

**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**

**State Designee Members**

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**Co-Chair**

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**Designee for Department of Environmental  
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Alicia Sullivan  
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Parent Representative  
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Juanita Hunter, Ed.D.  
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Public Health Nurse  
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**Public Members, continued**

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President  
EcoSpect, Inc.

William S. Schur  
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Schur Management Company, Ltd.

**Adjunct Members**

**Adjunct Designee for Insurance**

Bethney Lortie-Denno  
Special Assistant to the Superintendent  
NYS Insurance Department

**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  
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## 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<sup>1</sup>.

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

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<sup>1</sup> Canfield, R.L., Henderson, C.R., Cory-Slechta, 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**  
**FINAL**

Topics/Speaker	Discussion	Follow-Up
<b>Attendees</b>	<p> <b>Council Members:</b>            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.         </p> <p> <b>Excused Members:</b>            ➤ Thomas Ferrante, Manager of Training and Technical Services, Total Safety Consulting (Labor Union);            ➤ Tamara Henry-Kurtz, Executive Director, Syracuse Onondaga Drug and Alcohol Abuse         </p>	

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	<p>Commission (Local Government);</p> <ul style="list-style-type: none"> <li>➤ Philip Landrigan MD, MSc, DIH, Director, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital);</li> <li>➤ Ellen Migliore, RN, MS, Public Health Nurse Herkimer County Health Department (Child Health Advocate).</li> </ul> <p>Additional Attendees:</p> <ul style="list-style-type: none"> <li>➤ Rob Henry, Project Officer, Lead Poisoning Prevention Branch, Centers for Disease Control and Prevention</li> </ul> <p>Presenters:</p> <ul style="list-style-type: none"> <li>➤ Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health;</li> <li>➤ Barbara Leo, M.S., R.N., Childhood Lead Poisoning Prevention Program;</li> <li>➤ Deborah Nagin, M.P.H., Director &amp; Jacqueline Erlich, M.D., Medical Consultant, New York City Department of Health and Mental Hygiene;</li> <li>➤ Andrew McLellan, Environmental Education Associates;</li> <li>➤ Richard Svenson, Director, Division of Environmental Health Protection.</li> </ul>	
<p><b>Welcome and Introductions: Dr. Birkhead &amp; Mr. Tramontano</b></p>	<p>The meeting was convened at 9:45 am.</p> <ul style="list-style-type: none"> <li>➤ Dr. Birkhead opened the meeting and welcomed the members.</li> <li>➤ Dr. Birkhead reviewed the meeting agenda.</li> <li>➤ Council members and State Health Department representatives introduced themselves.</li> </ul>	
<p><b>Review of minutes</b></p>	<p>Draft minutes from the September 22, 2004 Advisory Council meeting were reviewed and approved by the Council, with two changes.</p> <ul style="list-style-type: none"> <li>➤ Ms. Antoine requested correction of a typographical error in her name.</li> <li>➤ Ms. Nagin requested correction of a typographical error.</li> </ul>	<p>Minutes were changed to reflect the corrections.</p>

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<p>Status of the elimination plan and next steps:  <b>Dr. de Long, with questions and discussion by the council.</b></p> <p>Status of the elimination plan and next steps:  <b>Dr. de Long, with questions and discussion by the council</b></p>	<p>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.)</p> <ul style="list-style-type: none"> <li>➤ Dr. Broadbent asked if initiatives are planned that focus on primary prevention. <ul style="list-style-type: none"> <li>▪ Dr. de Long reported that the Center for Environmental Health (CEH) would present on this topic in the afternoon session.</li> </ul> </li> <li>➤ 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. <ul style="list-style-type: none"> <li>▪ 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.</li> </ul> </li> <li>➤ 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.</li> <li>➤ Ms. Nagin reported that Dr. Erlich has reviewed capillary testing and continues to be concerned about the accuracy of this type of testing.</li> </ul>	

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	<ul style="list-style-type: none"> <li>▪ 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.</li> <li>➤ 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.</li> <li>➤ 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.</li> <li>➤ 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.</li> <li>➤ 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.</li> </ul>	
<b>Refugee Children: Ms. Leo, Public Health Program Nurse</b>	<p>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</p>	

