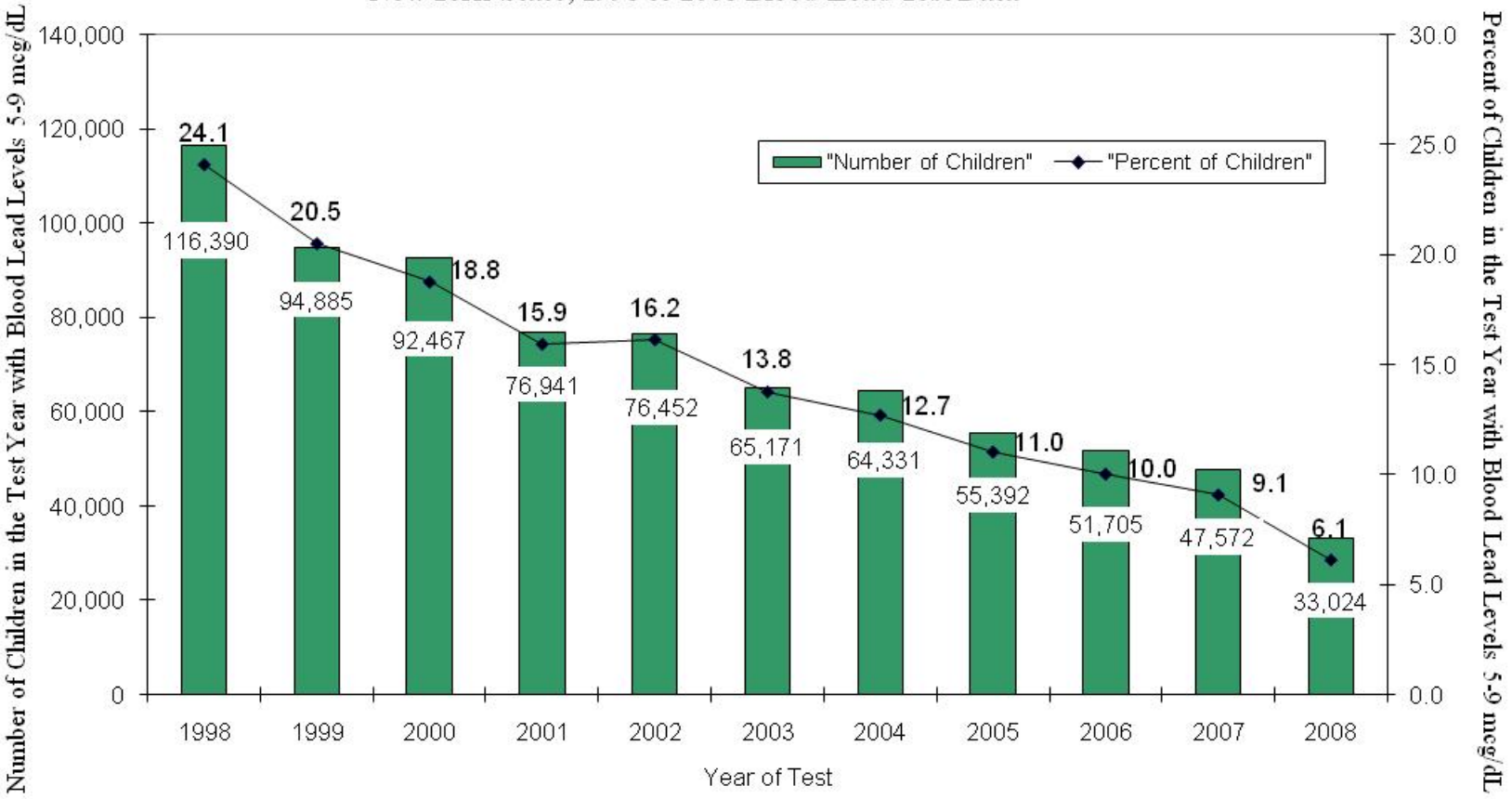
Under current NYS Public Health Law and implementing regulations, as well as national CDC guidelines, all parents should be provided with anticipatory guidance as part of routine health care on the major causes of lead poisoning and means for preventing lead exposure, with consideration of children's environments. Children whose BLLs are below 10 mcg/dL on their first routine blood lead tests at or around age one need to have second lead tests at or around age two to assure that BLLs are still within this range. Children with one or more identified risk factors for lead exposure based on clinical risk assessments may require more frequent testing, and should be tested at least annually beginning at age six months and continuing up to age six. In addition, population-based community education and primary prevention strategies should be advanced to eliminate children's exposure to lead in their environments.

Data Highlights

Trends for BLLs 5-9 mcg/dL parallel those for BLLs over 10 mcg/dL. In 2008, a total of 33,024 children were identified with BLLs of 5 - 9 mcg/dL, representing 6.1 percent of all 538,684 children under age six tested for lead in that year in NYS, including NYC. Trend data show a steady decline in both the number and percent of children identified with BLLs in this range since 1998, paralleling the declines in higher EBLLs over the same period. The total number of children with BLLs between 5 - 9 mcg/dL declined 71.6 percent between 1998 and 2008, from 116,390 children in 1998 to 33,024 children in 2008. The percent of children with BLLs 5 - 9 mcg/dL declined 74.7 percent over the same period, from 24.1 percent of children tested in 1998 to 6.1 percent of children tested in 2008 (Refer to Figure 4). During this same time period, the number of children with the lowest measurable BLLs of 0 - < 5 mcg/dL increased from 346,501 (71.8 percent of children tested) in 1998 to 501,431 (93.1 percent of children tested) in 2008 (data not shown).

Figure 4: Number and Percent of Children Under Age Six Years with Blood Lead Levels of 5 - 9 mcg/dL

New York State, 1998 to 2008 Blood Lead Test Data [1]



[1] The number of children with a BLL of 5-9 mcg/dL divided by the number of children that had a lead test in that given year multiplied by 100. Values reported below 10 mcg/dL are subject to increased measurement error and should not be interpreted as an absolute value.

KEY ACCOMPLISHMENTS AND STRATEGIES FOR CONTINUED SUCCESS

A Continued Commitment to the Elimination of Childhood Lead Poisoning

The DOH is committed to achieving the elimination of childhood lead poisoning. As a central focus of this commitment, the DOH has worked in partnership with many other state and local agencies, organizations and stakeholder groups to develop and implement a strategic plan, *Eliminating Childhood Lead Poisoning in New York State by 2010*. Published in 2004, this state plan is a companion to the strategic plan developed by NYCDOHMH that specifically covers NYC. The NYS plan outlines a series of goals, objectives and strategies within three overarching focus areas: surveillance and screening, targeting high-risk populations and primary prevention. The complete plan can be found on the DOH website at: www.nyhealth.gov/environmental/lead/index.htm.

The plan is intended to serve as a roadmap to guide the work of the DOH and partner organizations statewide in efforts to eliminate childhood lead poisoning. At the same time, it is a living document that may be refined in response to changing needs and opportunities in NYS. Eliminating childhood lead poisoning continues to be a top public health priority for the DOH. This report serves to update and further define current progress and priorities for achieving elimination.

The DOH implements a comprehensive public health approach to prevent and eliminate childhood lead poisoning. As knowledge of the problem of lead poisoning and the identification of effective strategies for elimination has grown, the framework outlined in the 2004 elimination plan has also expanded. The DOH's current comprehensive public health approach encompasses and goes beyond the objectives and strategies outlined in the original elimination plan to include:

- Surveillance, data analysis and laboratory reporting;
- Education to families, health care providers, professionals and the public;
- Policy and program activities to advance primary prevention of lead poisoning to reduce lead hazards before children become poisoned;
- Policy and program activities to promote secondary prevention of lead poisoning, including blood lead testing of children and pregnant women;
- Assurance of timely, comprehensive medical and environmental management for children with lead poisoning; and
- Response to emerging lead-related public health issues, such as lead poisoning among immigrant and refugee children and recalls of lead-contaminated consumer products.

Across all of these areas, universal population-based strategies are balanced with more intensive strategies targeted to the communities and populations at highest risk, and emphasis is placed on establishing and maintaining strong partnerships with a range of federal, state and local agencies, organizations and other stakeholder groups. In particular, strengthening local capacity for carrying out effective lead prevention work has been a focus of the DOH's efforts in the last several years. Additional detail on key progress in these areas is described below.

Achieving Elimination: Progress and Priorities for the Future

During the period covered by this report (July to December 2008), and building on work accomplished in the first half of the year, significant progress was made across multiple programs and initiatives. With ongoing input and support from the Advisory Council and many partner agencies and organizations, the DOH will continue to build on these accomplishments to achieve further progress toward elimination of childhood lead poisoning in NYS. Key accomplishments and ongoing priorities include:

Continuation and expansion of surveillance activities to guide, target and monitor lead poisoning prevention activities

- Analysis of data completed in 2008 culminated in the subsequent release of a comprehensive report of 2006-2007 childhood lead surveillance data in 2009. The report highlighted continued improvements in lead testing rates and continued steady decline in the number and rate of new cases of lead poisoning among young children. Based on input from Council members, this report included results of a new analysis of serial blood lead test results that further reinforces the importance of testing children at both age one and two years. The DOH will continue to solicit feedback and recommendations from the Advisory Council to further develop future data reports.

- In 2008, work continued to enhance LeadWeb, the statewide Web-based lead registry and data system that supports timely and accurate analysis of childhood blood lead data and tracking of children by LHDs. In 2008, with input from a workgroup of LHD users, new LeadWeb case coordination modules and reporting functions were implemented to support documentation and tracking of follow-up services for children with EBLLs. Three new aggregate statistical reports for LHDs on local blood lead testing and incidence measures were also implemented. A second user workgroup of LHD environmental health staff was organized to provide ongoing input on the development and use of Environmental LeadWeb modules, resulting in the development of several new LeadWeb forms, modules and reports to support documentation and tracking of local environmental management activities. Training and technical assistance was provided to LHDs to support the use of these enhancements. Building on these improvements, steps were taken in 2008 to develop and implement a series of additional enhancements to LeadWeb, which subsequently were launched in June 2009, and to continue work on the creation of expanded dynamic reporting functions for LHDs.

- Lead Poisoning Prevention Program (LPPP) staff continued collaboration with the DOH's Environmental Public Health Tracking (EPHT) program to incorporate state and local lead-related information and data in the State's EPHT public portal. NYS' EPHT program is part of a national CDC initiative to provide more dynamic public access to a range of environmental health data. The NYS EPHT portal can be accessed at: www.nyhealth.gov/environmental/public_health_tracking/.

- During this period, initial work was completed on a pilot project to match the LeadWeb statewide childhood lead registry with the Medicaid enrollment data base to expand the assessment of lead testing and lead poisoning rates among the Medicaid-eligible

population. Specific steps during this period included the development of a matching algorithm and testing measures, which laid the groundwork for subsequent creation and analysis of a matched dataset in 2009.

- Continued analysis of childhood lead surveillance data remains a key priority. Further expansion of data analyses is also a priority, including completion of geocoding and expanded geographic analysis of key lead testing and incidence measures, including sub-county level analysis, to support targeting and monitoring of prevention activities. Additional priorities include the completion and implementation of expanded dynamic reporting capabilities within the data system to further support LHD prevention and follow-up efforts and additional analysis of lead testing and lead poisoning among the Medicaid-eligible population.

Expanding education of the public, parents and professionals to promote both primary and secondary lead prevention practices

- In 2008, with extensive input from a stakeholder work group convened by the DOH, new materials were developed for parents and health care providers that include information about what different BLL results mean and what specific follow-up and preventive actions can be taken to address them. Draft materials were completed in 2008 and subsequently finalized and disseminated to health care providers and local health departments in 2009. This project was conducted in parallel to a process initiated by the DOH's Wadsworth Laboratory to require inclusion of language about the harmful effects of lower BLLs on laboratory reports of BLL results below 10 mcg/dL. This policy change was subsequently finalized and disseminated to laboratories in 2009, concurrent with the distribution of new educational materials to health care providers.

- Updates were made to several existing lead poisoning prevention educational materials, including printing of posters and stickers in English and Spanish and translation of the two most popular educational brochures into Spanish and Chinese.

- In the summer of 2008, the DOH sponsored a web-based educational campaign on lead-safe renovation and remodeling, targeting contractors and do-it-yourselfers on how to perform renovation and remodeling using lead-safe work practices. The campaign utilized internet advertisements on selected websites that in turn directed readers to the DOH website for additional information. Response to the campaign was positive.

- In October of 2008, a media kit was developed and disseminated to all LHDs to support local activities related to National Lead Poisoning Prevention Week. The kits included sample press releases and proclamations, scripts for local PSAs, ideas for education and outreach activities and additional media materials developed by the federal Environmental Protection Agency (EPA) and the CDC. New York's "Let's Wipe Out Lead" theme was adapted by CDC for national use for this week.

- A series of changes were made to the lead pages of the DOH public website to reduce reading level, increase ease of navigation and improve access to Spanish language

materials. New pages on federal lead hazard-related product recalls and the State's Childhood Lead Poisoning Primary Prevention Program (CLPPPP) were added.

- Increasing awareness of the problem of lead poisoning and effective prevention strategies directed to the public, parents and professionals remain important priorities. Specific priorities include completion and dissemination of an expanded clinical lead poisoning prevention toolkit for health care providers; further updates and reorganization of the lead pages on the DOH's public website to provide easier access to timely, evidence-based and practical lead poisoning prevention information for a variety of target audiences; and exploration of a potential statewide public awareness media campaign.

Additional policy and program activities to promote secondary prevention of lead poisoning, including blood lead testing and follow-up services for children and pregnant women with elevated blood lead levels

- In November 2008, a formal Notice of Proposed Rulemaking was issued to revise state regulations to authorize blood lead testing in private physician office laboratories (POLs) and limited service laboratories and to require reporting of BLL results from these entities. These proposed changes, subsequently adopted and implemented in 2009, were pursued to reduce known barriers to improving lead testing rates by supporting the expanded use of new office-based portable lead testing devices in physician offices and clinics.

- As part of the 2009-2010 executive budget, the DOH and Governor introduced a legislative proposal to amend state law to authorize the linkage of the statewide childhood lead registry (LeadWeb) and immunization information system (NYSIIS). This proposal, subsequently enacted in 2009, is expected to improve childhood lead testing rates by prompting and reinforcing lead testing by health care providers and by providing a tool for state and LHDs to more systematically identify children who have not been tested for lead and to target quality improvement strategies. The linkage will also streamline reporting of blood lead test results from POLs that conduct office-based testing by facilitating submission of lead test results through NYSIIS. Concurrent with the introduction of the legislative proposal, initial work was completed in 2008 on the development of the technical requirements for the systems linkage and data exchange, with additional work to be completed in 2009.

- In November 2008, as part of the Notice of Proposed Rulemaking noted above, the DOH formally proposed changes to state regulations to expand the BLL criterion for comprehensive follow-up services, including environmental management, for children with lead poisoning from the previous level of 20 mcg/dL to 15 mcg/dL. These proposed changes, subsequently adopted and implemented in 2009, expand comprehensive follow-up services to hundreds of additional children with lead poisoning statewide. In parallel to the regulatory process, the DOH developed an updated comprehensive guidance document for LHDs on follow-up of children with elevated blood lead levels that reflects the revised regulations and includes new protocols and tools for appropriately tailored follow-up of older children with lead poisoning. A draft document was completed in

2008 with significant input from the NYS Association of County Health Officials and individual LHDs, and subsequently was finalized and disseminated in 2009.

- In October 2008, Governor Paterson charged the DOH with reviewing available scientific research and data and reporting to the Advisory Council on Lead Poisoning Prevention, as to whether the State should further revise the threshold for comprehensive interventions, including environmental management services, from 15 mcg/dL to 10 mcg/dL. In response, DOH staff conducted a preliminary review of available state surveillance data and published scientific literature, subsequently presented to the Advisory Council in 2009. Following the Advisory Council's initial discussion, a stakeholder workgroup was convened in 2009 to assist the DOH in completing this assessment.

- The DOH Center for Environmental Health (CEH) established a working relationship with the State Attorney General's office (SAG) to provide additional legal support for the enforcement of Notice and Demands that are issued by LHD and State District Office environmental health units to require remediation of lead hazards pursuant to environmental inspections. The SAG's office offered additional assistance in enforcement of Notice and Demands (defined as a written, legal request given to a property owner for discontinuance of a condition conducive to lead poisoning that is determined to be in existence in a dwelling) and the standard language on the Notice and Demand form was revised to incorporate this participation.

- The DOH Bureau of Occupational Health (BOH), which receives all blood lead test results for adults, continued to conduct follow-up telephone interviews with women of childbearing age (ages 16 to 45) who have elevated blood lead levels to determine potential sources of lead exposure and provide tailored risk reduction education, including information to share with their health care providers about testing their infants after delivery. These activities complement the medical follow-up provided for pregnant women by prenatal health care providers and by occupational health clinics for women with occupational lead exposure. In 2006, BOH lowered the BLL threshold for women of childbearing age that triggers interviews and follow-up risk reduction education for women ages 16 to 45 from $\geq$ 25 mcg/dL to $\geq$ 15 mcg/dL. Further expansion of the number of women contacted was implemented in 2009 by lowering this threshold for follow-up interviews to a BLL of 10 mcg/dL.

- The DOH continues to provide grant funding to support a statewide network of hospital-based Regional Lead Resource Centers (RLRCs) that provide outreach, education, clinical consultation and technical assistance to health care providers and LHDs on lead testing and management of children and pregnant women with lead poisoning. In 2008, a new five-year cycle of competitive funding began to support three RLRCs at Montefiore Medical Center, SUNY Upstate Medical University (including a partnership with Albany Medical Center) and Kaleida Health (including a partnership with University of Rochester). Informed by input from the Advisory Council on effective strategies and messages for health care providers, the focus of RLRC activities in this funding cycle

was expanded to better emphasize blood lead testing and other clinical preventive practices.

- Improving lead testing and follow-up for children and pregnant women remains a priority for 2009. Specific priorities for 2009 and beyond include: securing passage of legislative changes to support linkage of the lead registry and immunization information system to promote lead testing and implementing the linkage once authorized; finalizing and implementing regulation changes related to office-based lead testing technology and expanded environmental management services for children with elevated BLLs; completing an assessment of whether the criterion for comprehensive follow-up services should be further expanded to a BLL of 10 mcg/dL; implementing expanded telephone follow-up for pregnant women with elevated BLLs; and completing and disseminating updated guidelines for prenatal care providers on the prevention, identification and management of lead poisoning in pregnant women.

Expansion of primary prevention strategies to identify and reduce lead hazards before children become lead poisoned

- The 2007-08 State Budget amended NYS Public Health Law and appropriated funding of $3 million to support a new primary prevention pilot program to develop and implement local primary prevention plans in targeted high-incidence communities. Work on this initiative progressed rapidly in 2007 and continued and expanded in 2008. Based on analysis of childhood lead poisoning incidence data, high-incidence municipalities within seven counties (Erie, Monroe, Onondaga, Oneida, Albany, Orange and Westchester) and NYC were targeted for the first year of this initiative that began in October 2007. Target counties receive grant funding to develop and implement local childhood lead poisoning primary prevention plans in and near the target areas, including identification and inspection of high-risk properties, community involvement, capacity building and enforcement. LHDs collaborate with code enforcement officials, local housing authorities and other community partners to accomplish this work. In the 2008-09 State Budget, annual state funding for the pilot program increased to $4.9 million, supporting expansion of the program to four additional target communities in the second year of the program (Chautauqua, Broome, Dutchess and Schenectady counties). Advisory Council members provided ongoing input and feedback on the development and implementation of this important new initiative. The 2009-10 State Budget included an additional $2.5 million in funding for the program (already funded at $4.9 million in 2008-2009) as proposed by the Governor in the 2009-10 Executive Budget, bringing the total annual funding for this initiative to over $7 million, along with statutory changes to enhance and make permanent the previous pilot program.

- As part of the Childhood Lead Poisoning Primary Prevention Program (CLPPPP) noted above, the DOH has engaged the National Center for Healthy Housing, a highly respected and uniquely experienced expert national organization, to provide consultation and assistance to the DOH and the target communities in the development, implementation and evaluation of this pilot program. Two evaluation reports were completed for the first full year of the pilot program, including *Early Lessons Learned:*

New York's Primary Prevention of Childhood Lead Poisoning Pilot Project and *New York State's Primary Prevention of Childhood Lead Poisoning Pilot Program: Year One Implementation Final Report*. Both reports are available on the NYSDOH public website. Highlights of the first year of the pilot program include:

- Reaching 6,290 households through direct outreach and referral and nearly 26,000 additional individuals through informational meetings and other events;
- Conducting home visits for 1,289 children age six and under, with 582 children referred for blood lead testing;
- Investigating 1,514 housing units for lead-based paint (LBP), of which 699 units were found to have deteriorated paint or LBP dust hazards;
- Creating at least 215 lead-safe housing units, with many planned; and
- Training 518 property owners, contractors and do-it-yourselfers in Lead-Safe Work Practices, with over 12,000 others trained through prior agreements between these LHDs and other programs.

- During this time period, the Advisory Council provided ongoing feedback on the lead prevention component of the DOH's Healthy Neighborhoods Program (HNP), a door-to-door outreach program in targeted high-need areas that provides residents with practical information and tools to reduce environmental hazards in their homes, including risks for lead exposure. Through resident interviews and room-by-room visual inspections, programs identify peeling paint, carbon monoxide hazards, asthma triggers and fire hazards. In 2007, a new scannable data collection form and process were introduced to allow for uniform collection of field data and analysis of individual de-identified data for comprehensive evaluation of field visits and of program outcome measures. During the 2008 period covered by this report, over 21,000 dwelling units were approached by HNPs across the state. Home assessments were initiated in over 9,800 (45 percent) of these units, with deteriorating paint identified in nearly 2,300 of those assessed. Unsafe paint conditions were referred to local primary prevention programs and/or code enforcement for correction, and all families receive education on the dangers of lead paint. Local programs revisit 25 percent of these homes to assess completion and effectiveness of corrections for any hazards identified.

- Advisory Council members have discussed the importance of incorporating lead prevention within local codes enforcement inspections. In collaboration with the DOS Advisory Council representative and other DOS staff, the DOH provided lead awareness training to certified codes enforcement officers across NYS. During the period corresponding to this report, training was provided to over 100 local code enforcement officials on the identification and control of lead hazards, bringing the total number trained to nearly1,400.

- In 2008, Advisory Council members discussed the issue of unsafe residential renovation and remodeling practices as a potential source of lead exposure for children and provided input on the development of new educational messages and strategies to address this issue. In collaboration with CDC, DOH staff completed an updated analysis of renovation and remodeling as a potential lead exposure source for children with EBLLs, with

findings subsequently published in the January 2009 Morbidity and Mortality Weekly Report.

- Following a series of high-volume recalls of children's toys found to be contaminated with lead paint in 2007, the DOH has continued to monitor and disseminate information on federal Consumer Products Safety Commission (CPSC) lead-related recalls to LHDs, health care providers and the public.

- In October 2008, the DOH invited Mr. Larry Franklin, the state's CDC Project Officer for Childhood Lead Poisoning Prevention, to present to the Advisory Council on the topic of healthy housing promotion. CDC has increasingly emphasized healthy housing as a holistic approach to addressing lead and other environmental health hazards and has initiated discussions with states and other grantees about transitioning from lead-specific primary prevention activities and funding towards a healthy housing approach. During this time period, DOH staff began exploring opportunities to work with the National Center for Healthy Housing (NCHH) and several possible NYS training partners to develop capacity within the state to offer the NCHH-developed "**Essentials for Healthy Housing Practitioners**" course, as a key strategy for continuing to move NYS towards a comprehensive and integrated "Healthy Homes" model of addressing housing-related health issues. This course provides a forum for professionals who visit homes for various reasons (such as case management, public health nursing or other environmental investigations) to learn how housing and health are related and actions they can take to improve the health of their clients. By understanding and following key healthy homes principles, home visitors can address many environmental challenges such as lead, mold, air quality, asthma and pests. After meeting with various community-based agencies and educational institutions, Cornell Cooperative Extension agreed to partner with NYS to offer this training and a funding request was developed to submit to CDC, which was subsequently approved in 2009 to support initial trainings and credentialing of core staff.