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	<p>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.</p> <ul style="list-style-type: none"> <li>➤ Mr. Dorr inquired whether all counties were notified of this issue. <ul style="list-style-type: none"> <li>▪ 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.</li> </ul> </li> <li>➤ Dr. Birkhead questioned whether New York City (NYC) was involved. <ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ Ms. Nagin further 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.</li> </ul> </li> <li>➤ Dr. Morgan commented that the refugee resettlement agencies downstate might engage universities to assist with the challenge of specific language dialects.</li> <li>➤ 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.</li> </ul>	
<b>New York City Update: Lead Poisoning among Pregnant Women</b>	<ul style="list-style-type: none"> <li>➤ 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 <math>\geq</math> 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</li> </ul>	Ms. Nagin will provide materials to the Council for consideration of

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<p><b>in NYC: Ms. Nagin and Dr. Erlich</b></p>	<p>cognitive and developmental delays, low-birth weight and smaller head circumference. The NYCDOHMH convened an expert panel charged to:</p> <ul style="list-style-type: none"> <li>▪ Determine the appropriate LPPP intervention activities for pregnant women and other family members;</li> <li>▪ Identify the recommended testing for pregnant women;</li> <li>▪ 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.</li> </ul> <p>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.</p> <ul style="list-style-type: none"> <li>➤ Dr. Birkhead inquired about the anthropological context and need for provider education. <ul style="list-style-type: none"> <li>▪ 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.</li> </ul> </li> <li>➤ 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.</li> <li>➤ 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.</li> </ul>	<p>statewide implementation.</p>

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	<ul style="list-style-type: none"> <li>➤ Dr. Broadbent inquired when the guidance document on lead poisoning and pregnant women for health care providers would be released. <ul style="list-style-type: none"> <li>▪ Ms. Nagin responded that it is scheduled to be released by June 2005.</li> </ul> </li> <li>➤ Mr. Olin inquired about lead exposure risk during pregnancy posed from the release of any existing lead that might be stored in bones. <ul style="list-style-type: none"> <li>▪ Dr. Erlich responded that it does appear to be the number one problem in combination with nutritional status.</li> </ul> </li> <li>➤ 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. <ul style="list-style-type: none"> <li>▪ 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.</li> </ul> </li> <li>➤ Dr. Birkhead inquired about third trimester testing and whether women are being tested late. <ul style="list-style-type: none"> <li>• Ms. Nagin indicated these numbers likely relate to women receiving late prenatal care.</li> </ul> </li> </ul>	
<b>General Discussion</b>	<ul style="list-style-type: none"> <li>➤ 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.</li> <li>➤ 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.</li> </ul>	
<b>Lead Connections: A Successful</b>	<ul style="list-style-type: none"> <li>➤ 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</li> </ul>	

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<p><b>Primary Prevention Program in Western NY: Mr. McLellan</b></p>	<p>from the U.S. Housing and Urban Development (HUD) Office of Lead Hazard Control &amp; 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 (<a href="http://www.leadconnections.org">www.leadconnections.org</a>) 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.</p> <ul style="list-style-type: none"> <li>➤ Ms. Antoine requested clarification between the number of people receiving assistance and the number of units cleared. <ul style="list-style-type: none"> <li>▪ 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.</li> </ul> </li> <li>➤ 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. <ul style="list-style-type: none"> <li>• 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</li> </ul> </li> </ul>	

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	<p style="text-align: center;">exterior paint, as well as provide education regarding lead in soil.</p> <ul style="list-style-type: none"> <li>➤ 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. <ul style="list-style-type: none"> <li>▪ 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.</li> </ul> </li> <li>➤ Dr. Broadbent inquired about Mr. McLellan's statement regarding alternatives to incarceration. <ul style="list-style-type: none"> <li>▪ 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.</li> </ul> </li> <li>➤ Dr. Birkhead asked if Mr. McLellan was aware of the Rochester Coalition and if there are other organizations similar to Lead Connections. <ul style="list-style-type: none"> <li>▪ 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.</li> </ul> </li> <li>➤ Ms. Nagin inquired about the design of the lead safe housing registry and how it is updated/monitored. <ul style="list-style-type: none"> <li>▪ Mr. McLellan indicated the registry is still under development and is only available on their</li> </ul> </li> </ul>	

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	<p>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.</p> <ul style="list-style-type: none"> <li>➤ Mr. Henry questioned how optimum protection of residents is addressed during remediation and commended Lead Connections training of property owners. <ul style="list-style-type: none"> <li>▪ 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.</li> </ul> </li> </ul>	
<p><b>Elimination Plan Progress: CEH Update: Mr. Svenson</b></p>	<ul style="list-style-type: none"> <li>➤ 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.</li> </ul> <p>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.</p> <p>CEH has identified NYS Building Code Officials as potential local partners. Code enforcement</p>	

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	<p>officers will receive a three-hour training session, along with educational materials.</p> <p>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.</p> <p>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.</p> <p>CEH is in the process of revising DOH regulation Part 67-2 to conform to federal requirements.</p> <ul style="list-style-type: none"> <li>➤ Dr. Broadbent requested clarification on counties currently operating a Healthy Neighborhoods Program (HNP). <ul style="list-style-type: none"> <li>▪ Mr. Svenson reported that the following counties currently have a HNP: Niagara, Erie, Onondaga, Westchester, Oneida, Clinton, Rockland and New York City.</li> </ul> </li> <li>➤ Dr. Broadbent inquired if the state plan referenced by Mr. Svenson was distributed to the Advisory Council. <ul style="list-style-type: none"> <li>▪ 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.</li> </ul> </li> <li>➤ Dr. Broadbent requested clarification on practices regarding clearance testing. <ul style="list-style-type: none"> <li>▪ 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.</li> </ul> </li> </ul>	

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	<ul style="list-style-type: none"> <li>➤ Ms. Nagin requested clarification regarding the joint CDC/EPA letter. <ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ 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.</li> </ul> </li> <li>➤ 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.</li> <li>➤ Dr. Birkhead asked Mr. Svenson to elaborate on the NYSACHO workgroup convened to discuss the primary prevention role of local health departments. <ul style="list-style-type: none"> <li>▪ 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.</li> </ul> </li> <li>➤ Dr. Broadbent inquired if municipalities are hesitant to speak out due to liability issues.</li> </ul>	<p>NYSDOH will provide NYC DOH&amp;MH with the joint CDC/EPA letter.</p>

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<p><b>Update from other state agencies</b></p>	<ul style="list-style-type: none"> <li>▪ Mr. Svenson responded that court decisions have determined that municipalities are not liable.</li> </ul> <p><u>Division of Housing and Community Renewal (DHCR):</u>  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.</p> <p><u>Office of Children and Family Services (OCFS):</u>  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.</p> <p><u>Office of Temporary Disability Assistance (OTDA):</u>  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.</p> <p><u>Department of State (DOS):</u>  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.</p> <p><u>Department of Labor (DOL):</u>  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.</p> <p><u>Insurance Department:</u>  Ms. Lortie-Denno will be in contact with Mr. McLellan regarding working with the insurance industry.</p> <p><u>Department of Environmental Conservation (DEC):</u></p>	<p>A list of targeted zip codes will be provided to Council members.</p>

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	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.	
<b>Public Comments</b>	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.	
<b>Closing comments from Council members</b>	<p>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.</p> <p style="text-align: center;"><b>The meeting was adjourned at 2:20 p.m.</b></p>	A list of Advisory Council Members will be distributed. Options for next meeting date will be explored.

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<b>Attendees</b>	<p>Council Members:</p> <ul style="list-style-type: none"> <li>➤ Ronald Tramontano, Director, Center for Environmental Health-Council Co-Chair</li> <li>➤ 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</li> <li>➤ Rolaine Antoine (Parent)</li> <li>➤ Mary Binder, Environmental Analyst, Division of Housing and Community Renewal</li> <li>➤ David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group)</li> <li>➤ William Dorr, Assistant Director, Bureau of Early Childhood Services, NYS Office of Children and Family Services</li> <li>➤ Abby Greenberg, M.D., Director of Disease Control, Nassau County Department of Health (Local Government &amp; American Academy of Pediatrics-District II)</li> <li>➤ Philip Landrigan, M.D., MSc, DIH, Director, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital)</li> <li>➤ Ellen Migliore, R.N., MS, Public Health Nurse Herkimer County Health Department (Child Health Advocate)</li> <li>➤ Tom Mahar, Code Compliance Specialist II, NYS Department of State</li> <li>➤ Clifford Olin, President, EcoSpect, Inc. (Industry)</li> <li>➤ Robert Perez, Principal Industrial Hygienist, NYS Department of Labor</li> <li>➤ Alicia Sullivan, Assistant Counsel, NYS Office of Temporary and Disability Assistance</li> </ul> <p>Additional Attendees:</p> <ul style="list-style-type: none"> <li>➤ Bruce Phillips, Counsel, NYS Department of Health</li> <li>➤ Barbara McTague, Director, Division of Family Health</li> <li>➤ Michael Cambridge, Director, Bureau of Community Environmental Health and Food Protection</li> <li>➤ Eileen Franko, Dr.P.H., M.P.H., Director, Bureau of Occupational Health</li> <li>➤ Richard Svenson, Director, Division of Environmental Health Protection</li> <li>➤ Ellen J. Anderson, MS, Executive Deputy Director, Center for Community Health</li> </ul>	