- Expanding primary prevention strategies to effectively identify and reduce lead hazards before children become lead poisoned remains a top priority for the DOH. Primary prevention is central to achieving the goal of elimination. Specific priorities for 2009 and beyond include: implementing expansion of the CLPPPP to additional high-incidence communities; continuing evaluation of CLPPPP to identify successful tools and strategies for local programs; disseminating findings across programs and to other LHDs to support local primary prevention work; and exploring the integration of lead primary prevention work with other healthy housing approaches, including securing funding for and implementing statewide trainings of the NCHH Healthy Homes training in partnership with Cornell Cooperative Extension.

Supporting local childhood lead poisoning prevention programs and other local lead prevention activities

- The DOH continues to provide grant funding, training and technical assistance to LHDs to support local Lead Poisoning Prevention Programs (LPPPs). LHDs are the frontline providers of lead poisoning prevention services in communities across the state, including

public awareness and community education, promotion of lead testing for children and pregnant women, collection of lead testing data to support surveillance activities and coordination of follow-up services for children with lead poisoning in collaboration with children's health care providers. Current grant funding to LHD LPPPs is more than $7 million annually. The DOH provides ongoing guidance and technical assistance to LHD programs and facilitates sharing of challenges and best practices among counties, through quarterly conference calls and periodic trainings.

- Advisory Council members have highlighted the importance of leveraging available funding to support local lead prevention efforts. The DOH continues to coordinate communication with local Housing and Urban Development (HUD) grant recipients and regional HUD representatives through periodic videoconferences to highlight progress in meeting HUD grant milestones, discuss challenges, share accomplishments and provide updates from the federal level related to additional funding and training. The DOH has also supported applications from NYS localities for federal HUD lead hazard control funding.

- As described further in relevant sections above, a variety of program and data management guidance documents, protocols, tools and other resources were completed to directly support LHDs in effectively administering local LPPPs and conducting local prevention activities.

- Further strengthening of local capacity for elimination of lead poisoning remains a priority, with emphasis on targeting the highest risk communities. Specific priorities include continued provision of local data, training and other tools to support LHDs in conducting effective lead prevention strategies, and continued efforts to facilitate local partnerships between LHDs and other community partners, with a continued increasing emphasis on primary prevention.

Facilitating strategic partnerships to advance the elimination of childhood lead poisoning

- In November 2008, DOH staff participated in a series of stakeholder meetings convened by the Governor's Office to discuss progress, priorities and strategies related to both primary and secondary prevention of lead poisoning. Input from a wide range of external stakeholders obtained through these meetings informed subsequent policy and program strategies described in relevant sections above, including completion of regulations regarding lead testing and follow-up services, proposal of legislation to improve lead testing and advance local primary prevention efforts and expansion of funding for the CLPPPP.

- Over the past year, the LPPP has collaborated extensively with the NYS OTDA BRIA and the DOH Refugee Health Program to address emerging state and national concerns about lead poisoning among refugee populations. DOH and OTDA jointly conducted an assessment of educational needs for LHDs and refugee resettlement agencies, resulting in a collaboration to translate basic low literacy lead educational materials for refugees and to develop a new video for local agencies.

- The DOH also collaborated with the NYS OCFS Division of Child Care Services to update lead-related educational information, messages and materials for child care providers. In 2008, the DOH LPPP assisted OCFS with the implementation of an updated OCFS medical form for children in child care that includes expanded fields and information on state lead testing requirements and collaborated with OCFS on a broadcast to day care facility operators on environmental hazards.

- Continued partnerships with other programs, agencies and organizations to advance the elimination of lead poisoning remains an important priority for the DOH. Specific priorities for 2009 and beyond include exploring additional policy and program actions to assure appropriate lead testing of refugee children and pregnant women, facilitating linkages between local public health agencies and other local agencies and organizations that can contribute to housing-based lead poisoning prevention strategies, linking the NYS Immunization System and LeadWeb registry and supporting the work of a new interagency task force on childhood lead poisoning prevention to be established by Governor Paterson in 2009.

Appendix A

Abbreviations

Abbreviation	Definition
Ag & Mkts	Department of Agriculture and Markets, NYS
BCEHFP	Bureau of Community Environmental Health and Food Protection, NYSDOH
BLL	Blood Lead Level
BRIA	Bureau of Refugee and Immigration Assistance, NYS
BOH	Bureau of Occupational Health, NYSDOH
CCH	Center for Community Health, NYSDOH
CEH	Center for Environmental Health, NYSDOH
CDC	Centers for Disease Control and Prevention, federal
CLPPPP	Childhood Lead Poisoning Primary Prevention Program, NYSDOH
CPB	Consumer Protection Board, NYS
CPSC	Consumer Product Safety Commission, federal
DEC	Department of Environmental Conservation, NYSDOH
DFH	Division of Family Health, NYSDOH
DHCR	Division of Housing and Community Renewal, NYS
DO	District Office, NYSDOH
DOH	Department of Health (also NYSDOH)
DOI	Department of Insurance, NYS
DOL	Department of Labor, NYS
DOS	Department of State, NYS
EBLL	Elevated Blood Lead Level
EPA	Environmental Protection Agency, federal
HNP	Healthy Neighborhoods Program, NYSDOH
HUD	Department of Housing and Urban Development, federal
LHD	Local Health Department, NYSDOH
LPPP	Lead Poisoning Prevention Programs, NYSDOH
mcg/dL	micrograms per deciliter
NYCDOHMH	New York City Department of Health and Mental Hygiene
NYCRR	New York State Codes, Rules and Regulations
NYS	New York State
OCFS	Office of Children and Family Services, NYS
OHIP	Office of Health Insurance Programs, NYSDOH
OTDA	Office of Temporary and Disability Assistance, NYS

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Topics	Discussion	Follow Up
Attendees	**Council Members:** • Guthrie S. Birkhead, M.D., M.P.H., Deputy Commissioner, Office of Public Health (Council Chair) • Ray Andrews, Assistant Director for Code Development, Codes Division, NYS Department of State (Commissioner Designee, sitting in for Tom Mahar) • Mary Binder, Environmental Analyst, Division of Housing and Community Renewal (Commissioner Designee) • Susan Duchnycz, Child and Family Services Specialist 2, Division of Child Care Services, NYS Office of Children and Family Services, (Commissioner Designee) • Abby Greenberg, M.D., Director, Center for Public Health, Nassau County Health Department; Representative, American Academy of Pediatrics – Division II (Local Government) • Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY Buffalo (Professional Medical Organization) • Thomas Keenan, Temporary Assistance Specialist, NYS Office of Temporary Disability Assistance (OTDA), Bureau of Refugee and Immigrant Assistance (BRIA) (Adjunct Designee) • Monica Kreshik, EJ Coordinator, NYS Department of Environmental Conservation (Commissioner Designee) • Ellen Migliore, R.N., M.S., Public Health Nurse, Herkimer County Health Department (Child Health Advocate) • Lindsay Lake Morgan, R.N., Ph.D., A.N.P.; Assistant Professor, Decker School of Nursing, SUNY Binghamton (Education) • Deborah Nagin, M.P.H., Director, NYC Department of Health and Mental Hygiene (NYCDOHMH) – Lead Poisoning Prevention Program (Adjunct Designee) • Clifford Olin, President, EcoSpect, Inc. (Industry) • Tanya Ross, Associate Industrial Hygienist, NYS Department of Labor (Commissioner Designee) **Additional Attendees:** • Michael Cambridge, R.S., Director, Bureau of Community Environmental Health and Food Protection, NYSDOH • Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection,	

	NYSDOH • Larry T. Franklin, MPH, Centers for Disease Control and Prevention • Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health, NYSDOH • Bruce Phillips, Counsel, Division of Legal Affairs, NYSDOH • Alithia Rodriguez-Rolon, Deputy Director, Division of Governmental Affairs, Office of Governmental and External Affairs **Absent Council Members:** • David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) • Thomas Ferrante, Manager of Training and Technical Services, Total Safety Consulting (Labor Union) • Philip J. Landrigan, M.D., M.Sc., FAAP, Director and Professor of Pediatrics, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital) • Stacy Rowland, Deputy Superintendent, Legislative Affairs, State Insurance Program (Adjunct Designee) • William Schur, Vice President, Schur Management Company, Ltd. (Real Estate)	

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Welcome and Introductions	• The meeting was convened at 10:05 a.m. • Dr. Birkhead opened the meeting, welcomed special guest Larry Franklin from the Centers for Disease Control and Prevention (CDC), and the Council members. • Dr. Birkhead provided opening remarks regarding compliance with relevant executive orders: ▪ In accordance with Executive Order #3 and the Open Meeting Law, this meeting is being made available on the internet. The meeting notice and links to the webcast are at http://www.nyhealth.gov/events. (Note: this webcast is archived until November 19, 2008 and all future webcasts are anticipated to be announced at this website and will be archived for one month following the meeting.); ▪ In accordance with Executive Law, section 166, members of the public who appear before the Council and represent any agency regulated by the Department of Health must fill out a record of attendance, provided at the registration table. • Dr. Birkhead noted that this meeting falls within National Lead Poisoning Prevention Week. The theme for this year is, "Let's Wipe Out Lead Poisoning – Renovate Right!" The theme was first developed by the NYS Lead Poisoning Prevention Program (LPPP), and then adapted by the CDC for national use. The Department of Health (DOH) LPPP sent local health departments (LHDs) a sample press release, public service announcements, sample proclamation for local jurisdictions, a list of activity ideas for the week, and a media kit developed by the Environmental Protection Agency (EPA). DOH is also distributing a poster for the week, developed by the CDC. A copy of the folder was circulated for council members to view. The LPPP will be surveying counties to learn what awareness activities they conducted for this week, and to share among LHDs.	
Overview of Agenda	• Dr. Birkhead provided an overview of the meeting. • The scheduled presentation on the Renovation and Remodeling Outreach Campaign, by Dr. Eileen Franko, Director, Bureau of Occupational Health, had to be cancelled, and will be presented at a future meeting. • In the afternoon, Larry Franklin from the CDC will be presenting on the topic of healthy housing promotion. CDC has increasingly emphasized healthy housing as a holistic approach to addressing lead and other environmental health hazards and has initiated discussions with states and other grantees about transitioning from lead-specific primary prevention activities towards a healthy housing approach. Healthy housing is an approach New York has been a national leader in developing with our own Healthy Neighborhoods Program.	

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Review and Approval of Minutes	Dr. Birkhead asked members if there were additions or edits to the minutes of the last meeting. No comments or edits were made. A motion to accept minutes was made by Dr. Hunter, seconded by Dr. Greenberg. Motion passed.	
Legislative Update **Alithia Rodriguez-Rolon, Office of Governmental and External Affairs, NYSDOH**	Ms. Rodriguez-Rolon discussed the childhood lead poisoning prevention bill (A-6399-C) that was recently vetoed by Governor Paterson. The bill was vetoed for a number of different reasons. A copy of the Governor's veto message is in Council member's folders. The veto was due mostly to fiscal concerns. Also, some aspects of the bill were redundant with ongoing efforts. In his veto message, Governor Paterson outlined several commitments to further advance lead poisoning prevention, including a proposal to make the current primary prevention project permanent, a proposal to amend state regulations to expand the blood lead level requiring environmental follow-up services from 20 mcg/dL to 15 mcg/dL, and a charge to the Department of Health to assess if the blood lead level for such interventions should be further lowered to 10 mcg/dL. The Governor also wants to assess if specific practices from the pilot primary prevention program should be written into law, and to advance a legislative proposal (previously introduced as a departmental bill last session) to link the immunization registry with the lead registry to improve lead testing.	
Blood Lead Levels < 10 mcg/dL: A Public Health Approach **Dr. Rachel de Long, Bureau of Child and Adolescent Health, and Dr. Patrick Parsons, Wadsworth Laboratory,**	Dr. de Long discussed how DOH is addressing children with blood lead levels (BLLs) less than 10 mcg/dL. Although the CDC has established 10 mcg/dL as the definition of lead poisoning and the blood lead level that triggers medical and public health interventions, 10 mcg/dL does not define a threshold for harmful effects. A growing body of evidence points to potential adverse effects of blood lead levels below 10 mcg/dL on children's development. In November of 2007, the CDC issued a report, *Interpreting and Managing BLLs less than 10 mcg/dL in Children: Recommendations of the CDC Advisory Committee on Childhood Lead Poisoning*. The report did not change the established definition or level of intervention, but provided additional recommendations for education and monitoring of children with blood lead levels below 10 mcg/dL. With input from the Advisory Council and other stakeholders, DOH has been developing a three-part public health approach to address this emerging issue that includes **surveillance**, **professional and parent education**, and **changes to laboratory report language**. Dr. de Long and Dr. Parsons summarized the steps taken to date in each of these areas and additional steps to be taken. Details are included in the	

NYSDOH	presentation slides that were distributed at the meeting. Key points covered include: **Surveillance** – DOH is now monitoring and reporting several measures of BLLs below 10 mcg/dL in its routine surveillance reports. • Preliminary analysis of 2007 data shows that 98.9% of children tested for lead had BLL results below 10 mcg/dL. Within this group, 9.8% of children had BLL 5-9 mcg/dL, and 89.1% of children tested had BLL < 5 mcg/dL. The number and percent of children with BLLs 5-9 mcg/dL are declining significantly over the past decade, paralleling the trends for BLLs $\geq$ 10 mcg/dL. • A new analysis of serial blood lead screening results found that among children born in 2004 who were tested for lead at both one and two years of age, children with BLL 5-9 mcg/dL at age one year were over six times more likely than those with a BLL < 5 mcg/dL to have a BLL $\geq$ 10 mcg/dL at age two. 8.5% of those with a BLL 5-9 mcg/dL at age one had a BLL $\geq$ 10 mcg/dL at age two, compared to 1.3% of those with a BLL < 5 mcg/dL at age one. This analysis was repeated for birth cohorts 1998 – 2004, and for additional age groups, with the same general patterns identified. In addition, the trend data showed that the percent of children with BLL 5-9 mcg/dL at one year that go on to have a BLL $\geq$ 10 mcg/dL at two years actually declined every year. Additional analysis is needed to more completely understand these findings. **Professional and Parent Education** – DOH is developing new materials for parents and health care providers that explain the importance of different BLL results and steps to prevent increasing BLLs. • A work group was convened to provide input on the development and distribution of the new materials. Over 30 individuals participated, including representatives from the Lead Advisory Council; Local Health Departments; Regional Lead Resource Centers; DOH Central and Regional Office staff from Community Health, Environmental Health, and Wadsworth Laboratory. Through a series of conference calls in 2008, draft documents have been developed and discussed. • Current draft materials include a "Dear colleague" letter to pediatric primary health care providers and public health commissioners, a new educational handout for parents (*What Your Child's Blood Lead Test Means*), order forms and information on local resources. A draft of the parent handout was shared at the meeting for further input from Council members. • The proposed dissemination plan includes a statewide mailing to health care providers for use with their patients, posting materials on the DOH web site, and incorporating materials into other lead materials	

	and activities, including an expanded health care provider tool kit that is in development. **Lab Reports** – DOH is adding a requirement for new comment language on laboratory reports for BLL results <10 mcg/dL. Within DOH, Wadsworth is responsible for certifying and setting standards for labs. All reports must have some sort of interpretation, a reference range for abnormal results. Wadsworth has proposed to add required comment language on the test reports that highlights the concern for BLLs under 10 mcg/dL, without changing the established reference range. • Following the standard process for adding new requirements, Wadsworth sent a letter to all laboratories holding a NYS permit for toxicology-blood lead that included proposed new comment language for lead test reports for BLL results < 10 mcg/dL. • Detailed comments were received from 12 lab directors. Comments reflected a consensus on the need to alert health care providers about dangers of BLLs under 10 mcg/dL, along with concerns about perceived inconsistency with the established intervention level established by CDC, concerns about attributing adverse effects to blood lead levels below the typical limit of detection of 5 mcg/dL given the allowable error window of plus/minus 4 mcg/dL, and concerns about changing laboratory report language without simultaneous education for physicians. • To address the comments received, Wadsworth has revised the proposed comment language to read: "Blood lead levels in the range 5-9 µg/dL have been associated with adverse health effects in children aged 6 years and younger." Implementation of the new standard will be coordinated with the distribution of educational materials to health care providers. Council discussion took place on several issues, including: • **Incorporating the new surveillance data into educational messages/materials to reinforce the importance of two year old lead tests.** Preliminary data for 2007 indicate that only about 41% of children are tested for lead at both ages one and two, and improving two-year-old testing rates is a specific objective. • **Completeness and quality of data for children with BLLs 5-9 mcg/dL to support additional analysis.** Obtaining complete, accurate laboratory data is a constant challenge. Address information is needed to support sub-county geographic analysis, but completeness of address data is more challenging for BLLs under 10 mcg/dL because there is not as much follow up. Similarly, information about the	
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	likely sources of exposure would not be available. Dr. Greenberg noted that Nassau County DOH might have more data than is typical because it conducts home visits for children with BLLs 5 to 9 mcg/dL who are under one year of age. • **Feedback on draft parent education materials.** A member of the work group praised the work group process. It was noted that the recommendations on the parent handout will also be reflected in updated guidelines for health care providers, and that the materials would be updated when proposed regulations to expand requirements for comprehensive follow-up services from 20 mcg/dL to 15 mcg/dL are adopted. It was suggested that the expanded toolkit include a poster to prompt parents to discuss lead testing with the provider. Use of the term "doctor" vs. "health care provider" was discussed, noting that the work group had recommended the use of the term "doctor" in the new parent handout to reduce the literacy level, while some Council members preferred the use of the term "health care provider" because it is more inclusive and generic. It was noted that it might be resolved this through rephrasing. It was recommended that the material be translated into multiple languages, which is planned. • **Application of the new reporting standard to lead tests conducted in physician offices.** Physician Office Laboratories may utilize new office-based "point of care" technology to analyze blood samples for lead within their offices. As private practices, there is no additional lab interpretation provided with these results, and the state does not have regulatory authority over those labs, which are overseen by the federal government. However, Wadsworth has been distributing standards of practice guidelines, and the Department is proposing regulations that would require that the results of office-based testing be reported to the state. Currently, a very small percentage of doctors conduct these tests, about 100 providers statewide, compared to over 20,000 total providers statewide. **Lab language for BLLs 10-14 mcg/dL**. This level gets flagged as "abnormal." The language for this is not changing. • **Interpreting results of under 5 mcg/dL.** There was a concern that providers might assume that anything under 5 mcg/dL is perfectly safe, and that is not known for certain. Dr. Parsons noted that a result below 5 mcg/dL will mean different things to different labs. Some labs have higher accuracy, while others will not report quantitative results below 5 mcg/dL, other than to say results are "less than 5	Dr. Greenberg will provide DOH with additional information about the information collected through Nassau County home visits.

	mcg/dL." It would be difficult to come up with standard language due to different processes within the allowable range.	
Primary Prevention of Childhood Lead Poisoning, October 2008 Update **Thomas Carroll, Section Chief, Bureau of Community Environmental Health and Food Protection**	Tom Carroll reported that October, 2008, marks the end of Year 1 of the Primary Prevention Pilot Initiative. The $3 million 07-08 initiative has been piloted in eight target communities. Proposed additional funding of $2.5 million for Year 2 would add six new counties to the initiative. Budget cuts have reduced the total to $4.9 million for 13 counties and NYC. Jurisdictions selected for the pilot project were counties with the highest incidence of elevated blood lead cases ($\geq$ 10 ug/dL) and, at least one zip code with more than 10 children with a blood lead level of $\geq$ 10 ug/dL. Funding levels are based on the incidence of lead poisoning within the identified zip codes. Current counties include: Albany, Erie, Oneida, Onondaga, Orange, Westchester, Monroe, New York City. Potential new grantees include: Dutchess, Schenectady, Chautauqua, Fulton, Montgomery, and Broome. In this project, the counties have to produce a local "Primary Prevention" plan that will: identify scope of problem locally; develop local partnerships and community outreach; develop feasible approaches to targeting, inspection, hazard control, and enforcement; build capacity of local health departments and community partners, and, improve funding capacity for hazard control projects. Mr. Carroll reviewed how each county was pursuing its project: Mr. Carroll reported: grantees began full implementation of their programs between April and June 2008 and it is still too early to determine the effectiveness of the pilot project. An early lesson learned is the time required to start this kind of project. It took six months to get started, finalize the contract, hire staff, purchase supplies, and formalize relationships and data-sharing with other agencies. By June 30, 2008, the grantees made direct contact with at least 3,404 units and completed some type of lead-based paint (LBP) inspection in 850 units. Of these, 278 units had LBP hazards, and 82 units had remediation completed by the end of the third quarter of the grant period. Due to the time required for start-up, most of this data is from one quarter. The National Center for Healthy Housing (NCHH) provided exceptional technical assistance to NYSDOH and to the local health departments (LHDs). The evaluation of the various approaches used by LHDs is in progress and the NCHH will prepare a summary report. Findings will be shared with other LHDs to improve effectiveness. Mr. Carroll believes there will be a cumulative effect, through media coverage, expansion of the contractor base, outreach to other agencies, and leveraging of grant money to obtain additional funds.	

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Council Discussion	Discussion took place on several issues, including: • **Use of the X-ray Fluorescence XRF Analyzer to detect lead** in **home inspections.** The XRF instrument provides quantitative elemental lead analysis. There was discussion about whether there was too much reliance on the XRF, which can detect the presence of lead inside an object, even if it is not accessible on the surface, leading to a false identification of a health hazard. It was noted that the inspection does not completely rely on the XRF, but also on visual inspection for peeling paint. DOH has found that the XRF, used with visual inspections, is reliable. • **Amount of evidence that remediation will lower a child's BLL.** The initiative is collecting and analyzing this kind of data. This project, however, is focused on primary prevention, and is not directed towards reducing individual children's BLLs. A Nassau County study on abatement found that there was a decrease in BLLs both with abatement and without abatement. They concluded that other factors influenced BLLs, such as education and clean-up. • **Matching requirement for the pilot grant.** There is no matching requirement for this initiative, but it is encouraged. Counties are knowledgeable about how to access HUD and other funding sources. • **Criteria for selection of new counties.** The criteria are the same as the original eight pilot counties. • **Analysis of geographic data.** DOH is doing geocoding and will be able to conduct additional analysis. The goal is to do sub-ZIP code geographic analysis, which should be available within the next year. In the old data system, DOH was limited by the completeness of address level data. Also, each county had its own system, and had to link BLL results with addresses. Now DOH is geocoding all addresses, to enable analysis of BLLs at every geographic level. DOH will have this analysis soon. • **Interaction of geographic data with existing lead registry.** The goal is to analyze across registries. DOH has started the process. A feature of the new LeadWeb system is the environmental module. DOH is determining how to match the child-centered registry with an address-centered registry.	

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From Lead Poisoning Prevention to Healthy Housing Promotion **Larry Franklin,** Senior Public Health Advisor and CDC Project Officer for the DOH LPPP	Larry Franklin, presented on CDC's intention to fold lead poisoning prevention into comprehensive healthy housing promotion, and on the close connection between the quality of housing and individual health. "Housing" includes workplaces, childcare, and other places people spend time. The percent of housing with moderate or severe physical problems changed very little from 1995 to 2005, approximately six million units. Healthy housing considerations include improving home safety, i.e. injury and fire prevention, disaster preparedness; and addressing conditions that cause health issues, such as, poor ventilation, radon, cigarette smoke, mold, dampness, pests, chemical contaminants, carbon monoxide poisoning and biological contaminants from unregulated water systems, which are used by 45 million people in the U.S. Housing design and green architecture are also important. As health care costs can be reduced by improving housing, the link between public health and housing policy is an important one. A framework for healthy housing promotion includes: 1. Increasing the public's understanding of the connection between housing and health; 2. Taking actions to ensure that all Americans have access to healthy, safe, and affordable housing; 3. Promoting people's physical and mental health through evidence-based healthy housing interventions, i.e. lowering the hot water temperature, installing window guards and smoke detectors, lead paint abatement, using CO monitors and radon detectors, pest management, and eliminating second-hand smoke; 4. Investing in research that advances our understanding of how healthy housing improves physical and mental health; and 5. Investing in research that increases our understanding of the long-term economic benefits of healthy housing.	
Council Discussion	Discussion took place with Mr. Franklin on several issues, including: • **CDC's new emphasis on integrating lead into healthy homes.** The Healthy Homes' approach has the potential for creating new partnerships, for example, between immunization and asthma programs. Both programs address very similar, young, at-risk populations and environmental issues in dwellings. With a Healthy Homes' approach, there are many creative possibilities to bring in different populations, such as seniors, and additional work force members who are out in the community, such as postal workers and home health aides, to address the issues. A challenge may be the need to address historic program silos. • **Categorical CDC funding for lead.** The CDC is developing a draft request for proposals (RFP), which will be issued sometime after the first of the year. The RFP will give all the qualifications for who is eligible and the criteria for eligible applicants. Although the details have not been finalized, eligible	

	applicants will not be solely state lead poisoning prevention programs, but also community based organizations. There is a lot of support from Congress for the Healthy Homes initiative, although most likely a relatively small amount of money is available. The CDC will probably competitively select a half-dozen projects, with awards of approximately $100,000 to $500,000. It is not known how lead will be transitioned into Healthy Homes. • **CDC collaboration with HUD.** It was noted that HUD's Healthy Homes pilot project is similar to the CDC initiative. Mr. Franklin did not know if the CDC has been collaborating with HUD, but would find out. • **Possible sources of funding for this new approach.** Private corporations, such as Home Depot and Lowe's, health care plans and insurers, third party incentives and public programs were all mentioned as possible sources. • **Engaging health care practitioners (physicians and public health nurses) to understand their roles in the Healthy Homes' approach.** Although many health care practitioners may already ask about home environmental issues, others may need education and training to incorporate these issues into well child care guidance. • **Support for ongoing surveillance, screening, and testing of children.** Healthy Homes makes sense for primary prevention, but there is still a high burden of lead poisoning. Lead-specific activities will continue, but the way of doing business is going to change. Surveillance and other lead activities are going to be incorporated into other Healthy Homes activities, so it is all in one. • **Healthy Homes' efforts already in place in New York State (NYS).** Mr. Franklin noted that New York State is already out front with its pilot primary prevention projects; has a good foundation, has built good relationships, and is acquiring good data, which could help with the upcoming RFP from the CDC.	
NYS Advisory Council on Lead	Dr. de Long distributed and discussed a draft outline for the next annual report of the Advisory Council. The Public Health Law that established the Advisory Council requires the council to report annually to the	

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Poisoning Prevention Report **Dr. Rachel de Long, Bureau of Child and Adolescent Health**	Governor and legislature on the development and implementation of the statewide plan and the operation of the Lead Poisoning Prevention Program. The proposed report will cover the period from 2006 to 2008, following the last report that was issued earlier this year reporting on the calendar year of 2005. The report will serve to update and summarize progress in implementing the strategic plan issued in 2004. A draft report is nearly done and will be sent to council members for review and input. Once completed, the report will be delivered to the Governor and legislature and will be publicly available. Dr. de Long asked Council members for input on the organization and content of the report.	
Council Discussion	Council discussion took place on several issues, including: • **The time period of the report.** The report will cover a 2 ½ year time period from January 1, 2006 – June 30, 2008, which will put the Council on track for subsequent annual reports covering the prior calendar year to be issued in a more timely manner. The June 30, 2008 date was selected because it coincides with the end of the federal CDC project year. • **Content and use of the report.** Members noted that this report could be a good tool that community advocates could use to advocate with legislators for more resources to promote lead poisoning prevention activities. It was suggested that keeping the report simple would be preferable, with references to other sources for additional information. It was specifically noted that although the proposed report includes a summary of updated surveillance data, the Council report will not take the place of the Department's annual lead surveillance report, which is currently being completed for 2006-07 data. The Council report will include a summary of core measures, while additional analysis and detail will be covered in the data report. • **Process for completing and issuing the report**. A draft report should be completed very soon. The draft will be mailed electronically to Council members to provide comments. Council members agreed that two weeks would be adequate for review and feedback.	The NYS LPPP will send the draft City Council report

	• **Report Template.** The NYC lead poisoning prevention program also has to produce a report that goes to the New York City Council, and a separate annual report. To prepare a report every year, it can help with the pace of the printing to have a template that can be used annually and that does not change. Dr. de Long noted that the NYC report has been a helpful example for crafting this updated Council report.	to Council members when completed for comments.
Council Member Updates	Council members provided the following updates on lead-related activities: • Tom Keenan announced that the Bureau of Refugee and Immigrant Assistance (BRIA) is in its second year of its EPA-funded translation grant, and is looking for translation projects, to translate currently available materials. BRIA has liaisons and refugee resource centers upstate to get access to the refugee communities. • Mary Binder announced that the Division of Housing and Community Renewal is providing funds for low-income housing development and rehabilitation. Through its Environmental Analysis Unit, the agency makes sure the work is done safely through interim and final dust clearance analysis. Ms. Binder emphasized the importance of interclearance dust wipes from contractors. • Deborah Nagin, Director of the NYCDOHMH Lead Poisoning Prevention Program, announced that her program currently does environmental intervention for children with BLLs of 15 mcg/dL and above, and sends letters to children with BLLs of 10-14 mcg/dL, and providers. NYC is going to start sending letters for children with BLLs of 5 to 9, about 25,000 children annually. For children under three years of age with confirmed venous BLLs 10-14 mcg/dL, NYC is proposing to do environmental inspections, approximately 530 children annually. NYC will also try to identify newborns, less than 3 months old, in the same building to do primary prevention inspections. NYC will also add inspection of the exterior to their inspection activities, to assess how that is associated with children with BLLs of 10-14 mcg/dL and above, to determine if that is an effective way to target efforts for primary prevention. Also, NYC has been approached by non-Medicaid health plans to do matching to improve lead testing rates. • Ms. Nagin indicated approximately 20-30% of children with elevated blood lead levels in NYC who receive environmental investigations have no identified paint source for lead. NYC is collaborating with Tom Keenan at OTDA on working with immigrant communities on non-paint sources, especially herbal medicines.	

Appendix B
Meeting Minutes
Advisory Council on Lead Poisoning Prevention
October 21, 2008

	• Dr. Greenberg reported that Nassau County has been conducting programs similar to NYC, providing case management for infants for BLLs 5-9 mcg/dL, and sending letters to providers. The County conducts home inspections for other children with a persistent elevation under 15 mcg/dL. As a member of the committee that worked on the new education materials related to BLLs < 10 mcg/dL, Dr. Greenberg expressed support for completing and disseminating the materials for county use. • Tanya Ross, Department of Labor (DOL), reported that the DOL has a division of Safety and Health that provides consultation to employers and contractors. DOL works with approximately 2,500 contractors, and provides to the public about 300 trainings. This is a resource that counties should know about, especially those with HUD money, to ensure that the contractors are doing the right job. DOL does free air testing and swipe testing. DOL is also looking for educational materials to get out to employers and materials could be distributed through DOL. • Monica Kreshik, Department of Environmental Conservation (DEC), announced the Governor has put together an environmental justice task force. DEC is identifying programs that impact environmental justice issues, figuring out how to engage communities and exchange information. DEC has a toxics workgroup, and lead poisoning was a main focus. The representatives in the group from DOH have the recommendations from that work group. It would be helpful to provide these recommendations in the minutes, or at the next council meeting. Ms. Kreshik offered several suggestions for improving outreach to local groups, especially low income minority communities, to engage their input or participation in Council activities, including more visible posting of Council meeting information and presentations on the public website, and potential membership on the Council. Dr. de Long noted the Department's interest in increasing the diversity of its councils and said she would follow-up with Ms. Kreshik. • Susan Duchnycz, Office of Children and Family Services (OCFS) requested DOH assistance in updating and distributing educational materials for day care providers related to lead poisoning prevention. She said OCFS does a lot of training, and she wants to make sure that lead is covered. • Ray Andrews, Department of State (DOS), informed the Council of the main state codes that prohibit the use of lead-based paint, i.e. the uniform code, and the energy conservation and construction code. There	Lead Program staff will follow up with Ms. Kreshik regarding possible candidates. Lead Program staff will follow up with Ms. Duchnycz on this joint

	is a maintenance piece for peeling paint. The two new codes are in the Office of Regulatory Reform. The Department's regulations include part 1203, which tells code officials in 1,604 communities how often to inspect buildings, not including one and two-family residences, and aspects of property maintenance. The DOS trains and certifies 4,000 to 6,000 code officials, not including NYC. They have to be trained on an annual basis. DOS trains people on lead, mold, and other issues.	project.
Public Comment	No comments were received.	
Adjournment	Meeting adjourned at 2:55 p.m.	

New York State Department of Health
Advisory Council on Lead Poisoning Prevention
Report

January 1, 2005 – December 31, 2005

Eliot L. Spitzer
Governor

Richard F. Daines, M.D.
Commissioner of Health

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Advisory Council on Lead Poisoning Prevention Council Members

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Guthrie S. Birkhead, MD, MPH
Co-Chair
Director, Center for Community Health
New York State Department of Health

Ronald Tramontano
Co-Chair
Director, Center for Environmental Health
New York State Department of Health

Designee for Division of Housing and Community Renewal
Mary Binder
Environmental Analyst
NYS Division of Housing and Community Renewal

Designee for Office of Children and Family Services
William Dorr
Assistant Director
Bureau of Early Childhood Services
NYS Office of Children and Family Services

Designee for Department of Environmental Conservation
Carl Johnson
Deputy Commissioner
NYS Department of Environmental Conservation

Designee for Department of Labor
Robert Perez, CIH, MBA
Principal Industrial Hygienist
NYS Department of Labor

Designee for Office of Temporary and Disability Assistance
Alicia Sullivan
Senior Attorney
NYS Office of Temporary and Disability Assistance

Public Members

Rolaine Antoine
Parent Representative
Queens Village, New York

David N. Broadbent, MD, MPH
Coalition Co-Chair
Coalition to End Lead Poisoning in New York

Thomas Ferrante
Manager of Training and Technical Services
Total Safety Consulting

Abby Greenberg, MD, FAAP
Director, Division of Disease Control
Nassau County Department of Health
Representative, American Academy of Pediatrics, District II

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Professor and Chairman, Department of Community & Preventive Medicine
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Adjunct Designee for Insurance
Bethney Lortie-Denno
Special Assistant to the Superintendent
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Adjunct Designee for Department of State
Thomas Mahar
Code Compliance Specialist II
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Adjunct Designee for New York City
Deborah Nagin, M.P.H.
Director, Lead Poisoning Prevention Program
New York City Department of Health and Mental Hygiene

Summary

Lead poisoning continues to be a major, preventable environmental health problem for young children in New York State and is an important cause of preventable brain injury and neurodevelopmental dysfunction. Blood lead levels among children have declined steadily in New York State and nationwide. While significant progress has been made, continued efforts are needed to achieve elimination of lead poisoning in New York State. In particular, our efforts must address those populations at highest risk for lead poisoning, including children living in older, deteriorating housing that contains lead-based paint; children living in homes undergoing renovation, where contaminated dust is released from lead-based paint; and children in certain immigrant communities, especially Latin American and South Asian communities, that use traditional medications, cosmetics and cooking utensils containing lead. Moreover, growing knowledge about the toxicity of lead demonstrates that even levels of lead exposure once thought to be safe have serious detrimental effects on young children[1].

The New York State Advisory Council on Lead Poisoning meets at least three times annually to discuss issues and initiatives relevant to treatment and prevention of lead poisoning in New York State. In 2005, the Council met on April 18, July 28, and October 20 in Albany, New York. The Council's work in this period focused on implementing and tracking the progress of the comprehensive plan to eliminate childhood lead poisoning in New York State. The formal plan, **Eliminating Childhood Lead Poisoning in New York State by 2010**, was published in July 2004 (see Appendix B). The Plan can also be found online at http://www.nyhealth.gov/nysdoh/environ/lead/finalplantoc.htm.

Council meetings included update reports from the New York State Department of Health (DOH), Center for Community Health, the DOH Center for Environmental Health's Bureaus of Community Environmental Health and Food Protection, and Occupational Health, and the New York City Department of Health and Mental Hygiene. Each meeting included presentations from experts on topics relevant to the elimination of lead poisoning. Topics discussed in 2005 included lead poisoning in African refugee children, lead poisoning in pregnant women, successful primary prevention programs in lead paint remediation, non-paint lead hazards, Connecticut's local enforcement initiative for lead removal activities, office-based capillary blood lead testing, and Westchester County's Healthy Neighborhood Program. The Council also provided feedback on and support of various lead poisoning prevention and awareness initiatives. Such activities included support for an educational letter that was sent to all pediatric health care providers in New York State in September 2005, support to develop a comprehensive tool kit for health care providers, and support for and feedback on one-time funding of local coalitions in high-risk communities to implement lead elimination plan goals. Meeting minutes are included as Appendix A of this report.

The Council and other stakeholders provide important ongoing input on the implementation, refinement, and evaluation of the Elimination Plan. Much progress was achieved in 2005 in implementing the Elimination Plan. Building the existing public health infrastructure and

[1] Canfield, R.L., Henderson, C.R., Cory-Sletchta, D.A., Cox, C., Jusko, T.A., Lanphear, B.P. Intellectual impairment in children with blood lead concentrations below 10 micrograms per deciliter. New England Journal of Medicine 2003; 348:1517-1526.

strengthening public health and primary care collaboration is a cornerstone of elimination. Finding lead poisoned children as early as possible and eliminating lead sources to prevent initial lead exposure are two integral ways to reduce this environmental threat to New York's children. These are among the goals of the state's lead elimination plan and the work of the Council.

Statutory Charge and Role of the Council

The Lead Poisoning Prevention Act of 1992 called for the establishment of a State Advisory Council on Lead Poisoning Prevention to be convened by the Commissioner of Health and comprised of the Commissioners of Social Services (now with representation of both the Office of Temporary and Disability Assistance and the Office of Children and Family Services), Environmental Conservation, Labor and Housing and Community Renewal, with appointed representatives of local government, labor unions, real estate, industry, community environmental and child advocacy groups, professional medical organizations, hospitals, parents and educators. The Department and Council recognize that coordination and collaboration are essential to the success of childhood lead poisoning elimination, and have reached out to additional important governmental entities to assist with Council deliberations. These Council "Adjuncts" include representatives from the New York City Department of Health and Mental Hygiene, the Department of Insurance, and the Department of State. Title X, section 1370(b) of Public Health Law defines the Council's role and duties as:

- developing a comprehensive statewide plan to prevent lead poisoning and to minimize lead exposure;
- coordinating the activities of its member agencies with respect to environmental lead policy and the statewide plan;
- recommending adoption of policies with regard to the detection and elimination of lead hazards in the environment;
- recommending the adoption of policies with regard to the identification and management of children with elevated lead levels;
- recommending the adoption of policies with regard to education and outreach strategies related to lead exposure, detection, and risk reduction;
- commenting on regulations of the Department of Health under this title when the Council deems appropriate;
- making recommendations to ensure the qualifications of persons performing inspection and abatement of lead through a system of licensure and certification;
- recommending strategies for funding the lead poisoning prevention program, including but not limited to ways to enhance the funding of screening through insurance coverage and other means, and ways to financially assist property owners in abating environmental lead, such as tax credits, loan funds, and other approaches; and
- reporting on or before January first of each year to the governor and the legislature concerning the development and implementation of the statewide plan and operation of the program, together with recommendations it deems necessary.

Summary of Department of Health Lead Poisoning Prevention Activities

The New York State Department of Health's Childhood Lead Poisoning Prevention Program (C LPPP), in partnership with local health departments, the health care provider community and the Council, coordinates a wide range of efforts to prevent, detect, and treat children with elevated levels of lead. The partners work together to:

- Promote universal screening of one and two year olds and targeted screening of children ages six months to six years assessed to be at high-risk for lead exposure;
- Promote anticipatory guidance about lead poisoning to all pregnant women and screen pregnant women at high risk for lead exposure; the Council and Department recognize the need to adopt policies and practices that will protect mothers, fetuses, and newborn infants at risk;
- Educate the public and health professionals about prevention, early detection, and treatment;
- Provide case management or oversight of case management for children with elevated blood lead levels, including environmental assessment and requiring lead hazard control;
- Ensure that families of children with lead poisoning are given advice and technical assistance in locating sources of lead in children's environments;
- Provide assistance to pediatric health care providers about medical management of children with elevated blood lead levels through the establishment of regional lead poisoning prevention resource centers;
- Collect, analyze and report on data, and
- Administer state grant funding to local health department lead poisoning prevention programs.

The Department's Center for Environmental Health (CEH) oversees the environmental assessment, lead hazard control components of case management and occupational health related issues. CEH also:

- Develops standards for local health department environmental staff,
- Provides direct environmental services for 21 local health departments without environmental services through District Offices,
- Administers Healthy Neighborhoods Program grants to 13 local health departments. (The Program was recently expanded from 8 to 13 local health departments in accordance with primary prevention objective 2 in the plan "Eliminating Childhood Lead Poisoning in New York state by 2010.");
- Works with Federal and State Departments of Labor and designated local education agents to discuss various worker and apprentice training programs (such as skilled construction craft laborers, painters, decorators, carpenters, etc.) where lead hazard awareness and lead-safe work practices will prove beneficial, and
- Collaborates with and improves compliance with a variety of existing federal Housing and Urban Development (HUD) and Environmental Protection Agency (EPA) laws and regulations to significantly strengthen primary prevention actions statewide.

Summary of Priority Focus Areas

The New York State Elimination Plan outlines the strategies that will be employed to build on the existing program success and outlines measures that will result in greater protection for children before they are identified with elevated blood lead levels. These strategies center on screening and surveillance, targeting high-risk populations, and primary prevention. The plan is consistent with the national goal to eliminate childhood lead poisoning before 2010. The plan covers the 57 counties excluding New York City's five boroughs (Upstate New York) and is a companion of the New York City Plan to Eliminate Childhood Lead Poisoning.

Screening and Surveillance

Health care providers play a critical role in the screening of young children for lead poisoning, the provision of ongoing lead poisoning prevention education, and the medical management of children with elevated blood lead levels. In 2005, several key initiatives were accomplished to increase lead screening in New York State. These have included:

- With input from the Advisory Council, a Commissioner's letter was sent to all pediatric health care providers, in September 2005, with an update on the status of childhood lead poisoning prevention and to reinforce universal childhood lead screening as the standard of medical care in New York State. The letter was jointly signed by the President of the American Academy of Pediatrics, District Office II, the New York State Academy of Family Physicians and the Medical Society of the State of New York.
- The Department, in conjunction with the state-funded Regional Lead Resource Centers and the state medical academies began discussion on the value of a toolkit to improve health care provider understanding and practice of the requirements for risk assessment, anticipatory guidance and blood lead screening, and to develop office systems to improve the rates of preventive care being done for childhood lead poisoning prevention.
- The Council discussed new Department efforts to assess the potential for promoting in-office capillary testing to help achieve the goals for universal screening.
- The Program contributed to the December 2005 Medicaid Update, a publication distributed to over 44,000 health care providers statewide. The article entitled "Mandatory Lead Testing for Children" included information for health care providers on universal screening, risk assessment of all children age six months to age six years, and the most common sources of childhood lead poisoning.

Targeting High-Risk Populations

Communities with the highest proportion of old housing (pre-1950) and low-income minority populations face the highest burden of childhood lead poisoning. In 2005, several initiatives were carried out to strengthen local coalitions in high-risk communities to bring community stakeholders together to work on accomplishing change at the local level.

- Council members contributed to ongoing discussions regarding the definition of "high risk" communities. Members emphasized the importance of considering total case numbers, relative incidence, high risk housing stock, and other demographic indicators.
- The Council discussed an alert from the Centers for Disease Control and Prevention (CDC) regarding lead poisoning among refugee children newly arrived from Africa. African refugee children's blood lead levels that were 'normal' upon arriving to this country became elevated shortly following relocation to the United States. The Council discussed the implementation of CDC recommendations for medical monitoring of

refugee children. Council members relayed possible strategies for overcoming barriers to communication and education of the refugee population.

- Five existing community coalitions from high lead-risk areas across the state received one-time funding to develop local initiatives to work towards the elimination of childhood lead poisoning by 2010.
- With the assistance of State agency council members, meetings were convened with other State agencies that serve high-risk populations, including the Office of Children and Family Services and the Office of Temporary and Disability Assistance. These strategic planning meetings helped to identify statewide and community level opportunities for advancing priority lead elimination efforts in target populations. Specific opportunities that were identified for further development include:
    - Incorporation of lead hazard identification and referral and remediation in programs that serve young children in their homes or other dwellings, and
    - Training and educational materials for child care providers to reinforce and support their role in childhood lead poisoning prevention;

Primary Prevention

Primary prevention refers to feasible and cost effective approaches to assess and reduce or eliminate lead exposure or risk factors for lead exposure before a child becomes lead poisoned. Some of these initiatives include building partnerships with other public and private agencies and organizations; conducting assessments of local needs and resources for primary prevention; developing and implementing local policies and programs to identify and reduce paint and non-paint lead hazards in the environment; incorporating lead hazard identification into health and other agency programs that involve home visits; supporting educational programs on lead-based paint hazards and safe work practices in local communities; and expanding the Healthy Neighborhoods Program. Key initiatives carried out in 2005 with input from the Advisory Council include:

- The New York State Department of Health Center for Environmental Health Bureau of Occupational Health, in conjunction with the Department of State, has developed a certified training curriculum for local housing code enforcement staff on the importance of identifying lead risks during routine inspections. In 2005, BOH provided trainings to 177 code enforcement officers (CEOs) at two training sites. NYS has a property maintenance code that prohibits peeling and chipped paint. Code enforcement offers a basis for lead hazard reduction that is not currently maximized in high-risk communities. Continuing education credits are available for CEOs who complete the training.
- The Healthy Neighborhood Programs, a comprehensive home environmental health initiative, which uses a door-to-door approach in high-risk communities, has been expanded from eight to 13 programs. The recent addition of 5 new Healthy Neighborhood Programs make 9 Healthy Neighborhood Programs outside of NYC. The new contractors specially selected jurisdictions with high incidence zip codes for childhood lead poisoning. The advantage of HNP is that each dwelling receives a visual assessment and education regarding lead and other hazards that is specific to the dwelling. The Council provided input and feedback related to ongoing HNP updates and a specific presentation from the Westchester County HNP.
- The Center for Environmental Health proactively supports the grantees of federal Housing and Urban Development (HUD) initiatives targeting lead hazard reduction

activities. The Department organizes periodic videoconferences to facilitate information exchange, promote collaboration and to provide the opportunity to raise issues for which technical assistance is needed. The Department also gives the HUD grantees updates from NYS regarding activities to eliminate childhood lead poisoning. A HUD representative frequently participates to provide updates on HUD's Healthy Homes-Healthy Families Initiative, new funding opportunities and other information. Regional NYSDOH lead staff regularly interact with HUD grantees between videoconferences via e-mails, meetings and at local coalition meetings.

The New York State Advisory Council on Lead Poisoning Prevention will continue to provide recommendations to the New York State Department of Health to continue progress of ongoing and planned initiatives to reach the local, state, and national goal of eliminating childhood lead poisoning by 2010.