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<p><b>Center for Community Health Update</b></p>	<p>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.</p> <p>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. <i>(See handouts distributed at the meeting).</i></p> <ul style="list-style-type: none"> <li>➤ Screening identifies children exposed to lead. Children with low to moderate results are typically not readily identified without blood lead screening.</li> <li>➤ 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.</li> <li>➤ Next step will be to work with the academies, societies and other partners to develop a tool kit for providers.</li> <li>➤ Council members offered suggestions and provided comments on this initiative. <ul style="list-style-type: none"> <li>• Risk assessment questionnaire should have two columns for “yes” and “no” responses.</li> <li>• In the letter, bold on first bullet “all children” and the word, “and”.</li> <li>• Engage insurers as partners in screening promotion activities</li> <li>• Explore strategies to support blood drawing in provider offices to improve screening</li> </ul> </li> </ul> <p>Dr. de Long presented an update on implementation of elimination plan focus area two, targeting high-risk populations to reduce disparities. <i>(See handouts distributed at meeting).</i></p>	<ul style="list-style-type: none"> <li>• Suggested changes were incorporated into the letter.</li> <li>• Managed care plans were added to the distribution list, in coordination with Office of Managed Care.</li> <li>• Discussion of office-based testing methods will be planned for a future Council meeting</li> </ul>

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	<ul style="list-style-type: none"> <li>➤ 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.</li> <li>➤ 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.</li> <li>➤ The intent is to learn from these projects and share information with other coalitions.</li> <li>➤ 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. <ul style="list-style-type: none"> <li>• 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.</li> </ul> </li> </ul>	
<b>Center for Environmental Health Updates</b>	<p>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. <i>(See handouts distributed at meeting).</i></p> <ul style="list-style-type: none"> <li>➤ 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.</li> <li>➤ 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.</li> </ul>	

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	<ul style="list-style-type: none"> <li>➤ 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.</li> <li>➤ 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.</li> <li>➤ 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.</li> <li>➤ 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.</li> </ul> <p>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. (<i>See handouts distributed at the meeting</i>).</p> <ul style="list-style-type: none"> <li>➤ 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.</li> <li>➤ 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” &amp;</li> </ul>	

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	<p>‘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.</p> <ul style="list-style-type: none"> <li>➤ 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.</li> <li>➤ 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.’</li> <li>➤ 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.</li> <li>➤ 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. <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul> </li> </ul>	

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	<ul style="list-style-type: none"> <li>➤ 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. <ul style="list-style-type: none"> <li>• 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.</li> </ul> </li> <li>➤ 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. <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul> </li> </ul>	
<b>Recognition and Assessment of Non-Paint Lead Hazard</b>	<p>Dr. Vincent Coluccio, Dr.P.H., Senior Consultant, TRC Environmental, provided an overview of non-lead paint hazards (<i>See handouts distributed at the meeting</i>).</p> <ul style="list-style-type: none"> <li>➤ 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.</li> <li>➤ Dr. Coluccio emphasized two major sources of non-paint exposure: immigrants’ pre-existing body lead burden and foreign products brought into US.</li> <li>➤ 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</li> </ul>	

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	<p>expose children. Lack of child labor laws also contributes to widespread exposure. He estimated that 75% of immigrants are from countries with lead problems</p> <ul style="list-style-type: none"> <li>➤ Other non-paint sources of lead include Mexican chilies that are not cleaned before shipment, <i>chapulines</i> (grasshoppers), which are considered a delicacy and promoted as a protein source, and <i>Sindoor</i>, a lead-containing cosmetic. He noted it may be challenging to address such concerns in the context of cultural beliefs.</li> <li>➤ Council members raised several discussion items in response to the presentation: <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> </ul> </li> </ul>	
<p><b>Local Enforcement Initiative in Connecticut</b></p>	<p>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. <i>(See handouts distributed at the meeting).</i></p> <ul style="list-style-type: none"> <li>➤ 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.</li> <li>➤ Gene Burch noted that LRAWG was formed to hear from people in the field including private sector companies, federal and state OSHA, Department of Environmental Protection, Department of Public Works, economic and community development, environmental health associations, and Connecticut Department of Transportation. <ul style="list-style-type: none"> <li>• 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</li> </ul> </li> </ul>	

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	<p>local regulations.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>➤ 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).</li> <li>➤ 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.</li> <li>➤ 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.</li> <li>➤ 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.</li> </ul>	

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	<ul style="list-style-type: none"> <li>• 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.</li> <li>➤ Mr. Tramontano requested further detail about the process of ‘identifying and declaring an area of nuisance (or high risk) in Connecticut.</li> <li>• 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.</li> </ul>	
<b>Updates from Council members</b>	<p><u>Office of Children and Family Services (OCFS):</u>  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.</p> <p><u>Office of Temporary Disability Assistance (OTDA):</u>  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.</p> <ul style="list-style-type: none"> <li>➤ Dr. Broadbent commented that OTDA can play an important role due to its work with a high-risk population.</li> </ul>	

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	<ul style="list-style-type: none"> <li>➤ 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.</li> <li>➤ 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.</li> </ul> <p><u>Division of Housing and Community Renewal (DHCR):</u>  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.</p> <p><u>Department of State (DOS):</u> The update on code enforcement training provided earlier by Dr. Franko was referenced.</p> <p><u>Department of Labor (DOL):</u> 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</p>	

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	<p>disseminate information such as lead-safe work practice training.</p> <p><u>Parent Representative:</u> 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.</p> <p><u>Hospital Representative:</u> 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.</p> <p><u>Community Group:</u> 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.</p>	

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<p><b>Public Comments</b></p>	<p>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.</p> <p>Ms. Johnson relayed the following observations and questions.</p> <ul style="list-style-type: none"> <li>➤ 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.</li> <li>➤ Training community members in order to create a skilled workforce in those neighborhoods will contribute to eliminating lead poisoning.</li> <li>➤ The State should look at opportunities to leverage ideas, maximizing resources to engage community as drivers of the programs to end lead poisoning.</li> <li>➤ 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.</li> <li>➤ Ms. Johnson inquired about how lead testing can be incorporated in Women’s Infants and Children’s (WIC) program.</li> </ul> <p>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.</p>	<p>Department staff will continue to explore collaboration between lead and WIC program.</p>
<p><b>Closing Comments</b></p>	<ul style="list-style-type: none"> <li>➤ Dr. Broadbent inquired about exchanging contact information between Council members to facilitate communication. <ul style="list-style-type: none"> <li>• Dr. de Long agreed to send an email to members to ascertain their individual preferences for</li> </ul> </li> </ul>	<p>Lead program to follow up with Council members</p>

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	<p style="text-align: center;">sharing information and will provide information at the next meeting.</p> <p>➤ Dr. de Long noted the next Council meeting will take place on October 20, 2005. Agendas and information will be forthcoming.</p> <p style="text-align: center;"><b>The meeting was adjourned at 1:45 p.m.</b></p>	<p>about acceptability of sharing information</p>