APPENDIX A

Meeting Minutes:
April 18, 2005
July 28, 2005
October 20, 2005

NEW YORK STATE LEAD POISONING PREVENTION ADVISORY COUNCIL
NYS DEPARTMENT OF HEALTH
APRIL 18, 2005
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow-Up
Attendees	Council Members: Guthrie Birkhead, M.D., M.P.H., Director, Center for Community Health-Council Co-Chair; Ronald Tramontano, Director, Center for Environmental Health-Council Co-Chair; Rolaine Antoine (Parent); Mary Binder, Environmental Analyst, Division of Housing and Community Renewal; David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group); William Dorr, Assistant Director, Bureau of Early Childhood Services, NYS Office of Children and Family Services; Abby Greenberg, M.D., Director of Disease Control, Nassau County Department of Health (AAP/Local Government); Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY-Buffalo (Professional Medical (Nursing) Organization); Carl Johnson, Deputy Commissioner, NYS Dept. of Environmental Conservation; Lindsay Lake Morgan, R.N., PhD, A.N.P., Assistant Professor, Decker School of Nursing, SUNY Binghamton (Educator); Bethney Lortie-Denno, Special Assistant to the Superintendent, NYS Insurance Department; Tom Mahar, Code Compliance Specialist II, NYS Department of State; Clifford Olin, President, EcoSpect, Inc. (Industry); Norm Labbe for Robert Perez, Principal Industrial Hygienist, NYS Department of Labor; William S. Schur, Vice President of Schur Management Company, Ltd., (Real Estate); Robert Loz and Alicia Sullivan, Assistant Counsel for Jerry Vigeant-NYS Office of Temporary and Disability Assistance. Excused Members: ➢ Thomas Ferrante, Manager of Training and Technical Services, Total Safety Consulting (Labor Union); ➢ Tamara Henry-Kurtz, Executive Director, Syracuse Onondaga Drug and Alcohol Abuse	

Topics/Speaker	Discussion	Follow-Up
	Commission (Local Government); ➢ Philip Landrigan MD, MSc, DIH, Director, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital); ➢ Ellen Migliore, RN, MS, Public Health Nurse Herkimer County Health Department (Child Health Advocate). Additional Attendees: ➢ Rob Henry, Project Officer, Lead Poisoning Prevention Branch, Centers for Disease Control and Prevention Presenters: ➢ Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health; ➢ Barbara Leo, M.S., R.N., Childhood Lead Poisoning Prevention Program; ➢ Deborah Nagin, M.P.H., Director &, Jacqueline Erlich, M.D., Medical Consultant, New York City Department of Health and Mental Hygiene; ➢ Andrew McLellan, Environmental Education Associates; ➢ Richard Svenson, Director, Division of Environmental Health Protection.	
Welcome and Introductions: Dr. Birkhead & Mr. Tramontano	The meeting was convened at 9:45 am. ➢ Dr. Birkhead opened the meeting and welcomed the members. ➢ Dr. Birkhead reviewed the meeting agenda. ➢ Council members and State Health Department representatives introduced themselves.	
Review of minutes	Draft minutes from the September 22, 2004 Advisory Council meeting were reviewed and approved by the Council, with two changes. ➢ Ms. Antoine requested correction of a typographical error in her name. ➢ Ms. Nagin requested correction of a typographical error.	Minutes were changed to reflect the corrections.

Topics/Speaker	Discussion	Follow-Up
Status of the elimination plan and next steps: **Dr. de Long, with questions and discussion by the council.**	Dr. de Long provided an update on the elimination plan Focus Area One: Screening and Surveillance. The plan includes three (3) key objectives to improve screening: to improve awareness of NYS screening regulations and the rationale for universal screening; to enhance implementation of screening requirements in provider practices; and to assure that homeless children receive lead screening and testing in all communities. Dr. de Long reported on the Lead Screening Roundtable convened in November 2004. The roundtable discussion brought together key leaders and experts from across the state to clarify potential challenges to improving screening rates in NYS, and to identify promising strategies for improving screening rates. (Handout provided.) ➢ Dr. Broadbent asked if initiatives are planned that focus on primary prevention. ▪ Dr. de Long reported that the Center for Environmental Health (CEH) would present on this topic in the afternoon session. ➢ Dr. Broadbent noted concern over the type of enforcement that NYSDOH may implement for health care providers who are non-compliant with Public Health Regulations concerning childhood lead testing. ▪ Dr. de Long responded that the Department of Health (DOH) is working with the Medicaid Program, the Office of Managed Care; the American Academy of Pediatrics and the American Academy of Family Physicians, developing a protocol to improve compliance.	
Status of the elimination plan and **next steps: Dr. de Long, with questions and discussion by the council**	➢ Dr. Greenberg commended DOH on addressing barriers to lead testing. In addition, she added that physicians are not reimbursed for the time it takes to obtain a lead test on a child in the office setting. In addition, children are not being tested due to lack of parental follow through to have the test done at another location. Highlighting capillary testing may encourage some pediatricians to resume office testing. She noted that more doctors were utilizing capillary testing a decade ago. ➢ Ms. Nagin reported that Dr. Erlich has reviewed capillary testing and continues to be concerned about the accuracy of this type of testing.	

Topics/Speaker	Discussion	Follow-Up
	▪ Dr. de Long indicated an in-depth analysis regarding the false positive rate and the pros and cons of capillary vs. venous testing may be in order. ➢ Ms. Antoine commented that parents failing to comply might be assisted by a reminder system such as a visual aide in the form of a sticker, similar to what is used on the child's immunization record. ➢ Dr. Broadbent commented that the terminology of screening vs. testing could be confusing. Everyone agreed that lead-related educational materials must be consistent and clearly understood by the target audience. ➢ Ms. Nagin commented that the NYSDOH Lead Screening Roundtable discussions were valuable and New York City would like to model a similar forum. In addition, providing doctors information on the age of housing and environmental risk factors may help compliance with lead testing. ➢ Dr. Broadbent commented that Monroe County uses data matching to develop report cards to provide the physicians with feedback on their lead testing rates. He further indicated this reinforces the idea that lead affects all geographic areas; matching is a strong resource utilized by local health departments and coalitions.	
Refugee Children: Ms. Leo, Public Health Program Nurse	Ms. Leo presented on a recent alert from the Centers for Disease Control and Prevention (CDC) that identified a troubling set of circumstances affecting refugee children newly arrived from Africa (Handout provided.) It is known that in many countries the lead regulations are not as stringent as those in the United States, causing some children to have elevated blood lead levels upon arrival to this county. However, in recent reports from New Hampshire, African refugee childrens' blood lead levels that were 'normal' upon arriving to this country became elevated shortly following relocation to the United States. A letter was sent to all refugee resettlement agencies in NYS and the nine (9) state contracted refugee health care providers alerting them to the potential risk of lead poisoning and the need for a second lead test after some interval following relocation for African refugee children. A list of all African refugee children resettled in NYS in 2004 was provided to the appropriate local lead programs. The local programs performed a data match of refugee children resettled in 2004 with data in	

Topics/Speaker	Discussion	Follow-Up
	the lead registry to determine initial lead test, contacted resettlement agencies to enlist their assistance in getting the children retested, and any needed follow-up for children with elevated levels. The local programs provide DOH with a monthly update of the status of second testing for African refugee children. DOH is looking to develop new protocols for preventing and monitoring lead poisoning in refugee children, and to work closely with CDC and disseminate a toolkit, when available. ➢ Mr. Dorr inquired whether all counties were notified of this issue. ▪ Ms. Leo responded that all counties were advised of this issue but that the targets of the re-testing efforts were African refugee children (and their families) resettled in 2004 in the five (5) New York State counties of Broome, Erie, Monroe, Oneida, and Onondaga. ➢ Dr. Birkhead questioned whether New York City (NYC) was involved. ▪ Ms. Leo responded that the NYC Childhood Lead Program medical director was present at the presentation given for downstate refugee resettlement agencies and were available for questions relating to NYC. ▪ Ms. Nagin furthered elaborated that a data match is planned with the Bureau of Refugee and Immigrant Affairs (BRIA) for the refugee children arriving at JFK to obtain a better scope of the issue. Data match will look at BLL, last country of residence, date of birth and other variables. ➢ Dr. Morgan commented that the refugee resettlement agencies downstate might engage universities to assist with the challenge of specific language dialects. ➢ Dr. Hunter offered that it might be useful to get local churches involved as sponsoring groups. They could perform as an outreach education resource. These populations tend to cluster in the same areas and frequent the same markets, churches and other facilities.	
New York City Update: Lead Poisoning among Pregnant Women	➢ Ms. Nagin discussed New York City's efforts to expand and enhance services for lead poisoned pregnant women. (Handout provided.) It is estimated 0.5% to 2% of women giving birth in the U.S. have BLLs $\geq$ 10 ug/dL leading to increased risks of miscarriage, premature labor and pregnancy induced hypertension. Children born with elevated BLLs are at increased risk of	Ms. Nagin will provide materials to the Council for consideration of

Topics/Speaker	Discussion	Follow-Up
in NYC: **Ms. Nagin and** **Dr. Erlich**	cognitive and developmental delays, low-birth weight and smaller head circumference. The NYCDOHMH convened an expert panel charged to: ▪ Determine the appropriate LPPP intervention activities for pregnant women and other family members; ▪ Identify the recommended testing for pregnant women; ▪ Identify the barriers that prevent health care providers from conducting risk assessment, testing, and providing case management and coordinating care for pregnant and lactating women and newborns. Cultural, ethnic and linguistic issues need to be addressed in the medical information health care providers give to pregnant women about lead poisoning. It was noted that Mt. Sinai did an extensive literature review that was supported by CDC. National experts for medicine, toxicology and cultural anthropology offered recommendations to the NYC LPPP for the development of the case management protocols and environmental interventions. ➢ Dr. Birkhead inquired about the anthropological context and need for provider education. ▪ Dr. Erlich responded there is not one simple answer. Some people eat non-food items based on homeland traditions. This practice may be culturally acceptable, and in some instances satisfy a physiologic or emotional craving. Some NYC hospitals that serve a high percentage of immigrant populations perform universal screening among pregnant women. ➢ Dr. Greenburg pointed out that pica may be an important practice in other cultures. Others in the audience seconded this observation. Ms. Antoine noted that in Haiti and Jamaica it is considered a treat to eat clay pots. It may actually become an addiction in certain impoverished areas. ➢ Dr. Morgan performed research in rural upstate New York that indicated different sources of lead poisoning. Interventions at this time are difficult, for example, environmental remediation.	statewide implementation.

Topics/Speaker	Discussion	Follow-Up
	➢ Dr. Broadbent inquired when the guidance document on lead poisoning and pregnant women for health care providers would be released. ▪ Ms. Nagin responded that it is scheduled to be released by June 2005. ➢ Mr. Olin inquired about lead exposure risk during pregnancy posed from the release of any existing lead that might be stored in bones. ▪ Dr. Erlich responded that it does appear to be the number one problem in combination with nutritional status. ➢ Dr. Birkhead discussed the state regulations concerning risk assessment and blood lead testing if risks are identified; questioned if testing should be done for all pregnant women in high-risk areas. ▪ Ms. Nagin responded that in general the current risk assessment approach is adequate. It does require a concerted outreach effort to educate populations at greatest risk. Dr. Ehrlich added that some NYC facilities serving high-risk neighborhoods provide blood lead screening to all pregnant women because the hospital has determined that more that 10% of women presenting for prenatal care have an identified lead risk. ➢ Dr. Birkhead inquired about third trimester testing and whether women are being tested late. • Ms. Nagin indicated these numbers likely relate to women receiving late prenatal care.	
General Discussion	➢ Dr. Broadbent provided an update on the Medical Society of the State of New York (MSSNY) resolutions to support the NYS regulations for blood lead testing at ages one and two, along with a formal endorsement of the DOH elimination plan. ➢ Dr. de Long mentioned that the Department will be issuing a letter to educate doctors and other health professionals regarding lead poisoning to be co-signed by the NYS Chapter of the American Academy of Pediatrics, the NYS Academy of Family Physicians, and MSSNY.	
Lead Connections: A Successful	➢ Andrew McLellan from Lead Connections was invited to present to the council. Lead Connections is a partnership among private, public, local and national organizations dedicated to lead safe housing in Erie and Niagara Counties. (Handout provided.) Lead Connections is funded by a grant	

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Primary Prevention Program in Western NY: Mr. McLellan	from the U.S. Housing and Urban Development (HUD) Office of Lead Hazard Control & Healthy Homes and also receives in-kind contributions from partners and participants. Lead Connections mission is to encourage and increase opportunities for property owners to make necessary repairs and maintain lead-safe housing. Lead Connections provides $500-$1,000 in home repair supplies to property owners or designees. Supplies may include paint, scrapers, brushes, and paper masks. The organization also works with local retailers to provide education regarding what supplies should be stocked to perform clean, safe remediation. Lead Connections has developed a user-friendly website (www.leadconnections.org) and attempts to raise public awareness through training, outreach at community events, and local advertising. The organization's next grant proposal will be submitted in June 2005, and will be expanded to include all of Western New York, a total of 18 counties. ➢ Ms. Antoine requested clarification between the number of people receiving assistance and the number of units cleared. ▪ Mr. McLellan responded that assisted families are those who have received supplies; cleared units are those that have passed inspection. The ideal schedule is for the property owner to be trained and receive supplies within a week; have work completed within two weeks, and the property cleared of lead dust within a month. The actual timeline for completion of the work is 6-8 weeks. ➢ Mr. Olin inquired as to the percentage of participants passing renovation inspections the first time, and how Lead Connections technicians determine if lead is present. • Mr. McLellan responded that Lead Connections works with property owners to assure success. If work is not completed in time for inspection, the technician reschedules the inspection for a later date. Lead Connections technicians perform clearance testing, and if not acceptable, additional clean-up education is done. The inspection is rescheduled to allow for thorough and safe clean-up. Even with these procedures, 20% of participants fail their inspection. Follow-up inspections take place six months later, and paint is usually in good shape. At any point in the process if paint is deteriorated, technicians check for lead with an XRF. Lead Connections has determined that paper masks are generally supplied. Lead Connections will provide interior and	

Topics/Speaker	Discussion	Follow-Up
	exterior paint, as well as provide education regarding lead in soil. ➢ Dr. Broadbent inquired what guidance is given for dust wipe clearance. He further questioned partnerships with bankers and insurers and whether there was difficulty securing buy-in from these institutions. Dr. Broadbent was also curious about the role of local coalitions. ▪ Mr. McLellan responded that HUD standards are used for dust wipe clearance. Mr. McLellan responded that to ensure success of Lead Connections' mission, various types of partners must be secured, including property insurance firms and bankers, although this has yet to be accomplished. Mr. McLellan stated that his experience and knowledge of the community aids in understanding who to go to for local participation. ➢ Dr. Broadbent inquired about Mr. McLellan's statement regarding alternatives to incarceration. ▪ Mr. McLellan responded that Erie County has a county-wide housing court. The City of Buffalo will refer property owners that have substandard housing to the housing court. As part of pre-sentencing conference, the judge will send property owners to Lead Connections training to delay sentencing. ➢ Dr. Birkhead asked if Mr. McLellan was aware of the Rochester Coalition and if there are other organizations similar to Lead Connections. ▪ Mr. McLellan responded that he is aware of the Rochester Coalition and is a member. He has spoken with the coalition regarding expanding the Lead Connections initiative. He also spoke with county health department and Section 8 staff. Mr. McLellan feels Lead Connections is somewhat unique due to their additional federal accreditations. There are one or two others similar organizations in upstate NY, but it is his opinion that Lead Connections is unique on the grant side. ➢ Ms. Nagin inquired about the design of the lead safe housing registry and how it is updated/monitored. ▪ Mr. McLellan indicated the registry is still under development and is only available on their	

Topics/Speaker	Discussion	Follow-Up
	website via a password. They do periodic surveillance of units to update the status on the registry, and provide recommendations according to HUD guidelines. Even though there may be challenges with a safe housing registry, HUD encourages development of such a registry. ➢ Mr. Henry questioned how optimum protection of residents is addressed during remediation and commended Lead Connections training of property owners. ▪ Mr. McLellan responded that technicians visit properties during the renovation process to check on work practices. Lead Connections stresses safe work practices to owners during training sessions and continue to provide clear guidance during the renovations. Their technicians stay in touch by phone with property owners; technicians can also go to the property with a HEPA vacuum to perform clean up and monitor the work site.	
Elimination Plan Progress: CEH Update: Mr. Svenson	➢ Mr. Svenson provided an update on the elimination plan primary prevention activities. Mr. Svenson noted the importance of using a targeted approach, to focus on outcomes and build on on-going work in high-risk communities. NYSDOH will confer with local health departments and NYC Department of Health and Mental Hygiene regarding their roles. Mr. Svenson reminded the audience that the Elimination plan (Focus Area Three: Primary Prevention) includes objectives and action steps that target high-risk areas across upstate NY and proposes innovative approaches such as the home visitation initiative by DOH and other state agencies to identify hazards before children are exposed. The Healthy Neighborhood Program is planned to expand to five additional sites to receive $100,000 each: Albany, Rensselaer, Schenectady, Monroe and Orange. A critical concern is the possible cut of $1.2 million to the Federal Prevent Block Grant funding for the other eight projects. The Center for Environmental Health is communicating with CDC in an effort to maintain funding. As a result of the funding situation, the annual meeting of the Healthy Neighborhoods Program has been put on hold. A one-year extension of current contracts is being sought at this time. CEH has identified NYS Building Code Officials as potential local partners. Code enforcement	

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	officers will receive a three-hour training session, along with educational materials. Mr. Dorr stated that OCFS would like to get involved and can expand their field instruction checklist to include the identification of possible lead hazards. Changes can be incorporated into what OCFS is currently using in order to avoid duplication/overlap. The Environmental Protection Agency (EPA) and CDC are partnering to review compliance in Western New York concerning a federal mandated disclosure requirement before renting or selling a home built before 1978. Compliance with existing federal programs in targeted areas, including Section 8, can be beneficial. CEH is in the process of revising DOH regulation Part 67-2 to conform to federal requirements. ➢ Dr. Broadbent requested clarification on counties currently operating a Healthy Neighborhoods Program (HNP). ▪ Mr. Svenson reported that the following counties currently have a HNP: Niagara, Erie, Onondaga, Westchester, Oneida, Clinton, Rockland and New York City. ➢ Dr. Broadbent inquired if the state plan referenced by Mr. Svenson was distributed to the Advisory Council. ▪ Dr. de Long and Mr. Svenson clarified that the plan has not changed. The CDC grant proposal for the upcoming year includes specific objectives and activities to be accomplished to implement the elimination plan. ➢ Dr. Broadbent requested clarification on practices regarding clearance testing. ▪ Mr. Svenson responded that the state and local health departments use clearance tests. A meeting of risk assessors concluded that 85% of housing units were inspected utilizing clearance tests. The number of wipes depends on the activity and number of rooms. The use of clearance tests continues to be based on the judgment of risk assessors.	

Topics/Speaker	Discussion	Follow-Up
	➢ Ms. Nagin requested clarification regarding the joint CDC/EPA letter. ▪ Mr. Svenson responded that the joint CDC/EPA letter asks selected municipalities to provide access to addresses that over time have repeatedly been associated with children with elevated blood lead levels. He further stated that EPA/HUD have coordinated their separate authority and official responses regarding compliance/disclosure. It is a significant commitment on the part of these agencies to come to upstate New York to review compliance. ▪ Mr. Henry clarified that EPA utilizes regional goals and acts as a regional agency. Each region has a target goal of properties visited and disclosure. EPA/CDC decided to work with states to target areas. A parallel effort is being conducted by HUD Healthy Homes for lead hazard control to go to several cities in New York State including Syracuse, Buffalo, and Chautauqua that have effective infrastructure including where HUD has a presence to clean up lead based housing hazards. For properties that are not federally assisted, work regarding disclosure was done with the largest properties through a review of real estate records. This resulted in court actions affecting more than 160,000 units. This is the translation of the elimination plan down to local action. ➢ Dr. Broadbent inquired whether the revision to Part 67 would be accomplished easily. Mr. Svenson indicated the regulation is being updated to allow for standardization of terminology and language. ➢ Dr. Birkhead asked Mr. Svenson to elaborate on the NYSACHO workgroup convened to discuss the primary prevention role of local health departments. ▪ Mr. Svenson reported that CEH would like to examine targeted areas and engage local leadership to focus on resources and share thoughts on what works, what the concerns are, and the barriers. ➢ Dr. Broadbent inquired if municipalities are hesitant to speak out due to liability issues.	NYSDOH will provide NYC DOH&MH with the joint CDC/EPA letter.

Topics/Speaker	Discussion	Follow-Up
	▪ Mr. Svenson responded that court decisions have determined that municipalities are not liable.	
Update from other state agencies	Division of Housing and Community Renewal (DHCR): Ms. Binder reported DHCR continues its on-going work with regard to Section 8 and disclosure, weatherization and worker safety. For capital and single site projects that include rehab the agency attempts to apply HUD rules for abatement consistently, particularly for projects over the $25,000 limit. Office of Children and Family Services (OCFS): Mr. Dorr would like to formulate next steps with DOH on publications for the childcare provider community and families using services to tap into daycare providers. They would like to target units in Healthy Neighborhoods. Mr. Dorr requested the targeted zip codes in order to check for any problems with their day care providers and be proactive in locating alternative sites. Office of Temporary Disability Assistance (OTDA): Ms. Sullivan is new to the Lead Advisory Council, and is now researching pertinent issues related to OTDA such as shelters and the homeless population. She is interested in receiving recommendations. Department of State (DOS): Mr. Mahar reported that NYSDOH-CEH is working with the DOS Education Unit to utilize one and two-hour lead programs for presentation to the 13 Chapter Code Officials Organization. DOS will coordinate with DOH to provide a certified program. Department of Labor (DOL): Mr. Labbe stated that DOL works with employers and employee groups to provide outreach and training, and could distribute lead education materials. DOL can also provide links on their website. Insurance Department: Ms. Lortie-Denno will be in contact with Mr. McLellan regarding working with the insurance industry. Department of Environmental Conservation (DEC):	A list of targeted zip codes will be provided to Council members.

NEW YORK STATE LEAD POISONING PREVENTION ADVISORY COUNCIL
NYS DEPARTMENT OF HEALTH
APRIL 18, 2005
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
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Topics/Speaker	Discussion	Follow-Up
	Mr. Johnson reported on the implementation of Superfund Brown Fields 2003 project. This has reinvigorated the State Superfund program to clean up contaminated properties. It has been very successful; lead is one of the compounds under review in the development of guidelines for reuse of the properties in urban and rural areas.	
Public Comments	Mr. John Fennimore of Loudonville addressed the Council. Mr. Fennimore stated that he is a member of the steering committee for the NYS Coalition to End Lead Poisoning, member of the Board of Directors of the Capital District Association of Rental Property Owners, but spoke on behalf of himself. Mr. Fennimore stated his concerns with the financial implications of remediation and the devotion of resources that will be required by government and property owners.	
Closing comments from Council members	Dr. Broadbent inquired about meeting over the summer. Dr. Broadbent requested a contact list for Advisory Council members, which includes names, telephone numbers and e-mail addresses to be distributed prior to the next meeting. **The meeting was adjourned at 2:20 p.m.**	A list of Advisory Council Members will be distributed. Options for next meeting date will be explored.

NEW YORK STATE LEAD POISONING PREVENTION ADVISORY COUNCIL
NYS DEPARTMENT OF HEALTH
JULY 28, 2005
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow-Up
Attendees	Council Members: ➢ Ronald Tramontano, Director, Center for Environmental Health-Council Co-Chair ➢ Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health for Guthrie Birkhead, M.D., M.P.H., Director, Center for Community Health-Council Co-Chair ➢ Rolaine Antoine (Parent) ➢ Mary Binder, Environmental Analyst, Division of Housing and Community Renewal ➢ David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) ➢ William Dorr, Assistant Director, Bureau of Early Childhood Services, NYS Office of Children and Family Services ➢ Abby Greenberg, M.D., Director of Disease Control, Nassau County Department of Health (Local Government & American Academy of Pediatrics-District II) ➢ Philip Landrigan, M.D., MSc, DIH, Director, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital) ➢ Ellen Migliore, R.N., MS, Public Health Nurse Herkimer County Health Department (Child Health Advocate) ➢ Tom Mahar, Code Compliance Specialist II, NYS Department of State ➢ Clifford Olin, President, EcoSpect, Inc. (Industry) ➢ Robert Perez, Principal Industrial Hygienist, NYS Department of Labor ➢ Alicia Sullivan, Assistant Counsel, NYS Office of Temporary and Disability Assistance Additional Attendees: ➢ Bruce Phillips, Counsel, NYS Department of Health ➢ Barbara McTague, Director, Division of Family Health ➢ Michael Cambridge, Director, Bureau of Community Environmental Health and Food Protection ➢ Eileen Franko, Dr.P.H., M.P.H., Director, Bureau of Occupational Health ➢ Richard Svenson, Director, Division of Environmental Health Protection ➢ Ellen J. Anderson, MS, Executive Deputy Director, Center for Community Health	

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Topics/Speaker	Discussion	Follow-Up
Absent	➢ Guthrie Birkhead, M.D., M.P.H., Director, Center for Community Health-Council Co-Chair ➢ Thomas Ferrante, Manager of Training and Technical Services, Total Safety Consulting (Labor Union) ➢ Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY-Buffalo (Professional Medical Nursing Organization) ➢ Carl Johnson, Deputy Commissioner, NYS Dept. of Environmental Conservation ➢ Lindsay Lake Morgan, R.N., Ph.D., A.N.P., Assistant Professor, Decker School of Nursing, SUNY Binghamton (Educator) ➢ Bethney Lortie-Denno, Special Assistant to the Superintendent, NYS Insurance Department ➢ Deborah Nagin, M.P.H., Director, New York City Department of Health and Mental Hygiene ➢ William S. Schur, Vice President of Schur Management Company, Ltd., (Real Estate)	
Presenters	➢ Barbara Leo, M.S., R.N., Childhood Lead Poisoning Prevention Program ➢ Thomas Carroll, Acting Section Chief, Bureau of Community Environmental Health and Food Protection ➢ Vincent Coluccio, Dr.P.H., Senior Consultant, TRC Environmental ➢ Neal Freuden, President, EnviroScience Consultants, Inc. ➢ Gene Burch, Project Manager, Leadsafe Environmental ➢ Mark Aschenbach, Senior Environmental Analyst, Connecticut Department of Public Health	
Welcome and Introductions: Mr. Tramontano & Dr. de Long	The meeting was convened at 10:00 am. ➢ Mr. Tramontano opened the meeting and welcomed the members. ➢ Dr. de Long initiated a roll call of the members and reviewed the meeting agenda.	
Review of minutes	Draft minutes from the April 18, 2005 Advisory Council meeting were reviewed and approved by the Council, with one change. ➢ Dr. Greenberg requested amendment of her affiliation to include the American Academy of Pediatrics.	Minutes were amended to reflect Dr. Greenburg's affiliation

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Topics/Speaker	Discussion	Follow-Up
Center for Community Health Update	Dr. de Long reported that implementation of the Elimination Plan is a major priority for the next several years. A Department of Health workgroup that includes staff from the Bureau of Child and Adolescent Health, the Bureau of Community Environmental Health and Food Protection and the Bureau of Occupational Health meets bi-weekly to assure communication and coordination within the Health Department and with Elimination Plan partners. Barbara Leo, Bureau of Child and Adolescent Health Public Health Program Nurse discussed progress on implementation of elimination plan focus area one, screening and surveillance. *(See handouts distributed at the meeting).* ➢ Screening identifies children exposed to lead. Children with low to moderate results are typically not readily identified without blood lead screening. ➢ A letter to physicians has been developed. It is co-signed by the Commissioner of Health, the NYS Chapter of the American Academy of Pediatrics, NYS Academy of Family Physicians and the Medical Society of the State of New York. A copy of the letter was provided to Council members. The letter will be sent to 25,000 providers in New York State, including pediatricians, family practitioners, nurse practitioners in pediatrics and family practice, physician assistants, as well as commissioners of county health departments and public health directors. ➢ Next step will be to work with the academies, societies and other partners to develop a tool kit for providers. ➢ Council members offered suggestions and provided comments on this initiative. • Risk assessment questionnaire should have two columns for "yes" and "no" responses. • In the letter, bold on first bullet "all children" and the word, "and". • Engage insurers as partners in screening promotion activities • Explore strategies to support blood drawing in provider offices to improve screening Dr. de Long presented an update on implementation of elimination plan focus area two, targeting high-risk populations to reduce disparities. *(See handouts distributed at meeting).*	• Suggested changes were incorporated into the letter. • Managed care plans were added to the distribution list, in coordination with Office of Managed Care. • Discussion of office-based testing methods will be planned for a future Council meeting

Topics/Speaker	Discussion	Follow-Up
	➢ Five local coalitions in high-risk upstate communities will receive one time funding of $28,000 to support local implementation of the elimination plan's goals and objectives for the period 7/1/05-6/30/06. ➢ The Department will work with coalitions to help engage additional local partners and provide technical assistance, depending on the coalition's stage of development. Existing coalitions are in different stages of development and can use these funds as 'seed money' for one-time projects including community needs assessment, local implementation of elimination plan activities, evaluation of activities, or development of toolkits to inform replication of best practices. ➢ The intent is to learn from these projects and share information with other coalitions. ➢ Ms. Migliore inquired whether future coalition funding would be based exclusively on areas where elevated blood levels are already identified or on areas with older housing. • Dr. de Long responded that the Department will continue to evaluate criteria for targeting communities based on a variety of factors, including community demographics and housing information. The coalitions for these initial one-time projects were selected based on the methodology in the last data report.	
Center for Environmental Health Updates	Thomas Carroll, Acting Section Chief, Bureau of Community Environmental Health and Food Protection presented information related to elimination plan focus area two, targeting high-risk populations, and focus area three, primary prevention. *(See handouts distributed at meeting).* ➢ As noted in the Elimination Plan and the most recent lead data report (2000-2001 data), there are 36 zip codes, comprising only 2% of the state zip codes outside NYC, which account for 41% of all of the children identified with EBL outside of NYC. When the absolute number of environmental referrals for children for elevated blood levels over 20ug/dLs were considered (2003 data), 78% were located in 10 upstate counties. When NYC is included in this analysis, these counties account for 85% of referrals statewide. ➢ The Healthy Neighborhoods Program was expanded to include five additional counties with a comprehensive approach to environmental health of housing (lead prevention, indoor air, asthma triggers, fire safety, etc.) The 15 highest risk counties identified have been targeted for enhanced environmental activity.	

Topics/Speaker	Discussion	Follow-Up
	➢ The Department is looking at Public Health Law and the NYSDOH Environmental Health Manual to examine existing authority of local health department commissioners/public health directors, with the goal of improving environmental intervention. Currently, a commissioner of health can declare an 'area of high-risk' where most of the dwellings were constructed before 1960, more than 20% of the dwellings are deteriorating, and if lead hazards or children with elevated blood lead levels have been previously identified in the same building or area. ➢ The new version of Leadtrac will include an environmental module that will further assist with targeting elimination efforts. Forty-eight counties are currently utilizing the medical management component of this new system, and the environmental component will be implemented this fall. ➢ The Department continues to meet with other state agencies to coordinate efforts and identify opportunities for implementation of the elimination plan. CEH also is working with the federal Housing and Urban Development (HUD)-funded contractors in NYS on their Elimination Plan efforts. Collaboration with the federal agencies, including the EPA, can help support efforts to enforce federal real estate disclosure violations, lead hazards in federally subsidized housing and other issues. ➢ Council members were provided with a copy of draft updated version of NYCRR Title 10 Subpart 67-2. Comments were requested by September 1, 2005. These changes will adopt federal standards, set requirements for certification of risk assessors and require certified firms to conduct abatement activities. Eileen Franko, Director, Bureau of Occupational Health presented an update on implementation of the elimination plan focus area three, primary prevention, for the Bureau of Occupational Health. *(See handouts distributed at the meeting).* ➢ A training program (3 continuing education credits from the Department of State) has been developed for local code enforcement officials. The program has already reached 120 building officials in a recent Albany training. The program has been well received. ➢ A clearinghouse has been developed that includes an inventory of technical information and state and federal regulations. CEH also would like to identify programs such as "Welfare-to-Work" &	

Topics/Speaker	Discussion	Follow-Up
	'Women-to-Work" where a lead educational component can be included. CEH is exploring efforts to put this information on the Occupational Health Program webpage. ➢ CEH is working with EPA regarding the range of EPA's training courses and certification for training agencies to conduct lead-safe work practice programs. EPA issues certificates and audits the training courses. CEH will be collaborating with them to do more of the course audits. EPA will be preparing rules regarding pre-renovation rule related to any property built before 1978. Lead hazard exposure during home renovation is a serious issue. An earlier study (1993-1994) indicated that 7% of NYS children with elevated blood lead levels were exposed during remodeling and renovation. ➢ Educational efforts to reach contractors and do-it-yourselfers were summarized. Dr. Franko has met with Glidden paint to develop a program for small businesses, to prevent contractors and homeowners from exacerbating lead hazards. The Department is developing an updated educational campaign: 'Work Clean, Work Wet, Work Smart.' ➢ Other action steps associated with the elimination plan include a one-hour contractor training, similar to the program for building inspectors. Outreach and education staff are assisting with the identification of places where contractors can be reached and strategies to raise awareness. ➢ The Heavy Metals Registry requires all laboratories to report blood lead levels of any person tested in NYS regardless of level for people 14 years and older. The Bureau of Occupational Health in 2004 monitored and tracked more than 3,000 cases of adults with results greater than 10 ug/dL. These are mostly males and are typically screened because of their occupation. Those with elevated blood lead levels above 25ug/dL are interviewed. • This adult lead exposure information is used to help DOH monitor companies regarding lead safe work practices. For example, the Department sends letters each April to all contractors with NYS Department of Transportation and Thruway Authority before bridge work is performed to minimize exposure, cut down on lead brought into workers' homes and further impact on neighborhoods. • The Heavy Metals Registry also works with pregnant women who have been exposed and with new industries such as electronic recyclers to assess risk and explore numerous primary prevention opportunities.	

Topics/Speaker	Discussion	Follow-Up
	➢ One council member asked about the various types of do-it yourself home lead tests and the need for guidance when selecting a product, and suggested that DOH could be a clearinghouse to help individuals select the best home test kit for the job. • Dr. Franko stated that EPA has written reports on many of these consumer products. There is only a small number of false negative results Dr. Franko suggested that if a homeowner gets a positive test, they should proceed as if there is a lead hazard. ➢ One Council member commented that the housing code inspector training is voluntary and inquired if there is a certified safe work practice training program for lead, and how the lists are maintained. • Dr. Franko responded that safe work practice trainings are authorized at the Federal level. There are lists of trainings and training program sponsors on the agency web pages. The Department has no direct authority over contractors and so a collaborative approach is used. • Mr. Tramontano stated that the Department is not presently an EPA agent. We are attempting to secure that designation through the EPA power to 'delegation authority'. A case is being made that the Department would be a better agent.	
Recognition and Assessment of Non-Paint Lead Hazard	Dr. Vincent Coluccio, Dr.P.H., Senior Consultant, TRC Environmental, provided an overview of non-lead paint hazards *(See handouts distributed at the meeting).* ➢ Dr. Coluccio highlighted the concern posed by immigrant populations arriving from developing countries with fewer environmental protections, controls, and enforcement on hazardous substances and higher EBLLs relative to the US. In addition, he noted that the US lacks adequate lead hazard recognition, assessment and control of non-paint lead sources. ➢ Dr. Coluccio emphasized two major sources of non-paint exposure: immigrants' pre-existing body lead burden and foreign products brought into US. ➢ Dr. Coluccio stated that immigrants, pregnant women and children need further attention with regard to lead poisoning. Nations such as China, Bangladesh, Central America, Cuba, India and Pakistan have major problems with lead contamination due to industries such as ship breaking. Developing nations lag far behind in recognizing sources of lead, PCBs and other hazardous materials. Other countries have cottage industries such as battery breakdown sites, which can	

Topics/Speaker	Discussion	Follow-Up
	expose children. Lack of child labor laws also contributes to widespread exposure. He estimated that 75% of immigrants are from countries with lead problems ➢ Other non-paint sources of lead include Mexican chilies that are not cleaned before shipment, *chapulines* (grasshoppers), which are considered a delicacy and promoted as a protein source, and *Sindoor*, a lead-containing cosmetic. He noted it may be challenging to address such concerns in the context of cultural beliefs. ➢ Council members raised several discussion items in response to the presentation: • Dr. Landrigan indicated that Elmhurst Hospital, a NYC facility that serves a diverse immigrant population (50 countries represented), found a prevalence of pregnant women with elevated blood lead exposure higher than expected, especially among women from Bangladesh, Mexico, and Pakistan. • Another Council member noted the importance of considering young adopted children as a subset of high-risk immigrant and refugee population. They reported that many adopted children from China, Eastern Europe, and Russia have evidence of lead poisoning. Pediatricians who specialize in adoptees routinely test and find elevations. • Dr. Coluccio noted there is no specific regulation to test entering/arriving immigrants. There is an effort by CDC to get such a regulation promulgated.	
Local Enforcement Initiative in Connecticut	Invited guest presenters Mark Aschenbach from the Connecticut Department of Public Health, Gene Burch from Leadsafe Environmental and Neal Freuden from EnviroScience Consultants discussed the State of Connecticut's local enforcement initiatives. *(See handouts distributed at the meeting).* ➢ The presenters described the impetus and process for joining efforts in Connecticut to form the Lead Removal Activities Working Group (LRWAG), a local enforcement initiative. ➢ Gene Burch noted that LRAWG was formed to hear from people in the field including private sector companies, federal and state OHSA, Department of Environmental Protection, Department of Public Works, economic and community development, environmental health associations, and Connecticut Department of Transportation. • The Lead Removal Activities Work Group (LRAWG) was formed in 1999 in response to a variety of events that highlighted challenges in responding to local complaints and enforcing	

Topics/Speaker	Discussion	Follow-Up
	local regulations. • A memorandum of understanding was developed between the Connecticut Health Department and Federal OSHA to formalize a complaint process. A model ordinance was put together to inform towns of the problem-solving procedures performed by homeowners and contractors. This collaboration process was used to model efforts to eliminate some problems on a voluntary basis. ➢ Mark Aschenbach discussed the 'Keep It Clean Campaign' (KIC) initiated in 1999. Connecticut was part of a 6-state New England-wide education and outreach initiative to help eliminate lead poisoning resulting from painting, renovation, and other home improvement projects. This voluntary program was implemented in partnership with local health departments and hardware and paint stores to distribute instructional brochures, promotional give-aways, and training videos for employees through in-store distribution and community events. Evaluation surveys demonstrated increased knowledge among target audiences. were designed to evaluate knowledge gained by participants (store manager, store employees and customers). ➢ Gene Burch discussed environmental issues other than lead, including asbestos, silica, PCBs, mercury, and hazardous household waste, that were addressed as an extension of the lead-related LRAWG activities. LRAWG efforts focused on getting the word out to contractors, building officials, architects, consultants and homeowners to raise awareness of hazards due to renovation and demolition. Comprehensive, practical reference guides were developed and distributed to help clarify and coordinate response to these types of issues. ➢ At the conclusion of the presentation, speakers noted relevant issue of recent EPA decision to pursue rulemaking for lead safe work practice, which will replace the voluntary program EPA had initially called for. EPA is expected to issue draft rules in Fall 2005. The speakers noted that lead safe work practices are an important element of Connecticut's state plan for the elimination of lead poisoning by 2010. ➢ Dr. Broadbent inquired if the intention of LRAWG's model ordinance is to "fill in the holes." He further inquired if LRAWG had an awareness of New York State procedure regarding local ordinances.	

Topics/Speaker	Discussion	Follow-Up
	• Mr. Freuden responded that the model ordinance is to provide a theme of education and awareness. He responded that Connecticut has a different approach and works to develop partnerships. ➢ Mr. Tramontano requested further detail about the process of 'identifying and declaring an area of nuisance (or high risk) in Connecticut. • Mr. Aschenbach explained that the Connecticut local health directors do have the authority, but many are reluctant to utilize it, they think there is not enough legal footing so it is rarely done. Mr. Tramontano noted that the nuisance authority is used frequently in New York.	
Updates from Council members	<u>Office of Children and Family Services</u> (OCFS): William Dorr, Assistant Director, Bureau of Early Childhood Services, NYS Office of Children and Family Services (OCFS), provided an agency update. Through his role on the Lead Advisory Council, Mr. Dorr has taken steps to identify OCFS programs that are engaged in home visiting and other program areas that could benefit from lead prevention education and staff training. OCFS has a many professional staff who have the opportunity to interact with local agencies, to reach clients in their homes, and to provide technical assistance around childcare. The local Departments of Social Services also have home visitors going into foster homes. Mr. Dorr noted in particular the potential for identifying peeling, chipping paint and for addressing non-paint lead sources highlighted in Dr. Coluccio's presentation. <u>Office of Temporary Disability Assistance</u> (OTDA): Alicia Sullivan, Assistant Counsel, NYS Office of Temporary and Disability Assistance, provided an agency update. Ms. Sullivan reported that initial contact was made with agency staff that deal with homelessness, shelters and temporary assistance to put together an overview of local districts activities regarding lead exposure issues. ➢ Dr. Broadbent commented that OTDA can play an important role due to its work with a high-risk population.	

Topics/Speaker	Discussion	Follow-Up
	➢ Ms. Sullivan responded that OTDA is very concerned about this population and administers a number of resources to support high-need families. She also clarified the role of local social service districts. OTDA uses written administrative directives to the local Social Services, sends out informational letters and conducts staff trainings that could be utilized to promote lead awareness. ➢ The possibility of offering lead screening in homeless shelters and other settings was discussed briefly by the Council. Dr. de Long noted that ideally screening should be delivered in the context of comprehensive primary care. The Department encourages linking children with a primary care provider, ideally a medical home, and having blood lead screening done in that context. Local health departments provide screening as a safety net for families who have no other access to care. <u>Division of Housing and Community Renewal</u> (DHCR): Mary Binder, Environmental Analyst, Division of Housing and Community Renewal, provided an agency update. Ms. Binder reported on a new program called 'Access to Home.' These state-funded services are provided by local not-for-profit agencies that will visit homes of special needs clients to improve access for disability. Examples of improvements include a ramp to the front door or putting in a wider door to access a bathroom, depending on what is needed. As it relates to lead hazards in houses, this initiative could provide another 'set of trained eyes' within this subset of homes that may have children at risk. There may also be opportunities for lead safe work practices training for contractors going into homes. While there, the contract agency will know what to do to address potential lead hazard concerns and how to advise the client. They will also be able to give the homeowner access to other related grant possibilities, if applicable. <u>Department of State</u> (DOS): The update on code enforcement training provided earlier by Dr. Franko was referenced. <u>Department of Labor</u> (DOL): Robert Perez, Principal Industrial Hygienist, NYS Department of Labor, provided an agency update. Mr. Perez reported that DOL is a statewide agency that has contacts with employers and employees from all parts of the economy. This can be utilized as a resource to	

Topics/Speaker	Discussion	Follow-Up
	disseminate information such as lead-safe work practice training. Parent Representative: Rolaine Antoine, parent representative, provided an update. As a parent and also as a vice president of a civic association, Ms. Antoine has an opportunity to speak about issues within her community. She speaks about lead poisoning prevention and responds to requests from individuals and organizations to provide brochures to get the word out about lead poisoning. Hospital Representative: Philip Landrigan, M.D., MSc, DIH, Director, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center, provided an update on the National Children's Study. For the past 4-5 years the National Institute for Child Health and Human Development has been planning a prospective epidemiological study called the National Children's Study. It will follow 100,000 American children across the country from conception to age 21. The goal is to assess the influence of the environment on children's health, development and risk of disease. The study will examine chemicals including lead, mercury, PCBs, pesticides, and air pollution, and their relationship with a variety of social and economic factors. Eight communities across the country have been selected as 'vanguard sites', including the Borough of Queens. A New York City coalition with Mount Sinai Hospital, Columbia Medical Center, the New York City Health Department, and an environmental specialist from Rutgers developed an application that heavily involves community groups in Queens. The eight vanguard sites in the aggregate will enroll 10,000 children over the next five years. Community Group: David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS, provided an update. Dr. Broadbent recently worked with the State Medical Society to pass a strong resolution against lead poisoning. He has also contributed an article to the AAP newsletter to promote lead testing on the part of pediatricians. The Rochester Coalition supported changes to the local housing code in Rochester. The Coalition also worked with insurers, such as Preferred Care in the Rochester area, to fax letters to 1,500 physicians with information promoting blood lead testing.	

NEW YORK STATE LEAD POISONING PREVENTION ADVISORY COUNCIL
NYS DEPARTMENT OF HEALTH
JULY 28, 2005
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow-Up
Public Comments	Valerie Johnson addressed the Council. Ms. Johnson is a member of the CDC Community Advisory Committee on Childhood Lead Poisoning and a concerned citizen from Rochester. This is the first meeting she has attended of the NYS Lead Poisoning Prevention Advisory Council. Ms. Johnson relayed the following observations and questions. ➢ A medical professional perspective and a parent perspective to the statewide plan are both valuable and important. She hopes there is a broad invitation to have parent perspective, from both upstate and downstate, be included in discussions and decisions. ➢ Training community members in order to create a skilled workforce in those neighborhoods will contribute to eliminating lead poisoning. ➢ The State should look at opportunities to leverage ideas, maximizing resources to engage community as drivers of the programs to end lead poisoning. ➢ Ms. Johnson stated she hopes the outcomes empower active communities to continue to identify and recognize other environmental hazards such as mold and asthma triggers within those communities. ➢ Ms. Johnson inquired about how lead testing can be incorporated in Women's Infants and Children's (WIC) program. Mr. Tramontano responded that Ms. Johnson provided great comments. He noted that NYSDOH was a national leader in developing models for addressing homes comprehensively through the Healthy Neighborhoods Program, which served as a model for later federal initiatives. Dr. de Long noted agreement with the importance of building local capacity, and referenced the elimination plan components dedicated to strengthening and supporting local partnerships and coalitions. She also noted that lead program staff have initiated discussions with WIC program staff to explore opportunities for collaboration, which have been promising. Because WIC has many federal requirements, a strict requirement for lead testing as part of WIC eligibility may not be feasible.	Department staff will continue to explore collaboration between lead and WIC program.
Closing Comments	➢ Dr. Broadbent inquired about exchanging contact information between Council members to facilitate communication. • Dr. de Long agreed to send an email to members to ascertain their individual preferences for	Lead program to follow up with Council members

Topics/Speaker	Discussion	Follow-Up
	sharing information and will provide information at the next meeting. ➢ Dr. de Long noted the next Council meeting will take place on October 20, 2005. Agendas and information will be forthcoming. **The meeting was adjourned at 1:45 p.m.**	about acceptability of sharing information

NEW YORK STATE LEAD POISONING PREVENTION ADVISORY COUNCIL
NYS DEPARTMENT OF HEALTH
OCTOBER 20, 2005
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow-Up
Attendees	Council Members: ➢ Ronald Tramontano, Director, Center for Environmental Health-Council Co-Chair ➢ Guthrie Birkhead, M.D., M.P.H., Director, Center for Community Health-Council Co-Chair ➢ Rolaine Antoine (Parent) ➢ Mary Binder, Environmental Analyst, Division of Housing and Community Renewal ➢ David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group) ➢ William S. Schur, Vice President of Schur Management Company, Ltd., (Real Estate) ➢ Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY-Buffalo (Professional Medical Nursing Organization) ➢ Lindsay Lake Morgan, R.N., Ph.D., A.N.P., Assistant Professor, Decker School of Nursing, SUNY Binghamton (Educator) ➢ Bethney Lortie-Denno, Special Assistant to the Superintendent, NYS Insurance Department ➢ William Dorr, Assistant Director, Bureau of Early Childhood Services, NYS Office of Children and Family Services ➢ Abby Greenberg, M.D., Director of Disease Control, Nassau County Department of Health (Local Government & American Academy of Pediatrics-District II) ➢ Ellen Migliore, R.N., M.S., Public Health Nurse Herkimer County Health Department (Child Health Advocate) ➢ Tom Mahar, Code Compliance Specialist II, NYS Department of State ➢ Clifford Olin, President, EcoSpect, Inc. (Industry) ➢ Robert Perez, Principal Industrial Hygienist, NYS Department of Labor ➢ Kerry Delaney for Alicia Sullivan, Assistant Counsel, NYS Office of Temporary and Disability Assistance Additional Attendees: ➢ Bruce Phillips, Counsel, NYS Department of Health ➢ Barbara McTague, Director, Division of Family Health	

NEW YORK STATE LEAD POISONING PREVENTION ADVISORY COUNCIL
NYS DEPARTMENT OF HEALTH
OCTOBER 20, 2005
ALBANY, NEW YORK
Empire State Plaza - Meeting Room 7
F I N A L

Topics/Speaker	Discussion	Follow-Up
	➢ Michael Cambridge, Director, Bureau of Community Environmental Health and Food Protection ➢ Eileen Franko, Dr.P.H., M.P.H., Director, Bureau of Occupational Health ➢ Richard Svenson, Director, Division of Environmental Health Protection ➢ Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health	
Absent	➢ Carl Johnson, Deputy Commissioner, NYS Dept. of Environmental Conservation ➢ Philip Landrigan, M.D., M.Sc., D.I.H., Director, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital) ➢ Thomas Ferrante, Manager of Training and Technical Services, Total Safety Consulting (Labor Union) ➢ Deborah Nagin, Director, New York City Department of Health & Mental Hygiene- Lead Poisoning Prevention Program	
Presenters	➢ Hulda Martinez, Westchester County Department of Health, Coordinator- Healthy Neighborhoods Program	
Welcome and Introductions: Dr. Birkhead & Mr. Tramontano	The meeting was convened at 10:15 am. ➢ Dr. Birkhead opened the meeting and welcomed the members. ➢ Dr. Birkhead initiated a roll call of the members and reviewed the meeting agenda.	
Review of minutes	Draft minutes from the July 28, 2005 Advisory Council meeting were reviewed and accepted as written. Dr. Broadbent requested the minutes be sent electronically, and two to three weeks ahead of meetings.	
Center for Community Health (CCH) Update	Dr. de Long reported that NYSDOH sent a letter in September 2005 to 24,000 health care providers on universal screening and anticipatory guidance. Follow-up will include the development of a comprehensive tool kit for office practices through the Regional Lead Resource Centers, American Academy of Pediatrics (AAP), and NYS Academy of Family Practitioners (NYSAFP). In addition, DOH will be working on increasing lead poisoning prevention messages in WIC.	The Lead program will follow-up with the Immunization Program regarding lead updates at their

Topics/Speaker	Discussion	Follow-Up
	DOH has made funding available to community coalitions for implementing the Elimination Plan. Draft workplans are being reviewed, and technical assistance is being provided by CLPPP staff. Work continues with other state agencies to identify opportunities for collaboration (Office of Temporary Disability Assistance, Office of Children and Family Services). A Council member noted that the NYS American Academy of Pediatrics Immunization meeting would provide an opportunity to discuss lead poisoning prevention with physicians. Dr. de Long presented on office-based capillary testing as a method to enhance compliance with universal screening requirements, an integral part of the implementation of the NYS Plan for Elimination of Lead Poisoning by 2010. Barriers were identified during the screening roundtable that could be addressed by in-office testing. *(See handouts distributed at the meeting).* Major issues addressed: • advantages and disadvantages; • cost implications; • scientific evidence; and • New York State statewide capillary screening practices. Council members comments included: • regulatory requirements for BLL confirmation; • potential for lead contamination of capillary samples at the time of sample collection; • lack of insurance payment for in-office collection; • cost of collection/supplies/technicians time; • training needed for effective specimen collection; • evidence of adverse effects of low blood lead levels increasing physician interest in universal screening; • concerns about not doing environmental inspections for the homes of children with EBLL less	annual meetings.