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<b>Attendees</b>	<p>Council Members:</p> <ul style="list-style-type: none"> <li>➤ Ronald Tramontano, Director, Center for Environmental Health-Council Co-Chair</li> <li>➤ Guthrie Birkhead, M.D., M.P.H., Director, Center for Community Health-Council Co-Chair</li> <li>➤ Rolaine Antoine (Parent)</li> <li>➤ Mary Binder, Environmental Analyst, Division of Housing and Community Renewal</li> <li>➤ David Broadbent, M.D., M.P.H., Co-Chair, Coalition to End Lead Poisoning in NYS (Community Group)</li> <li>➤ William S. Schur, Vice President of Schur Management Company, Ltd., (Real Estate)</li> <li>➤ Juanita Hunter, Ed.D., Professor Emeritus, School of Nursing, SUNY-Buffalo (Professional Medical Nursing Organization)</li> <li>➤ Lindsay Lake Morgan, R.N., Ph.D., A.N.P., Assistant Professor, Decker School of Nursing, SUNY Binghamton (Educator)</li> <li>➤ Bethney Lortie-Denno, Special Assistant to the Superintendent, NYS Insurance Department</li> <li>➤ William Dorr, Assistant Director, Bureau of Early Childhood Services, NYS Office of Children and Family Services</li> <li>➤ Abby Greenberg, M.D., Director of Disease Control, Nassau County Department of Health (Local Government &amp; American Academy of Pediatrics-District II)</li> <li>➤ Ellen Migliore, R.N., M.S., Public Health Nurse Herkimer County Health Department (Child Health Advocate)</li> <li>➤ Tom Mahar, Code Compliance Specialist II, NYS Department of State</li> <li>➤ Clifford Olin, President, EcoSpect, Inc. (Industry)</li> <li>➤ Robert Perez, Principal Industrial Hygienist, NYS Department of Labor</li> <li>➤ Kerry Delaney for Alicia Sullivan, Assistant Counsel, NYS Office of Temporary and Disability Assistance</li> </ul> <p>Additional Attendees:</p> <ul style="list-style-type: none"> <li>➤ Bruce Phillips, Counsel, NYS Department of Health</li> <li>➤ Barbara McTague, Director, Division of Family Health</li> </ul>	

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<p><b>Absent</b></p> <p><b>Presenters</b></p>	<ul style="list-style-type: none"> <li>➤ Michael Cambridge, Director, Bureau of Community Environmental Health and Food Protection</li> <li>➤ Eileen Franko, Dr.P.H., M.P.H., Director, Bureau of Occupational Health</li> <li>➤ Richard Svenson, Director, Division of Environmental Health Protection</li> <li>➤ Rachel de Long, M.D., M.P.H., Director, Bureau of Child and Adolescent Health</li>   <li>➤ Carl Johnson, Deputy Commissioner, NYS Dept. of Environmental Conservation</li> <li>➤ Philip Landrigan, M.D., M.Sc., D.I.H., Director, Division of Environmental and Occupational Medicine, Mount Sinai Medical Center (Hospital)</li> <li>➤ Thomas Ferrante, Manager of Training and Technical Services, Total Safety Consulting (Labor Union)</li> <li>➤ Deborah Nagin, Director, New York City Department of Health &amp; Mental Hygiene- Lead Poisoning Prevention Program</li>   <li>➤ Hulda Martinez, Westchester County Department of Health, Coordinator- Healthy Neighborhoods Program</li> </ul>	
<p><b>Welcome and Introductions: Dr. Birkhead &amp; Mr. Tramontano</b></p>	<p>The meeting was convened at 10:15 am.</p> <ul style="list-style-type: none"> <li>➤ Dr. Birkhead opened the meeting and welcomed the members.</li> <li>➤ Dr. Birkhead initiated a roll call of the members and reviewed the meeting agenda.</li> </ul>	
<p><b>Review of minutes</b></p>	<p>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.</p>	
<p><b>Center for Community Health (CCH) Update</b></p>	<p>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.</p>	<p>The Lead program will follow-up with the Immunization Program regarding lead updates at their</p>

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	<p>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.</p> <p>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.</p> <p>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. (<i>See handouts distributed at the meeting</i>). Major issues addressed:</p> <ul style="list-style-type: none"> <li>• advantages and disadvantages;</li> <li>• cost implications;</li> <li>• scientific evidence; and</li> <li>• New York State statewide capillary screening practices.</li> </ul> <p>Council members comments included:</p> <ul style="list-style-type: none"> <li>• regulatory requirements for BLL confirmation;</li> <li>• potential for lead contamination of capillary samples at the time of sample collection;</li> <li>• lack of insurance payment for in-office collection;</li> <li>• cost of collection/supplies/technicians time;</li> <li>• training needed for effective specimen collection;</li> <li>• evidence of adverse effects of low blood lead levels increasing physician interest in universal screening;</li> <li>• concerns about not doing environmental inspections for the homes of children with EBLL less</li> </ul>	<p>annual meetings.</p>