Topics/Speaker	Discussion	Follow-Up
	than 20 ug/dL; and • elimination of barriers, including transportation to lab for parent/child, time required to go to second site for blood drawing; and • identification of additional locations for testing (day care, etc).	
Center for Environmental Health (CEH) Update	Tom Carroll presented CEH's update on strategic plan initiatives. Meetings were held with several state agencies about educational opportunities for consumers and agency-specific topics: • OCFS regarding daycare inspections; • OTDA regarding lead paint inspections in homeless shelters; • DHCR to assist with community targeting for housing rehabilitation programs and lead paint hazard outreach; • EPA regarding real estate disclosure enforcement; and • HUD regarding Safe and Healthy Homes initiative. *(See handouts distributed at the meeting).* The Lead Elimination Plan was discussed at the Conference of Environmental Health Directors' meeting in September 2005. Council comments on Subpart 67-2 were received. CEH will prepare another draft for review along with supporting documents needed for a formal rulemaking package. Council members comments included: • Whether dust sampling performed by LHD would be performed in accordance with HUD guidelines; the response was yes, that LHD would utilize HUD guidance documents. • CEH had requested comments related to regulatory revisions by 9/1/05. Council members requested, and received, additional time to comment. • Geographic targeting of zip codes vs. targeting by other demographic factors. Dr. Franko presented the update from Bureau of Occupational Health. (Refer to Bureau of Occupational Health handout.) Topics included:	

Topics/Speaker	Discussion	Follow-Up
	• Code Enforcement Training held in September on paint maintenance standards. This course has been advertised by the Department of State. • Planned presentation at an upcoming EPA meeting on pre-renovation activities. • Addressing Healthy People 2010 Goal 20-7 to reduce occupational exposure to 0. Continued employer surveillance and assistance revealed a high percentage of the total EBLL occupational cases are with the Metropolitan Transit Authority. Work continues with several state agencies: • DOT regarding contractors and lead exposure, and the heavy metals registry. • DOL regarding training during apprenticeship periods (carpenter, painter, construction) for those who may disturb lead based paint. Letter sent out to BOCES and training programs notifying them of this training. Council members comments included: • OSHA requirements for occupational exposure compliance and non-compliance; and • contact union and trade worker agencies and get training on lead in contracts.	
New York City Update	Deborah Nagin absent, no update given.	
Westchester County Healthy Neighborhoods Program	Tom Carroll introduced Hulda Martinez, Coordinator, Healthy Neighborhoods Program, Westchester County Department of Health. *(See handouts distributed at the meeting).* The HNP is a targeted door-to-door program that uses outreach, assessment and education to address a variety of environmental hazards, including lead. The program utilizes a visual environmental assessment prepared by NYSDOH focusing on potential lead hazards. Various environmental aids and educational materials are distributed. Periodic revisits are made to monitor interventions within the homes. Issues include overcrowded housing and little disposable income to purchase materials to maintain safe housing. Council comments included: • selection of housing units for visiting;	

Topics/Speaker	Discussion	Follow-Up
	• confidentiality; • outcome measures; and • implications of population mobility for follow-up.	
Updates from Council members	Division of Housing and Community Renewal (DHCR): Mary Binder, DHCR - awards were made in the Access to Home initiative, which provides funding to nonprofit agencies related to improving handicap accessibility in homes. This initiative develops another group of individuals visiting homes that can provide assessment of the status of paint in homes. Department of Insurance (DOI): Bethany Lortie-Denno, DOI - no new activities to report. Explained that some companies offer insurance for owners of buildings if employees have certificates of training regarding lead or lead-safe work practices. Coverage for lead-related issues can be an incentive for training. Office of Temporary Disability Assistance (OTDA): Kerry Delaney, OTDA - working with DOH on providing information on lead hazards and lead screening for the homeless population. Department of State (DOS): Tom Mahar, DOS - educational conferences for code inspectors are planned statewide as reported above by Dr. Franko. Department of Labor (DOL): Robert Perez, DOL - working with CEH as reported above by Dr. Franko. Dr. Greenberg- AAP Policy Statement on Lead has been released, requested copies be sent to Council members.	Ms. Lortie-Denno will provide additional information on certification. AAP Policy Statement to be sent to Council members.

Topics/Speaker	Discussion	Follow-Up
	Dr. Broadbent - AAP recommends two screenings in childhood. Suggested use of NYSDOH website to provide additional information on lead poisoning. Requests that the Council consider analyzing potential legislative initiatives at the next meeting.	
Public Comments	Lynn Lauzon-Russom - Capital District Coalition has been meeting with CDPHP, a member HMO. The plan performed a record review of non-compliance with lead screening, and in response began covering blood draws for lead testing in M.D. offices. Blue Cross and MVP may begin this practice.	
Closing Comments	Dates will be set for the 2006 Council meetings. **The meeting was adjourned at 1:45 p.m.**	

APPENDIX B

Eliminating Childhood Lead Poisoning
in New York State by 2010

Eliminating Childhood Lead Poisoning in New York State by 2010

New York State Department of Health
June 2004

Contents

I. Statement of Purpose: The Elimination of Childhood Lead Poisoning in New York State by 2010

Lead is the leading recognized environmental poison for children in New York State. Exposure to lead is associated with a range of serious health effects on children, including detrimental effects on cognitive and behavioral development with serious personal and social consequences that may persist throughout their lifetime.

Lead poisoning is a completely preventable condition. Reflecting decades of work at a federal, state, and local level, average blood lead levels among children have declined steadily in New York State and nationwide. Yet in some communities, especially those suffering from poverty and other social disadvantage, lead poisoning remains a significant problem. Moreover, growing knowledge about the toxicity of lead demonstrates that even levels of lead once thought to be safe can have serious detrimental effects on young children.

The Centers for Disease Control and Prevention (CDC), along with the President's Task Force on Environmental Health Risks and Safety Risks for Children, have called for the elimination of childhood lead poisoning (defined as blood lead levels at or above 10 mcg/dL among children aged six years and younger) by the year 2010. This goal is consistent with the long-standing work done in New York State under the leadership of the Department of Health, and serves as a call to action to strengthen current lead poisoning prevention activities.

In response to the CDC's charge, the New York State Department of Health (NYSDOH) has taken a leadership role in developing this strategic plan for the elimination of childhood lead poisoning in New York State by 2010. This plan, covering upstate New York, is a companion to the strategic plan under development by New York City Department of Health and Mental Hygiene, covering New York City. Because the burden of childhood lead poisoning is substantial in New York State, the plans developed by New York State and New York City represent key components of efforts to reach the national goal, as well as goals for the state of New York.

This plan is intended to serve as a roadmap to guide the work of the Department and partner organizations statewide in efforts to eliminate childhood lead poisoning over the next five years. At the same time, it is recognized to be a living document that may be refined in response to changing needs and opportunities in New York State.

II. Needs Assessment

Historical Background

The toxicity of lead has been recognized for thousands of years, and more precisely described in medical literature since the 1920s.[1] As knowledge about the effects of lead at various concentrations has grown, the defined level of intervention for children has been lowered steadily over the past four decades, and recent findings of harmful effects at blood lead levels even below the current "level of concern" of 10 mcg/dL have prompted discussion for potentially lowering acceptable blood levels even further. It is worth noting that standards for both blood lead levels and environmental lead sources (e.g. paint, residential dust, and drinking water) are not strictly health-based standards, but reflect ongoing consideration of toxicology, feasibility, and availability of effective intervention.[2,3]

Table 1. Changing definitions of acceptable blood lead levels in the United States

Year	Level of Concern
1960	60 mcg/dL
1970	40 mcg/dL
1975	35 mcg/dL
1985	25 mcg/dL
1991	10 mcg/dL
2004	*Discussions underway at CDC to determine if level should be further decreased to 5 mcg/dL, in light of growing body of research demonstrating no "safe" threshold of exposure*

In the 1970s, in response to heightened recognition of the widespread health effects of environmental lead exposures from gasoline and residential paint, federal environmental standards for lead levels in air, food, and water, and restrictions on use of lead in industry, were increased substantially. In 1977 the maximum allowable level of lead in gasoline was lowered from 0.78 g/L to 0.026 g/L; in 1976 the allowable level of lead in residential paint was lowered to 0.06%.[3] The combination of these and other lead-related regulations had dramatic impacts on lead levels in children: the median blood lead level (BLL) decreased from 14.6 mcg/dL in 1976 to 2.8 mcg/dL in 1990.[1] While this is a marked success at the population level, lead poisoning remains epidemic in certain sub-populations in the U.S., in particular among young children living in the most socially and economically disadvantaged urban environments.

Scope of the Problem

National Data:

Current national data on the prevalence of elevated blood lead levels in children are drawn from the National Health and Nutrition Examination Survey (NHANES), conducted between 1988-1994 and 1999-2000, and from state child blood lead surveillance data for test results collected during 1997-2000 and submitted to CDC.

Based on NHANES data for 1999-2000 an estimated 434,000, or 2.2%, of children aged one to five years had blood lead levels (BLL) at or above 10 mcg/dL.[4] This represents a decline from previous 1988-1994 data, which found 890,000, or 4.4% of children aged one to five years had BLL at or above 10 mcg/dL.[3] A separate analysis of 1988-1994 data demonstrated that one in every four children (25.6%) had BLL at or above 5 mcg/dL, the concentration under consideration as a potential new designation for level of concern.[5]

State surveillance data submitted to CDC for 1997-2001 indicate that children's blood lead levels are declining throughout the U.S. Between 1997 and 2001, the number of reported lead test results increased from 1.7 million (in 39 states and municipalities) to 2.4 million (in 46 states and municipalities), while the number of children reported with elevated BLL at or above 10 mcg/dL decreased steadily from 130,512 to 74,887 in 2001. Despite this substantial progress, the year 2000 national goal of elimination of blood lead levels $\geq$ 25 mcg/dL was not achieved. A total of 8,723 children nationally had blood lead levels $\geq$ 25 mcg/dL in 2000.

New York State Data: [2]

Blood Lead Screening Rates:

Annual screening rates for children under six years of age in NYS remain high. The purpose of testing, or screening for blood lead levels, is to provide for the early identification of children with elevated blood lead levels, and, once identified, coordinate intervention services. NYS regulations require health care providers to screen all children for blood lead levels at age one and two years, and with a risk assessment history followed by blood lead test as indicated up to age six years. State analysis indicates that 62% of children born between 1994 and 1999 received a blood screen by twenty-four months of age. An additional 30% of children were screened with a blood lead level after age twenty-four months, for an overall screening rate of 92% by age six. In the year 2000, 76% percent of children enrolled in Medicaid Managed Care plans were screened for blood lead levels by twenty-four months of age. Of the children found to have non-elevated (<10 mcg/dL) blood lead levels on initial screen, approximately one-third were screened a second time. Among those screened a second time, 8% were found to have a newly elevated blood lead level at or above 10 mcg/dL on second screening, emphasizing the importance of a second screening test even when an initial screening test is negative.

[2] For a more complete review of recent NYS surveillance data, refer to the companion document: *Promoting Lead Free Children in New York State: A Report of Lead Exposure Status among New York Children, 2000-2001. New York State Department of Health*

Burden of Childhood Lead Poisoning:

In New York State, excluding New York City, the number of children with newly-identified blood lead levels of 10 micrograms per deciliter (mcg/dL) or higher decreased by 14% between the years 2000 and 2001, from 3,672 to 3,178 children. The incidence *rate*, or number of newly identified cases of 10 mcg/dL or greater per 100 children screened, declined from 1.98 per 100 in 2000 to 1.7 in 2001. While incidence reflects only new cases, prevalence reflects both new cases and previous cases with ongoing blood lead measurement. Over the period of 2000-2001, the prevalence of children with elevated blood lead levels (EBLL) of 10 micrograms per deciliter (mcg/dL) or greater decreased by 18%, from 6,385 children in the year 2000 to 5,258 children in the year 2001. Similar declines were accomplished in both incidence and prevalence of blood lead levels of 20 mcg/dL or greater.

Despite these significant gains in the struggle against childhood lead poisoning in New York State, elimination of this preventable condition has not yet been achieved. In 2001, 5,258 children, or 2.7% of all children under six years of age in New York State (excluding New York City) had elevated blood lead levels of 10 mcg/dL or higher.

Geographic Distribution of Lead Poisoning in Upstate New York:

Rates of children with elevated lead levels vary geographically across the state. Much of this variation can be attributed to the age of housing, use of leaded paint, poverty rates of communities, and property values.

Analysis of aggregate data in large geographic areas can mask smaller populations with relatively high rates of elevated blood lead levels. To more easily identify geographic areas with high rates of children with elevated blood lead levels, an analysis of zip code level data was conducted for all zip codes outside of New York City.[3] In 2000-2001, thirty-six of the state's approximately 1,700 non-New York City zip codes were identified as having at least five new cases per one hundred children screened (or >5% incidence rate). These thirty-six high-incidence zip codes comprise only 2% of the state's zip codes outside of NYC, but account for 41% of all the children who were identified with EBLL outside of NYC. Among counties with one or more high-incidence zip codes, the high-incidence zip codes accounted for almost half of these counties' overall incidence rate. Not surprisingly, these thirty-six high-incidence zip codes have a substantially higher proportion of pre-1950 housing stock (59%) than the statewide (37%) and county figures.

[3] Zip codes were selected because they are more universally understood than other measures, such as census tracts. Most children in the database had only one street address associated with their record. In cases with multiple addresses, the zip code associated with a child's initial screening test was used. Zip codes were validated against the street name and city, and if necessary the zip code was corrected.

Defining the Goal of Elimination

The U.S. Department of Health and Human Services has called for the elimination of lead poisoning (defined as blood lead level at or above 10 mcg/dL) among children aged six years and younger. In support of this goal, states and cities funded by CDC's lead poisoning prevention program – including New York State and New York City, which each receive CDC funding individually - are required to develop and implement plans to eliminate childhood lead poisoning by the year 2010.

As a first step toward addressing the CDC goal for elimination, statistical projections for New York State in the year 2010 were prepared. Based on historical data and knowledge of past and current relationships among factors related to lead poisoning rates, several statistical methods were used to predict future trends in childhood lead poisoning in NYS. Because this methodology assumes that influential factors will persist in the future, and because these contributing factors are complex and interrelated with other social, economic, and legal issues, the extent to which these factors and their interrelationships change over the next six years will influence the trends that are actually observed. The statistical models indicate that incidence rates in NYS, exclusive of NYC, will have decreased by the year 2010 to very low levels, as shown in **Figure 1** and **Table 2**.

Figure 1. New York State incidence rate projection to 2010
(average percent decrease method)

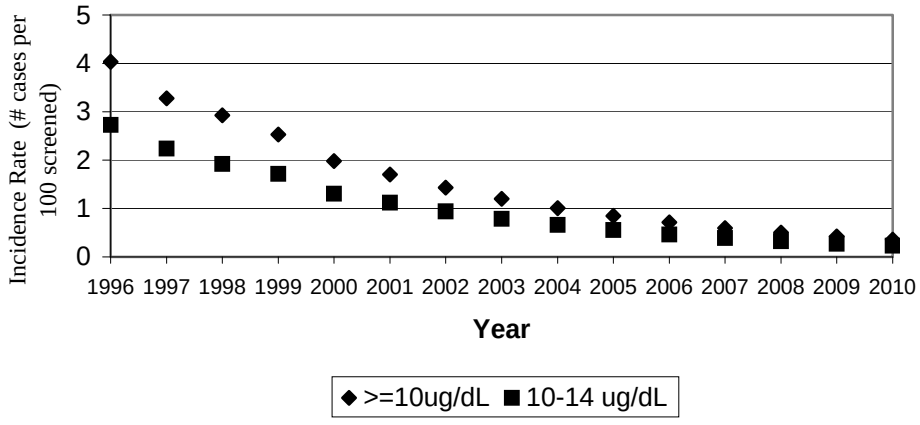


Table 2. Projected numbers of children less than six years old with elevated blood lead levels by level and county incidence type, 2010.

Geographic Descriptor	Number of Children Screened in 2001	10-14 mcg/dL	15-19 mcg/dL	20+ mcg/dL
High IR Counties	41886	314	149	99
Low IR Counties	99303	199	99	99
Moderate IR Counties	45392	91	45	45

High IR Counties = Counties with incidence rates at or above 75th percentile; Low IR Counties = Counties with incidence rates at or below 25th percentile; Moderate IR Counties = Counties with incidence rates between 26th and 74th percentile. Includes all NY State exclusive of five New York City counties. Projections based on number of children screened in 2001.

Several observations can reasonably be concluded from the projections.

- Elimination is possible
- Additional efforts are needed statewide to achieve elimination
- Some communities will need to do more than others to reach elimination

Risk Factors for Lead Exposure and Lead Poisoning

Associated Risk Factors:

Age

Children's blood lead levels typically rise rapidly between six and twelve months of age and peak between eighteen and thirty-six months of age, before gradually declining.[3] This pattern reflects active exploration of environment, increased mobility, high hand-to-mouth activity, and highly efficient gastrointestinal absorption of lead, which is estimated to be five to ten times higher than in adults.[1,3] Older children with developmental delays may continue to be at high risk for lead exposure, for example through persistence of mouthing behaviors.

Race

In the U.S., African American children are at the highest risk for elevated lead levels nationwide. NHANES III data demonstrated prevalence of BLL at or above 10 mcg/dL of 11.2 % of African American children ages one to five, compared to 2.3% of white children in the same age group; Hispanic children have prevalence rates intermediate to these.[6] When levels at or above 5 mcg/dL were assessed, 47% of African American children, 28% of Mexican American children, and 19% of non-Hispanic white children age one to five had elevated blood lead levels.[2]

Poverty/Socioeconomic Status

Socioeconomic status (SES) is a powerful predictor of lead exposure. NHANES III data found that 13% of Medicaid recipients had BLL at or above 10 mcg/dL, and 42% had levels at or above 5 mcg/dL. Poor children are more likely to live in lead-contaminated environments, including older and dilapidated housing and deposits of lead from years of leaded gasoline, hazardous waste disposal, and lead-related industry.[1] Furthermore, there is accumulating evidence in both human and animal studies that socially and economically disadvantaged children may be *more* vulnerable to the effects of a given level of lead exposure.[7]

Housing

Lead-based residential paint is the most significant source of high-level lead exposure for children in the U.S. The highest risk is for pre-1946 housing, with continued high risk for all housing built before the federal ban on high-lead paint in 1977. Nationally, tens of millions of existing housing units were built prior to the ban, and many of these units are in increasingly dilapidated condition.[1] Multiple studies have demonstrated household lead dust as the major source of lead exposure for young children.[8] Regional differences in prevalence of elevated lead levels, with highest prevalence rates in the Northeast and Midwest, reflect differences in housing stock. Lead paint can also be disturbed during renovation of older housing if lead-safe work practices are not followed.[9]

Nutritional Deficiency

Children with iron or calcium deficiencies have been shown to have increased absorption of lead, and to be at significantly higher risk for development of elevated blood lead levels.[4,10] However, there is currently no solid evidence that supplementation with calcium or iron prevents elevated blood lead levels in children.[3]

Immigration status

While more data are needed, several studies have suggested that immigrants to the U.S., including foreign-born adopted children, appear to have an increased prevalence of elevated lead levels, reflecting a variety of environmental exposures in their countries of origin and/or a variety of cultural practices. Continued use of leaded gasoline, industrial emissions, cottage industries, traditional folk medicines, cosmetics, ceramics, and foods all have been noted as sources of lead exposure among immigrant populations.[11-13]

Pregnancy

Pregnant women and fetuses may represent a unique population in terms of demographics and exposure pathways to lead. Women can carry lead from any lifetime exposure stored in their bones for decades, or may be exposed to lead during pregnancy from environmental, occupational, or other sources.[7] During pregnancy, maternal lead may be mobilized from bone stores into the bloodstream and then cross the placenta or enter breast milk. Various reports have estimated the prevalence of elevated blood lead levels among adult women to be between three and nineteen percent.[14] Dramatic increases in the population of immigrant women in some communities may mean that the prevalence of elevated BLL among pregnant women is higher than previous estimates.

Routes of Exposure:

The primary route of lead absorption in children is ingestion and absorption through the gastrointestinal tract. Only a small amount of ingested lead is needed to raise child's blood lead level. Because lead accumulates in the body, toxicity depends on the amount of lead one is exposed to and the duration of the exposure. Lead readily crosses the placenta, thus a developing fetus may be exposed to lead in the mother's bloodstream. Once absorbed, lead is carried in the blood and absorbed by all other tissues of body. The half-life of lead is approximately thirty-five days in blood, approximately two years in the brain, and decades in bone. Blood lead levels are primarily an indicator of recent exposure, although they can remain elevated longer due to mobilization of internal stores.

Sources of Lead*:*

Dusting, flaking and peeling residential lead paint is by far the most significant source of lead exposure to children.[1,3] Even in well-maintained housing units, some deterioration of paint occurs. As paint deteriorates, it is converted into dust-sized particles. Children living in dilapidated older houses or an older house undergoing renovations are at particular risk for lead poisoning due to lead contaminated dust and debris. Deteriorated exterior paint poses a similar threat to children who regularly play outside in soil near the structure.

Other important sources of childhood lead exposure include soil contaminated by industry or traffic, and contaminated drinking water systems. However, children can be exposed to lead from countless sources, including imported pottery and ceramics, imported foods, toys, or cosmetics, folk medicines, leaded weights and fishing sinkers, parent occupational exposures, and exposure to maternal lead stores during pregnancy or through breast milk.

Health Effects of Lead Exposure on Children

A solid and growing body of scientific evidence demonstrates that lead is a systemic toxin, resulting in adverse health effects in virtually all body systems. Lead exposure has been associated with anemia, hearing loss, diminished skeletal growth, delayed pubertal development, dental caries, cognitive and behavioral deficits, hypertension, osteoporosis, and a range of non-specific constitutional symptoms. In pregnant women, lead toxicity has been linked with pregnancy-induced hypertension/ toxemia, spontaneous abortion, preterm birth, and low birth weight. Lead is a potent neurotoxin and is especially detrimental to the vulnerable developing nervous system of babies and young children.[3,7] Most children with elevated blood lead levels are asymptomatic. Effects of lead on cognition and behavior may be insidious and lag behind the actual period of lead ingestion, even after blood lead levels have declined.[1,7]

Lead exposure has been associated with significant, dose-dependent declines in IQ and a range of other measurable cognitive, social-emotional, and behavioral deficits in children.,[3,7,15-18] A systematic review of published research demonstrates that an aggregate increase in blood lead levels from 10 to 20 mcg/dL is associated with an average decline of 2.6 IQ points in young children.[16] This finding is consistent across a range of study populations, and holds when important social and demographic co-variates are controlled.

Over the past several years, at least four peer-reviewed scientific studies have demonstrated an association between lead exposure and cognitive impairments at blood lead concentrations below 10 mcg/dL, the current "level of concern" as defined by the CDC.[7,16,19,20] The most rigorous of these studies, a prospective longitudinal analysis of blood lead levels and IQ between the age of 6 and 60 months, found an average decline of 7.4 IQ points over the first 10 mcg/dL of lifetime average blood levels, an observation consistent with other previous research.[20] Collectively, these findings demonstrate that there is no discernible threshold for the toxic effect of lead, and that in fact incremental negative effects on cognition may be highest at concentrations below the current "level of concern".[7,21] Perhaps most importantly, research increasingly demonstrates that the harmful effects of lead on cognition and behavior are not reversible.

While the observed average declines in IQ may appear small, the public health implications of such effects are likely to be significant. At a population level, a shift in the population curve even a few IQ points to left will notably increase the number of children at risk for problematic outcomes, and in need of special services, while concurrently decreasing the number of children at the other end of the curve whose intellectual potential and productivity is optimized.[21] Such shifts may have substantial public health and financial implications. For example, a 1994 cost-benefit analysis reportedly estimated that lowering the population average of children's BLL by only 1 mcg/dL would result in savings of $6.9 billion nationally.[1]

Equally important, average declines in IQ mask the susceptibility or resilience of individual children, which is likely to be quite variable.[7] In fact, several studies have demonstrated an effect-modifying relationship between lead exposure and poverty, suggesting that the most socially disadvantaged children may in fact be *more* vulnerable to a given lead exposure dose, thereby compounding the detrimental effects of lead in at-risk populations. Thus average group effects likely underestimate the effect on some individual children, and studies that statistically

control for the effects of poverty or other socio-economic contextual factors may actually obscure the most potent effects of lead exposure on high-risk populations.[7,22]

The assessment summarized above makes clear several related findings: 1) lead exerts harmful effects at concentrations commonly observed among young children, including at levels below 10 mcg/dL, perhaps without any identifiable threshold of safety; 2) a large proportion of the population of young children currently have BLL between 5-10 mcg/dL; 3) the cognitive effects of lead toxicity are believed to be irreversible; 4) children already at high risk for a range of health and developmental problems due to socio-economic disadvantage are the most likely to be exposed to lead, and may be most vulnerable to its debilitating effects. Based on this collective evidence, there is consensus among researchers, health care providers, and policymakers that comprehensive prevention strategies, and especially primary prevention strategies, must be strengthened to achieve elimination of childhood lead poisoning.

III. Environmental Scan

New York State Demographics

Based on 2000 Census data, New York State (including New York City) has nearly 1.7 million children under the age of 6 years, including 476,000 one and two year olds. Projections for 2010 indicate that New York State will have 1.65 million children under age six including 471,000 one and two year olds.

Children living in poverty is another important factor related to childhood lead poisoning. Because poverty limits housing choices, available housing for low-income families is generally found in communities with the oldest housing and the most deferred maintenance. As a result, these children are more likely to live in older deteriorated housing with lead paint hazards. The Federal General Accounting Office has estimated that 85% of lead poisoned children are eligible for Medicaid. According to the 2000 Census NYS has 198,252 or 20.2 % of families with children less than five years of age living below the federal poverty level. This places NYS 3rd among states with the most families with young children living in poverty.

New York State is experiencing a population change driven by foreign immigration and high levels of domestic in- and out migration. In 2000, 23% of New York's population was foreign born, more than twice the proportion in the nation. Meanwhile, New York State has the largest number of foreign and domestic residents (1.7 million) leaving the state. Out-migrations are typically young, educated, working-age adults and financially secure retirees. The effect of these moves on state and local economies and specifically on the real estate industry may be significant.

The age of New York State's housing stock makes it at high risk for containing lead paint. In New York State, 43.1% of dwellings, over 3.3 million homes, were built prior to 1950. Over fifty percent of the housing stock among the thirty-six high incidence zip codes previously identified was built before 1950. New York State has the most pre-1950 housing units in the country, with over one million more than the next highest state, Pennsylvania. The percentage of pre-1950 housing in New York State dwarfs that of states with a higher total number of homes.

Table 3. Age of housing among states with most housing units, 2000

States	% pre-1950 Housing	% Built pre-1950 **Renter** Occupied Housing
California	18.1	22.5
Texas	10.8	9.7
New York	**43.1**	**47.5**
Florida	6	4.2
Pennsylvania	40.3	43.3

Sorted by the total number of housing units (not shown)
Source: 2000 U.S. Census Data (Includes NYC data)

Review of Current Activities

***Federal Initiatives**:*

In February of 2000 the President's Task Force on Environmental Health risks and Safety Risks for Children issued a report entitled: Eliminating Childhood Lead Poisoning: A Federal Strategy Targeting Lead Paint Hazards. The report presents a coordinated federal program to eliminate childhood lead poisoning in the United States, and strategies for elimination of lead paint hazards over the next ten years. The report focuses primarily on expanding efforts to correct lead paint hazards, especially in low-income housing, as a major source of lead exposure for children. The report outlines a ten-year plan that will create 2.3 million lead-safe homes for low-income families with children, thereby resulting in net benefits of $8.9 billion as estimated by the federal Department of Housing and Urban Development. The report and proposed strategies focus on two major goals:

- By 2010 eliminate lead paint hazards in housing where children under six years of age live. This goal is to be achieved by federal grants and leveraged private funding to identify and eliminate lead paint hazards in order to produce an adequate supply of lead-safe housing for low-income families with children;

- By 2010 elevated blood lead levels in children will be eliminated through: increased compliance with existing policies concerning blood lead screening; and increased coordination across federal, state and local agencies responsible for outreach, education, technical assistance and data collection related to lead screening and abatement.

***New York State Department of Health**:*

Responsibility for programs and activities related to childhood lead poisoning is shared in the Department of Health between two major program areas: the Childhood Lead Poisoning Prevention Program, located in the Center for Community Health, and the Bureau of Community Environmental Health and Food Protection, located in the Center for Environmental Health.

Center for Community Health: Childhood Lead Poisoning Prevention Program

The New York State Department of Health's Childhood Lead Poisoning Prevention Program (CLPPP), in partnership with local health departments and the health care provider community, coordinates a wide range of efforts to prevent, detect, and treat children with elevated levels of lead. The partners work together to: (1) pursue universal screening of one and two year olds and targeted screening of children ages six months to six years assessed to be at high-risk for lead exposure; (2) educate the public and health professionals about prevention, early detection, and treatment; (3) provide case management or oversight of case management for children with elevated blood lead levels, including environmental assessment and requiring lead hazard control; (4) ensure that families of children with lead poisoning are given advice and technical assistance in locating sources of lead in the child's environment; (5) provide assistance to pediatric care providers about medical management of children with elevated blood lead level

through the establishment of regional lead poisoning prevention resource centers, and (6) provide lead-safe interim housing in some communities for families of children being treated for an elevated blood lead level of 20ug/dL or greater while the lead hazards in their environments are addressed.

Since 1992, New York State law has required health care providers to screen all children for lead by blood lead levels at one and two years of age, and allows the state to collect all blood lead test results on children. This law, combined with existing state and CDC resources, enables the state program to conduct surveillance, evaluate screening performance, and identify locations and other characteristics of lead poisoning cases. Analysis indicates that 62% of children born between 1994 and 1999 received a blood screen by twenty-four months of age. An additional 30% of children were screened after age twenty-four months, for an overall screening rate of 92% by age six. In the year 2000, 76% percent of children enrolled in Medicaid Managed Care plans were screened for blood lead levels by twenty-four months of age.

The Department of Health is modernizing its data collection and tracking systems. The department is in the process of launching an updated Internet based "Leadtrac" data system for local and state health department staff. The revised system will provide an enhanced system for matching tests to existing clients, a centralized database to help improve tracking of affected children moving between health jurisdictions, and additional data fields to improve program information and planning.

Specific activities carried out either directly by the state CLPPP or through contractual partners include:

- Data collection and analysis of all blood lead tests;
- Monitoring of lab reporting of blood lead tests;
- Case management of identified lead-poisoned children;
- Provision of temporary lead-safe housing for those children who are lead poisoned and need safe housing while their regular residence is undergoing remediation;
- Education of the public about lead hazards and methods to reduce exposure;
- Professional education to providers including assessment of lead screening in targeted provider offices;
- Provision of consultation for medical treatment of moderately to severely lead-poisoned children;

Center for Environmental Health

The environmental assessment and lead hazard control components of case management are under the direction of the New York State Department of Health's Center for Environmental Health (CEH). Under the direction of CEH, environmental work is conducted by environmental health personnel in thirty-six county health departments, the New York City Department of Health, and the Department's nine district offices (which cover 21 upstate counties that do not have their own environmental health services). Environmental management is provided for children with an elevated blood lead level of 20 mcg/dL or higher in order to identify and eliminate sources of lead exposure. By law, the property owner is required to correct hazardous lead conditions when a child under age six is identified as having an elevated blood lead level of 20 mcg/dL or higher.

Healthy Neighborhoods Program

The Center for Environmental Health currently supports eight local Healthy Neighborhood Programs, with a total of $1.2 million annually. The Healthy Neighborhoods Program (HNP) is designed to provide preventive environmental health services to targeted geographic areas with a high rate of documented unmet environmental health needs which often result in adverse health outcomes for residents. HNP performs door-to-door outreach and education in high-risk areas. The advantage of HNP is that each dwelling receives a visual assessment and education regarding lead and other hazards that is specific to the dwelling. Competitive awards are made to local health departments utilizing Federal Preventive Health and Health Services Block Grant Funds. The target areas are selected according to the level of environmental and socio-economic factors that are measured in the community, including: percent of housing built before 1960; lead-based paint hazards; incidence of fires and arson; homes without smoke detectors; and cockroach, rodent and garbage complaints. Four of the HNPs outside of NYC are located in county jurisdictions with high incidence zip codes for childhood lead poisoning.

Housing Initiatives:

The Division of Housing and Community Renewal (DHCR) is the state agency responsible for housing. The Department of Health has partnered with DHCR to build the capacity to implement regulations for federally -assisted housing (rental, mortgages and public housing). It is expected that regulations will impact 80,000 housing units in New York State, impacting $86 million in federal funds and a large number of children living in federally assisted housing.

Over the last nine years the NYS Department of Health has supported local government applications for federal HUD grants to make homes lead safe. During this period local governments have received over $46 million and have completed over 2,700 housing units . Future plans include :

- Hold numerous training events on lead based paint for renovators and remodelers;
- Work closely with the weatherization program to train lead based paint supervisors;
- Introduce peer-to-peer technical assistance focus groups pertinent to the needs and concerns of housing coalitions; and
- Produce and maintain a strategic plan to expand lead-based paint control and improve training opportunities within the state.

NYS has a property maintenance code that prohibits peeling and chipping paint. The code is enforced by local Code Enforcement Officers in municipalities. The provisions of this code apply to all existing structure and all existing premises, and constitute the minimum requirements and standards for premises. Minimum conditions specified in the code include that 1) all exterior peeling, flaking, and chipped paint shall be eliminated and surfaces repainted; and 2) all interior painting, chipping, flaking, or abraded paint shall be repaired, removed, or covered. While current enforcement is variable, the existing code offers a basis for lead hazard reduction that is not currently maximized in high-risk communities.

Review of promising strategies

As part of the strategic planning process, recent peer-reviewed published literature pertaining to strategies for prevention of lead poisoning in young children in the U.S. was reviewed. Comprehensive lead prevention strategies may include activities related to tertiary, secondary, and primary prevention of lead poisoning.

Screening and Education

Screening for elevated lead levels in at-risk children is a critical component of prevention efforts, supporting early identification and management of exposed children, and as a safety net to identify sources of lead exposure to prevent subsequent lead poisoning of other children.[1] However, screening and follow-up medical management alone are clearly insufficient to eliminate childhood lead poisoning. While chelation therapy has had dramatic effects on mortality historically associated with high levels of acute lead poisoning, recent studies including large scale randomized clinical trials have failed to demonstrate any benefit of chelation on children with moderately elevated BLL in range of 20-44 mcg/dL, as measured by either changes in blood lead concentration or cognitive and behavioral scores.[1,3,23-25] Intensive home-based educational efforts have been demonstrated to have some positive effects on reducing lead levels of lead-poisoned children, but alone are far from sufficient.[26,27] Similarly, residential lead hazard control activities in response to identification of exposed children can have measurable impact on reducing blood lead levels in the range of 20-30 mcg/dL or higher, but does not appear to benefit children with blood lead levels in lower ranges in most studies.[3,28,32]

Primary Prevention

There is increasing consensus among researchers, health care providers, and policymakers that primary prevention strategies must be strengthened to achieve elimination of childhood lead poisoning. Educational strategies related to exposure avoidance and improved nutrition have been demonstrated to contribute to primary prevention, but alone are not sufficient to prevent lead poisoning.[29-31] Residential lead hazard control measures, ranging from improved cleaning techniques to interim containment measures to complete lead abatement, are regarded as the most critical components of primary prevention. Scientific studies evaluating the efficacy of specific lead hazard reduction techniques, including low-cost interim hazard controls, confirm that such strategies can successfully reduce lead exposure, but more rigorous and detailed studies are greatly needed to guide primary prevention efforts.[29,32-36] Because of the substantial input costs required to remediate housing, policy changes and enforcement of regulations have been studied as a component of lead poisoning prevention strategies. Preliminary research demonstrates that communities with more rigorous lead remediation laws, and more stringent enforcement of those laws, can be both cost-effective and successful at breaking the cycle of lead exposure and reducing blood lead levels among at-risk children.[37-40]

IV. Challenges to Lead Poisoning Elimination in New York

Clearly new evidence is emerging that even levels of lead previously thought to be safe can have significant health effects for young children, which can ultimately result in large societal costs both financially and in terms of lost human potential. New strategies must be developed that have the ability to overcome the current challenges that face elimination of lead poisoning in New York State. The assessment presented in Sections I-III helps define opportunities that exist within New York State for the prevention and ultimately the elimination of childhood lead poisoning by the year 2010 and beyond.

Education
Since new evidence is emerging about the dangers of even relatively low levels of lead, we must ensure that new strategies include continuing education of health care providers, consumers, and policymakers. Current education efforts should be expanded to incorporate new information about the effects of low lead levels, identification of potential lead hazards, and feasible and effective methods to make environments lead safe. In addition, public health officials can help focus educational messages highlighting the significant societal burden that lead poisoning imposes – an outcome that is no less real than the individual adverse health effects of lead, but more difficult to accurately communicate.

Screening:
While universal screening of one and two-year olds is the law of the land in New York, more can be done to ensure that this is indeed the standard of pediatric practice. Evidence from NYSDOH clearly demonstrates that having a normal blood screen for lead at one year old does not eliminate the possibility of having lead poisoning at age two. Furthermore, in order to monitor elimination efforts, screening must be increased and surveillance must be kept high.

Housing:
As already described in this document, the biggest potential source of lead for New York State's children is older housing stock. This is very likely the most difficult challenge to overcome and new strategies will have to address the inherent problems associated with older housing stock. Location of problem housing, how it is maintained, safe and effective solutions for lead hazard control, and compliance with code regulations all need to be considered. At the same time, in addressing these issues care must be taken not to negatively affect the housing market for low-income residents.

Primary Prevention:
Despite educational initiatives, increased screening and surveillance, and targeted lead hazard controls, it is apparent that in order to achieve elimination additional primary prevention education and housing initiatives will be required. Based on the collective evidence presented below, there is consensus among researchers, health care providers, and policymakers that primary prevention strategies must be strengthened to achieve elimination of childhood lead poisoning. In New York State, both universal strategies and strategies targeting high-risk communities must be employed to achieve elimination of childhood lead poisoning.

The Case for Lead Poisoning Elimination

- Even at moderately elevated blood levels commonly observed among young children, lead is associated with measurable detrimental effects on cognitive, behavioral, and social-emotional developmental outcomes;

- The harmful effects of lead occur even at concentrations below the current "level of concern" of 10 mcg/dL. Lead may in fact exert the largest incremental effects on IQ at blood levels below 10 mcg/dL. These findings are consistent with basic science studies of lead neurotoxicity, and support the conclusion that there may be no identifiable threshold of safety for lead exposure among young children;

- The cognitive effects of lead toxicity are believed to be irreversible, and there is no evidence that medical treatment in the form of chelation benefits children with elevated blood lead levels in the low to moderate range;

- Small declines in average IQ scores and other developmental outcome measures at an aggregate level represent substantial health, social, and economic costs at a population level;

- Focusing on average lead levels in a population masks the susceptibility of individual children to the effects of lead. Children already at high risk for a range of health and developmental problems due to socio-economic disadvantage are the most likely to be exposed to lead, and appear to be most vulnerable to its debilitating effects.

V. Proposed Strategies for New York State

Strategic Work Plan Framework

This strategic plan was developed in recognition of the compelling need to eliminate childhood lead poisoning, and in response to CDC's call for the elimination of lead poisoning by 2010. This plan, covering upstate New York, is a companion to the strategic plan under development by New York City Department of Health and Mental Hygiene, covering New York City.

The New York State Department of Health (NYSDOH) developed the plan as a joint effort of the Centers for Community Health and Environmental Health, in cooperation with other state agencies and stakeholders. The plan incorporates input from a variety of partners, including the Governor's Lead Advisory Council, the Maternal Child Health Block Grant Advisory Council, the NYS Chapters of American Academy of Pediatrics and American College of Obstetricians and Gynecologists, and the New York State Association of County Health Officials (NYSACHO). A list of Lead Advisory Council members is attached as **Appendix A.**

The plan identifies goals related to the elimination of childhood lead poisoning, and outlines objectives and action steps to accomplish those goals. The plan encompasses three priority focus areas: Surveillance, Targeting High Risk Populations, and Primary Prevention. These focus areas reflect the priorities articulated by CDC, and address the significant variation in the burden of childhood lead poisoning across the state.

1) **Surveillance-** Use of data sources to identify the nature and scope of the existing childhood lead poisoning problem, assist in identifying high -risk populations and housing, monitor the scope of the problem and evaluate the effectiveness of interventions. Surveillance also contributes to individual case identification to ensure prompt, appropriate medical and environmental management.
2) **Targeting high-risk populations** – Use of an array of interventions to minimize the probability of continued exposure among populations with high rates of exposure.
3) **Primary prevention -** Before a child is poisoned, advance feasible approaches to assess and improve environmental lead safety while preserving affordability.

The plan incorporates long-term goals and objectives based on current capacity, known or anticipated resources, successful models, current needs and other relevant factors. It also acknowledges and supports the Healthy People 2010 goal to eliminate childhood lead poisoning defined as a blood lead level of 10 micrograms per deciliter in a child less than six years of age. The plan is a useful guide for decision makers, local health departments, communities, health care providers, advocacy groups and the general public to better understand the burden of childhood lead poisoning in New York State and the strategies for its elimination.

While much important work is already being done in New York State to prevent childhood lead poisoning, additional measures are needed to achieve elimination. While the strategies outlined in this plan provide a solid foundation for elimination of childhood lead poisoning, communities may choose to adopt additional or alternative effective strategies to augment the plan.

Focus Area One: Surveillance

Screening of blood lead levels is an essential component of prevention strategies. Screening is important for early identification and management of individual cases of lead poisoning. As a safety net, screening may prevent recurrent exposure and exposure of other children by triggering identification and remediation of sources of lead in children's environments. Screening also forms the basis of lead poisoning surveillance, a critical component of public health efforts to design effective prevention programs.

Under New York State Public Health Law and regulations, health care providers are required to screen all children for elevated blood lead at the ages of one and two years. Since 1994, NYS has required reporting of all blood lead tests regardless of blood lead level. Based on the most recent data available, 65% of children in New York State were screened at least once by the age of twenty-four months, and 94% were screened at least once by the age of six years.

Goal 1: **Health care providers who care for young children screen all children for lead poisoning by blood lead testing at the ages of one and two years, and by risk assessment with blood lead testing as indicated up to age six years.**

Objective 1: To increase provider awareness of NYS screening regulations and the rationale for universal screening.

Action Steps:

1) NYSDOH, in conjunction with the NYS Chapter of the American Academy of Pediatrics and New York State Academy of Family Physicians, will develop and implement a statewide campaign to increase screening practice by primary care providers. Specific strategies may include:
   - Dissemination of an educational packet to all physicians caring for children in New York State that includes information on recent medical literature demonstrating the adverse mental/developmental effects of low lead levels and the significant burden of lead poisoning in NYS, a summary of the NYS blood lead level screening requirements, and guidance to share with families on safe and effective methods for reducing lead exposure.
   - Establishment of a website to promote ongoing dissemination of up to date information on lead poisoning and recommended clinical practice
   - Other formal continuing education opportunities, including institutional grand rounds, conferences, and/or satellite broadcasts

2) NYSDOH Division of Family Health will work with the American College of Obstetricians and Gynecologists and New York State Academy of Family Physicians to reinforce provider awareness of current requirements for lead exposure risk assessment, targeted blood lead screening, and appropriate follow-up during pregnancy. This effort should build on the related work done in the past year by the New York City Department of Health and Mental Hygiene/Mt. Sinai Center for Children's Health and the Environment

3) Within the Department of Health, the Childhood Lead Poisoning Prevention Program will work with the Office of Medicaid Management and the Office of Managed Care to promote increased awareness of providers regarding the requirements and rationale for universal screening.

Objective 2: To enhance implementation of screening requirements in provider practice

Action Steps:

1) NYSDOH will expand the Physician Based Immunization Initiative (PBII), which evaluates individual providers' screening practices and gives the provider direct feedback to improve practice. Currently PBII is occurring in thirty-eight counties and has included over 160 providers' offices. Current PBII strategies to improve immunization rates, such as the missed opportunities concept and continuous monitoring of the chart for a lead lab test, can also be applied to screening for lead. Initial expansion will target providers serving high-risk communities, as described under Priority Focus Area 2 below.

2) NYSDOH, in collaboration with NY professional medical academies, will establish a protocol for enforcing regulations related to lead screening. Enforcement strategies will emphasize provider education, with targeted auditing, citation, or other penalties as needed in cases of significant non-compliance.