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	<p>than 20 ug/dL; and</p> <ul style="list-style-type: none"> <li>• elimination of barriers, including transportation to lab for parent/child, time required to go to second site for blood drawing; and</li> <li>• identification of additional locations for testing (day care, etc).</li> </ul>	
<p><b>Center for Environmental Health (CEH) Update</b></p>	<p>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:</p> <ul style="list-style-type: none"> <li>• OCFS regarding daycare inspections;</li> <li>• OTDA regarding lead paint inspections in homeless shelters;</li> <li>• DHCR to assist with community targeting for housing rehabilitation programs and lead paint hazard outreach;</li> <li>• EPA regarding real estate disclosure enforcement; and</li> <li>• HUD regarding Safe and Healthy Homes initiative.</li> </ul> <p><i>(See handouts distributed at the meeting).</i> 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.</p> <p>Council members comments included:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• CEH had requested comments related to regulatory revisions by 9/1/05. Council members requested, and received, additional time to comment.</li> <li>• Geographic targeting of zip codes vs. targeting by other demographic factors.</li> </ul> <p>Dr. Franko presented the update from Bureau of Occupational Health. (Refer to Bureau of Occupational Health handout.) Topics included:</p>	

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	<ul style="list-style-type: none"> <li>• Code Enforcement Training held in September on paint maintenance standards. This course has been advertised by the Department of State.</li> <li>• Planned presentation at an upcoming EPA meeting on pre-renovation activities.</li> <li>• 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.</li> </ul> <p>Work continues with several state agencies:</p> <ul style="list-style-type: none"> <li>• DOT regarding contractors and lead exposure, and the heavy metals registry.</li> <li>• 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.</li> </ul> <p>Council members comments included:</p> <ul style="list-style-type: none"> <li>• OSHA requirements for occupational exposure compliance and non-compliance; and</li> <li>• contact union and trade worker agencies and get training on lead in contracts.</li> </ul>	
<b>New York City Update</b>	Deborah Nagin absent, no update given.	
<b>Westchester County Healthy Neighborhoods Program</b>	<p>Tom Carroll introduced Hulda Martinez, Coordinator, Healthy Neighborhoods Program, Westchester County Department of Health. <i>(See handouts distributed at the meeting)</i>. 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.</p> <p>Council comments included:</p> <ul style="list-style-type: none"> <li>• selection of housing units for visiting;</li> </ul>	

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	<ul style="list-style-type: none"> <li>• confidentiality;</li> <li>• outcome measures; and</li> <li>• implications of population mobility for follow-up.</li> </ul>	
<b>Updates from Council members</b>	<p><u>Division of Housing and Community Renewal (DHCR):</u>  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.</p> <p><u>Department of Insurance (DOI):</u>  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.</p> <p><u>Office of Temporary Disability Assistance (OTDA):</u>  Kerry Delaney, OTDA - working with DOH on providing information on lead hazards and lead screening for the homeless population.</p> <p><u>Department of State (DOS):</u>  Tom Mahar, DOS - educational conferences for code inspectors are planned statewide as reported above by Dr. Franko.</p> <p><u>Department of Labor (DOL):</u>  Robert Perez, DOL - working with CEH as reported above by Dr. Franko.</p> <p>Dr. Greenberg- AAP Policy Statement on Lead has been released, requested copies be sent to Council members.</p>	<p>Ms. Lortie-Denno will provide additional information on certification.</p> <p>AAP Policy Statement to be sent to Council members.</p>

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	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.	
<b>Public Comments</b>	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.	
<b>Closing Comments</b>	<p>Dates will be set for the 2006 Council meetings.</p> <p style="text-align: center;"><b>The meeting was adjourned at 1:45 p.m.</b></p>	

# **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**

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## **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.<sup>1</sup> 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.<sup>2,3</sup>

<b>Year</b>	<b>Level of Concern</b>
1960	60 mcg/dL
1970	40 mcg/dL
1975	35 mcg/dL
1985	25 mcg/dL
1991	10 mcg/dL
2004	<i>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</i>

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%.<sup>3</sup> 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.<sup>1</sup> 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.<sup>4</sup> 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.<sup>3</sup> 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.<sup>5</sup>

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:*<sup>2</sup>

#### 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.

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<sup>2</sup> 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.<sup>3</sup> 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.