Objective 3: To assure that homeless children receive lead screening in all communities

Action Steps:

1) NYSDOH will work with local health departments, in coordination with local social service departments, to assure that homeless children are covered by lead screening programs, consistent with current regulations.

2) In counties where homeless children are excluded from Medicaid Managed Care enrollment (currently 11 counties), or are enrolled on a case-by-case basis (currently 27 counties), NYSDOH will work with counties to assure that mechanisms are in place for screening of homeless children.

Goal 2: The public, including families, are aware of the dangers of lead and the importance of lead screening.

Objective: To increase public demand for lead screening.

Action Steps:

1) The lead program's annual media campaign will be expanded to include a message about the risk of low lead levels and the need for screening. Messages will be focus tested with target audiences. For example, a new "Got Lead?…Find Out" theme could be developed.

2) The CLPPP will develop culturally competent educational materials about the risk of low lead levels and the need for screening to be distributed through community-based settings, including community health centers, child care providers, local health departments (LHDs), WIC offices, homeless shelters, community health worker programs, social service organizations, pharmacies, and other points of entry.

3) CLPPP will work with the NYSDOH Office of Managed Care and Office of Medicaid Management to improve lead screening among their patient populations. Building on a recent award-winning immunization project conducted by the Northeast Public Health Leadership Institute (NEPHLI) and MCOs, patient reminders for lead screening could be included in mailings to families around children's first and second birthdays.

Goal 3: All families of children with measurable blood lead levels have basic knowledge about sources of lead and simple methods to reduce lead hazard exposure.

Objective: To increase public awareness of the sources of lead and common methods to decrease lead exposure.

Action Steps:

1) The CLPPP will develop and disseminate educational materials specific for children with blood lead levels > 0 but below the current action level of 10 mcg / dL. Children with mildly elevated lead levels have demonstrated that they are exposed in some way to environmental lead. Under current guidelines, lead levels in this range do not usually prompt complete medical or environmental assessments. New materials will emphasize the importance of identifying sources of potential lead exposure, and describe effective methods of minimizing exposure, to be implemented by families. Educational materials can be mailed directly to families via either the county or the state, and/or can be distributed through health care providers' offices, to all children with blood lead levels in this range.

2) The CLPPP will evaluate the effectiveness of this intervention through surveying a sample of households who have received educational materials, and modify materials as needed to ensure maximum impact.

Goal 4: **A surveillance system provides the information needed to advance prevention activities and evaluate ongoing initiatives.**

Objective: To ensure the reliability of the existing surveillance system as an effective tool for identification of the nature and scope of the existing childhood lead poisoning problem, high-risk populations, and the effectiveness of interventions.

Action Steps:

1) CLPPP staff, in cooperation with staff from the Clinical Laboratory Evaluation Program (CLEP) and Electronic Clinical Laboratory Reporting System (ECLRS), CLPPP staff will take steps to improve the quality of lead laboratory data. CLEP is responsible for assuring quality of laboratory tests and reporting, and ECLRS for electronic transmission of test results from laboratories to the Department of Health. Specific strategies will be developed to improve monitoring and quality of data submitted by laboratories, and to provide feedback and education to laboratories that have problems with data quality. Consistency and adequacy of socio-demographic and geographic information on lead laboratory reports will be emphasized for quality improvement.

2) NYSDOH, in cooperation with local health departments, will utilize surveillance data to help identify gaps in screening practice at provider and/or community level, with an emphasis on application of findings to enhanced outreach and technical assistance to the provider community, and timely feedback of information to providers. Communities with highest prevalence of elevated lead levels and/or high risk housing stock will be targeted for enhanced efforts.

3) NYSDOH will explore methods for matching the lead screening registry with other available databases, such as Medicaid Fee For Service Database, Managed Care Encounter Database, or Early Intervention Program, to help identify groups of children not receiving blood lead screening.

Focus Area Two: High-Risk Populations

Surveillance data for New York State clearly document that lead hazards and risk for childhood lead poisoning are not evenly distributed statewide. Communities with the highest proportions of pre-1950 housing stock and low-income minority populations face the highest burden of childhood lead poisoning. At the same time, we know that elimination of lead hazards and childhood lead poisoning in the highest-risk communities is especially challenging due to a wide range of other community factors. Poverty, unemployment, low educational attainment, limited availability of affordable housing, and scarcity of financial resources for property maintenance and improvements all contribute to the challenge of preventing exposure to lead hazards and eliminating childhood lead poisoning. While elimination of childhood lead poisoning will require a variety of statewide actions, these disparities are unlikely to be remedied without more intensive efforts targeting communities at highest risk.

Reduction of disparities will require a combination of state and local activities that address multiple aspects of lead poisoning prevention. The cornerstone of the proposed strategy is the development or strengthening of regional and local coalitions in high-risk communities around the state. Through community coalitions, local organizations and stakeholders can work together effectively to mobilize support, leverage maximal resources, and develop and implement specific action steps – including many of the action steps outlined elsewhere in this plan - to accomplish change at a local level. The success of childhood asthma coalitions and ACT for Youth community partnerships in New York State in achieving meaningful change supports the decision to utilize community coalitions as a pivotal strategy for elimination of childhood lead poisoning in high-risk communities.

Goal 1: Community-level disparities in childhood lead poisoning are reduced through intensive lead elimination activities targeting the highest risk communities in New York State.

Objective 1: Communities with the highest burden of lead hazards and childhood lead poisoning will be identified and targeted for intensive intervention.

Action Steps:

1) Develop a tool for selecting and prioritizing communities on the basis of risk for lead exposure and/or burden of childhood lead poisoning. The methodology used in the recent lead data report can be applied or modified for this purpose. This method identified 36 zip codes with incidence rates more than three times the statewide average, which collectively account for over 40% of elevated blood lead level reports in the state.

2) Apply tool on annual or other regular interval to identify target communities for intensive intervention. Incorporate target status in eligibility for various funding or technical assistance opportunities supported by the Department of Health and its partners (for example, the Healthy Neighborhoods Program and lead poisoning prevention coalition activities)

Objective 2: The Department of Health will support the formation of childhood lead poisoning prevention coalitions (or, in the case of existing coalitions, will help strengthen coalitions) in targeted high-risk communities.

Action Steps:

1) The Department will develop a mechanism, including funding, to promote the development and support the activity of community coalitions in targeted high-risk communities. Funded coalitions will outline a plan for convening appropriate local partners and addressing target areas in their region. All funded coalitions must have their county health department as a full member.

2) Contracts between the Department's Childhood Lead Poisoning Prevention Program and local health units in target counties will be amended to require participation in the local coalition.

3) The Department will provide guidance and technical assistance to coalitions to support activities, including dissemination of "best practices" from and other innovative strategies from NYS communities and other states.

4) The Department will develop and disseminate to coalitions print and other materials that can be used to promote lead poisoning prevention activities in local communities.

Objective 3: Childhood lead poisoning prevention coalitions will develop and implement a range of local strategies to accomplish elimination of childhood lead poisoning in high-risk communities.

Action Steps:

1) Coalitions will engage appropriate local partners needed to ensure coalition effectiveness. Regional Resource Centers, local health departments, local departments of social services, local housing authorities, code enforcers, parents, advocacy groups, landlords, tenant organizations, researchers, local Healthy Neighborhood Program staff, community-based non-profit affordable housing organizations, and other stakeholders should be included in coalitions.

2) Coalitions will work to enhance residential risk assessment activities in target communities. Coalitions will be encouraged to apply or support partner organization applications for additional funding through the Healthy Neighborhoods Program to support expansion of intensive risk assessment and related educational activities.

3) Coalitions will work to maximize resources for lead hazard reduction, including federal grant programs and enforcement of federal housing policies. Coalitions will be encouraged to apply or support partner organization applications for all available funding sources to subsidize remediation of residential lead hazards, including the federal HUD lead hazard reduction program.

4) Coalitions will mobilize local support and resources to ensure that the state's Uniform Property Maintenance Code related to peeling and chipping paint is enforced. A targeted outreach effort will be undertaken to educate property owners on the NYS Property Maintenance Standard, which requires that all paint surfaces be maintained free of chipping and peeling conditions, as well as on safe and effective techniques for correction of the underlying cause of paint deterioration. Training will be offered to appropriate parties to ensure that findings specific to lead hazards are recognized, and appropriate interventions pursued.

5) Coalitions will be directed to pursue a variety of additional local strategies to augment the broader strategies outlined in the statewide elimination plan with technical assistance from NYSDOH. Coalitions may select specific activities presented by NYSDOH, or may propose their own activities to match local needs and resources. Example activities include:
   - Disseminating innovative educational messages to parents in the community, with an emphasis on using methods demonstrated to effect behavior change (e.g. modeling, hands-on skills training, etc) and on incorporating messages into existing venues where parents are likely to be most receptive to information.
   - Offering additional training on lead safe work practices to homeowners, landlords, and local builders/contractors.
   - Reinforcing messages directed to both families and health care providers related to requirements for blood lead screening.
   - Ensuring that all community providers who work with children age 0-6 are maximizing opportunities to identify blood lead screening results, and make referrals for appropriate follow-up when needed. Such parties may include primary care providers, childcare providers, Head Start/Early Head Start programs, and WIC clinics.

Objective 4: At a state level, the Department of Health will play a leadership role in working with other governmental agencies to ensure coordination of activities related to childhood lead poisoning prevention, and to maximize opportunities for prevention and intervention.

Action Steps:

1) NYSDOH will take a leadership role in coordination and collaboration with other agencies to ensure that opportunities to support elimination of childhood lead poisoning are maximized. A collaborative effort between the agencies will result in broader outreach and promotion of uniform messages regarding screening blood lead levels, assessment of potential lead hazards, and safe and effective methods to correct the hazards.

2) NYSDOH will act as a resource to other agencies for information on lead and current state and federal regulations. NYSDOH will develop and disseminate print materials, provide training and technical assistance, and offer ongoing consultation to other agencies.

3) The Childhood Lead Poisoning Prevention Program will seek to leverage maximal financial and non-financial resources for elimination of lead poisoning by linking this elimination plan to other planning processes in the state, including the evolving Early Childhood Strategic Plan and the state's Medical Home Initiative.

4) NYSDOH programs will explore opportunities for sharing financial and non-financial resources to jointly support promising strategies. For example, the Healthy Neighborhoods Program administered by Center for Environmental Health will be expanded to serve target communities identified for lead hazards (see above) and to incorporate specific strategies for reduction of lead exposure risks (see additional information under next section).

Focus Area Three: Primary Prevention

The third component of the strategic plan will generate new emphasis on primary prevention. These efforts will focus on protecting children from exposure to lead through a variety of methods that involve the work of government agencies, community leaders and community members. All opportunities for primary prevention for lead poisoning must be explored.

Goal 1: Environmental lead hazards are identified before children are exposed.

Objective 1: To incorporate lead hazard identification into all DOH programs with a home visitation component.

Action Steps:

1) New York State Department of Health (DOH), in cooperation with local health departments, will identify all programs that include visits to the home. These may include the DOH Healthy Neighborhoods Program (HNP), Community Health Worker Program, local health department home visiting nurses, and the Healthy Families New York (HFNY) home visiting program sponsored by the NYS Office of Children and Family Services (OCFS) in collaboration with NYSDOH. DOH staff will work with these programs to identify opportunities for their home visitors to provide educational information regarding lead, lead hazards, and screening for lead during these visits. Initially these efforts will focus on the areas in NYS at highest risk.

2) Staff performing home visits in appropriate programs will receive basic training on lead poisoning and visual lead hazard identification. Where feasible, staff will complete the HUD visual assessment on-line training program to increase knowledge and basic skills for identifying and categorizing potential lead hazards.

3) Where feasible, home visitation programs should incorporate a basic visual assessment of the conditions of the dwelling in home visits. Chipping or peeling paint, excessive dust, structural problems, or other visible potential lead hazards will be identified and categorized according to the HUD training program. Where feasible, home visiting staff should provide educational materials to residents, and make referrals for appropriate follow-up as needed.

4) NYSDOH will work with local communities to develop referral mechanisms to facilitate timely and coordinated communication, education, and more intensive follow-up as needed related to potential lead hazards identified. Referral mechanisms will be developed and implemented through a collaborative effort of home visiting staff, local health department childhood lead poisoning prevention programs, and local code enforcement. Mechanisms may be based on the current Healthy Neighborhoods Program, and may incorporate those programs where they exist.

Objective 2: To expand the Healthy Neighborhood Program to additional high-risk

target areas

Action Steps:

1) With funds from the state's Maternal Child Health Block Grant (MCHBG), funding to the DOH Healthy Neighborhood Program (HNP) will be increased to add programs in high-risk communities that are not currently served by HNP.

2) An evaluation of the HNP will be conducted to assess the number of dwellings that have been impacted by the program. Also assessed will be the number of homes where lead hazards are identified, as well as those who have been corrected during a follow up visit. Approximately 25% of all homes with lead hazards identified during the initial home visit will receive a follow up visit six months later to determine what efforts to control or eliminate the lead hazards were taken. In addition, the number of children who receive lead screening based on a HNP intervention will be assessed.

3) The program will work to identify other environmental lead sources that may impact target populations (such as playgrounds, urban dust, and bridges), and coordinate appropriate state and local agencies to address lead hazards that are identified.

Objective 3: To develop a lead hazard identification component for visual environmental inspection programs within other state agencies.

Action Steps:

1) DOH will meet with representatives of agencies represented on the Lead Poisoning Prevention Advisory Council to identify areas of training for other agency staff to visually assess potential lead based paint hazards. Currently, several of these agencies also have staff performing site visits to homes and other settings where children spend significant time, such as child care and foster care. The possibility of developing a program similar to that used by DOH (described above under Objective 1) will be explored. This integration of lead safety into other agencies programs would help broaden the impact of the primary prevention program.

2) DOH will work with representatives from other state agencies to form a workgroup to identify current state housing regulations that could be enforced to assure that housing is maintained in a lead-safe condition

3) DOH will work with other state agencies to establish a continuing education program. This program will provide continuing education to staff from programs that perform home visits, such as Code Enforcement Officials, Fire Investigators, Office of Children and Family Services child welfare investigators and Healthy Families New York home visiting program, as well as community based agencies that also perform home visitation. Currently, the HNP has a referral mechanism with these local agencies. This referral mechanism can be expanded to include other home visitation programs.

4) The DOH will work with other agencies to identify programs that currently exist, for example the Small Business Consulting Services, Welfare to Work programs, and specific trades training from the Department of Labor where an educational component regarding lead could be included.

5) DOH will include the regulations from all the agencies relating to housing on the DOH web site. In addition, information for individuals, contractors and local regulators will be included pertaining to how to comply with these regulations utilizing lead safe work practices.

6) The Interagency workgroup will focus on methods to increase enforcement of existing regulations, and to increase public education regarding the existence of these requirements. This increased enforcement will be emphasized on the DOH website for those who would be impacted for education and compliance assistance.

7) The Interagency workgroup will assess and strengthen mechanisms to ensure communication between agencies and programs when lead hazards are identified (for example, to notify child care licensing agency when a lead hazard is identified in a child care setting).

Objective 4: Disseminate updates on potential lead hazards to support prevention efforts

Action Steps:

1) Disseminate information from Consumer Product Safety Commission (CPSC), Food and Drug Administration (FDA), and other states and agencies regarding unusual sources of lead hazards, to support comprehensive environmental investigations by local health department/district office environmental staff.

Goal 2: Enhance community knowledge regarding the identification and selection of lead hazard control methods that are safe, effective, and feasible.

Objective: DOH will support and provide educational programs that address the relatively simple, low-cost tools and measures that can contribute significantly to lead based paint safety.

Action Steps:

1) Utilizing HUD's lead-safety rule for federally assisted housing as a model, require that local CLPP staff perform outreach and education to the community regarding these practices. The outreach would include educational pamphlets, information on educational programs, and in home education from the HNP staff, Lead Resource Centers and Childhood Lead Poisoning Prevention staff. Utilizing the "work safe, work clean, work smart" principle, educate people to understand lead based paint, the hazards of lead based paint and methods of lead-safe work practices to bring housing to a lead-safe status.

2) DOH, in cooperation with the local health departments, will participate and sponsor training sessions regarding lead, lead based paint hazards and lead-safe work practices. In addition, work with the local building, hardware and paint supply stores will be performed to assure that the stores staff are knowledgeable regarding lead based paint and lead-safe work practices. These training sessions for retail staff will also be effective at identifying "do-it-yourselfers" who may not live in targeted areas. With NYS having the highest number of housing units containing lead based paint in the nation, it is important that a variety of activities that result in the disturbance of lead-based paint be addressed and that workers be provided with education on performing the work in a lead-safe manner.

3) NYSDOH will utilize their relationships with the Local Health Departments to identify opportunities to provide outreach in the community. The local health departments will also help to provide access to landlord associations, tool loan programs, parent groups and community advocacy groups that can assist in gaining access to the community members.

Goal 3: Assure that homeowners, contractors, and other appropriate parties subject to Federal disclosure requirements are complying with these requirements.

Objective: To ensure that current federal requirements are followed.

Action Steps:

1) NYSDOH will work with Department of Health and Human Services (DHHS) Region II to convene a New York State meeting of state and federal partners, including CDC, EPA, HUD, ATSDR, and others to address coordination of efforts for childhood lead poisoning prevention.

2) Currently property owners and contractors are required to comply with the Federal Regulations regarding the disclosure of information under the Real Estate and Pre-Renovation Rules. To encourage compliance with these regulations, violators will be referred to the EPA Region 2 office for enforcement. In addition to these referrals, outreach to the community regarding compliance with these regulations will be performed.

3) The NYSDOH will work with the Office of Children and Family Services and Division of Housing and Community Renewal to assure that all NYS-

administered Section 8 housing is in compliance with the Lead-Based Paint in Federally Owned and Subsidized Housing rule, and to enhance the knowledge and skills needed by all Section 8 housing administrators to comply with the federal rule. This rule established primary prevention activities that are required in all housing subsidized by the federal government. Both of these agencies are represented on the Lead Poisoning Prevention Advisory Council.

Goal 4: Review and revise current DOH regulations and guidance for consistency with federal standards and guidelines.

Objective 1: To ensure that the DOH Regulations are consistent with federal requirements.

Action Steps:

1) Review Title 10 NYCRR Subpart 67-2 regarding changes for consistency with federal requirements.

2) Receive and review public comment regarding suggested changes to Subpart 67-2.

Objective 2: To ensure that all DOH Guidance Document to field staff are consistent with federal requirements.

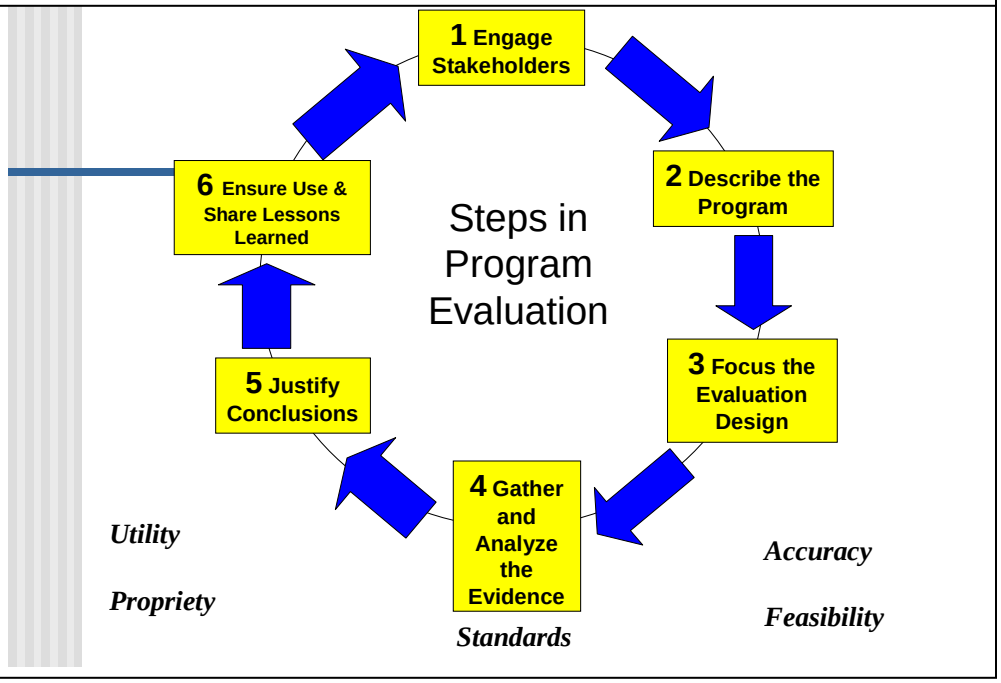
Action Steps:

1) Review the DOH Environmental Health Manual (EHM) Items for consistence with the Federal requirements and guidelines.
2) Re-emphasize to the local health departments the benefit of clearance testing for lead dust in dwellings after lead hazard control activities.
3) Provide training sessions to all local health department environmental lead staff regarding wipe samples for assessment of lead in dust. The training will include how, when, where and why to take dust samples, and how to interpret and apply dust sample results.
4) Revise the EHM items regarding lead dust testing after lead hazard control activities have been completed.

VI. Evaluation Plan:

The Department of Health will take a lead role in developing and implementing an evaluation of the lead elimination plan, beginning in the first year of plan implementation. Evaluation design will follow the six-step evaluation cycle of the CDC's Framework for Program Evaluation in Public Health illustrated in Figure 2.[41]

Figure 2. CDC Framework for Program Evaluation in Public Health



Consistent with the CDC framework, the evaluation plan will be based on a logic model for the elimination plan, presented in Appendix B. This logic model outlines the broad components of the elimination plan, including inputs, strategies, and expected short-, intermediate-, and long-term outcomes. Additional component-specific logic models (e.g., for the Healthy Neighborhoods Program expansion) will be developed to guide focused evaluation pieces, as described below.

Consistent with a Theory of Change approach, evaluation will incorporate both process and outcome components to assess progress toward fulfillment of the logic model. Initial efforts will focus on developing indicators and data sources for measuring inputs (e.g. stakeholder representation, adequacy of resources) and strategies (e.g. timely implementation of new initiatives, participation of providers, etc.). As plan components are implemented, focus will shift to measurement of short and intermediate term outcomes (e.g. changes in family knowledge/perceived benefits related to screening, timeliness of case management activities in target communities, demonstrated reduction of lead hazards in target communities, etc.). Finally blood lead levels (e.g. incidence and

prevalence of elevated blood lead levels statewide and within target communities) will be monitored at regular intervals to assess success in achieving desired health outcomes.

Data to support evaluation will be drawn from multiple sources. Surveillance data collected by the DOH Childhood Lead Poisoning Prevention Program will serve as an ongoing core information source, with anticipated data quality enhancements as outlined in the strategic work plan. The new Leadtrac system, when implemented, will be powerful tool for collecting and analyzing data from local health department lead programs. Additional data will be collected as needed from a variety of primary and secondary sources, including surveys, focus groups (e.g. for pre-testing of media materials), and program data, such as monitoring reports. DOH staff will work with various stakeholders, especially local health departments and grant recipients, to ensure coordination and consistency of data collection in support of evaluation.

Evaluation design will focus on measuring progress and accomplishments of specific plan components, as well as on overall coordination of elimination plan efforts and statewide outcomes attributable to the combined effect of multiple plan components. As outlined in the strategic work plan, specific components to be evaluated individually include:

- **Statewide Public Outreach Campaign** – to include focus testing of new materials (formative evaluation), and both process and short-term outcome measurement of parents' knowledge, attitudes, and behaviors related to lead poisoning prevention.

- **Healthy Neighborhoods Program** – to include process evaluation of reach (number of target communities served) and scope (incorporation of lead-specific outreach components), as well as measurement of selected relevant outcomes, including number of dwellings assessed, number of hazards identified, lead hazard reduction activities implemented, and changes in screening behaviors and results.

- **Community Coalitions** – to include initially quantitative and qualitative process evaluation of coalition formation, including engagement of local partners, activities carried out, and new financial and non-financial resources obtained through coalition activities.

Evaluation findings will be summarized and shared with stakeholders, including the Lead Advisory Council, on a regular basis. Findings will be utilized within the Department of Health to refine the elimination plan, and to improve program development and implementation.

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