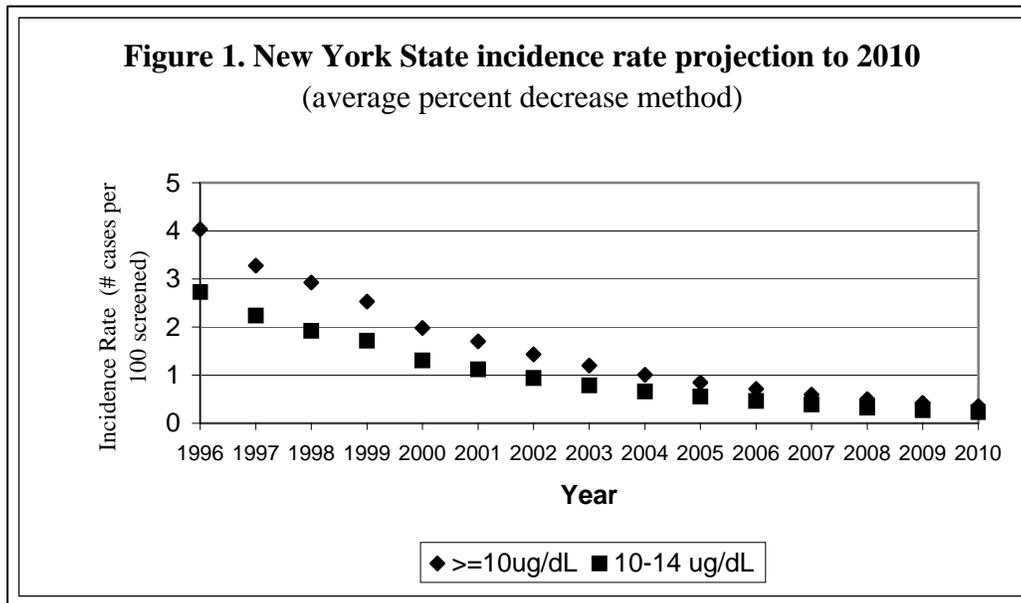
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<sup>3</sup> Zip codes were selected because they are more universally understood than other measures, such as census tracts. Most children in the database had only one street address associated with their record. In cases with multiple addresses, 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**.



<b>Table 2. Projected numbers of children less than six years old with elevated blood lead levels by level and county incidence type, 2010.</b>				
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 75 <sup>th</sup> percentile; Low IR Counties = Counties with incidence rates at or below 25 <sup>th</sup> percentile; Moderate IR Counties = Counties with incidence rates between 26 <sup>th</sup> and 74 <sup>th</sup> 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.<sup>3</sup> 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.<sup>1,3</sup> 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.<sup>6</sup> 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.<sup>2</sup>

#### 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.<sup>1</sup> 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.<sup>7</sup>

#### 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.<sup>1</sup> Multiple studies have demonstrated household lead dust as the major source of lead exposure for young children.<sup>8</sup> 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.<sup>9</sup>

#### 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.<sup>4,10</sup> However, there is currently no solid evidence that supplementation with calcium or iron prevents elevated blood lead levels in children.<sup>3</sup>

#### 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.<sup>11-13</sup>

### 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.<sup>7</sup> 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.<sup>14</sup> 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.<sup>1,3</sup> 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.<sup>3,7</sup> 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.<sup>1,7</sup>

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.<sup>3,7,15-18</sup> 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.<sup>16</sup> This finding is consistent across a range of study populations, and holds when important social and demographic co-variables 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.<sup>7,16,19,20</sup> 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.<sup>20</sup> 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”.<sup>7,21</sup> 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.<sup>21</sup> 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.<sup>1</sup>

Equally important, average declines in IQ mask the susceptibility or resilience of individual children, which is likely to be quite variable.<sup>7</sup> 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.<sup>7,22</sup>

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 3<sup>rd</sup> 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.

States	% pre-1950 Housing	% Built pre-1950 <b>Renter</b> Occupied Housing
California	18.1	22.5
Texas	10.8	9.7
<b>New York</b>	<b>43.1</b>	<b>47.5</b>
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.<sup>1</sup> 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.<sup>1,3,23-25</sup> 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.<sup>26,27</sup> 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.<sup>3,28,32</sup>

### ***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.<sup>29-31</sup> 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.<sup>29,32-36</sup> 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.<sup>37-40</sup>

## **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.

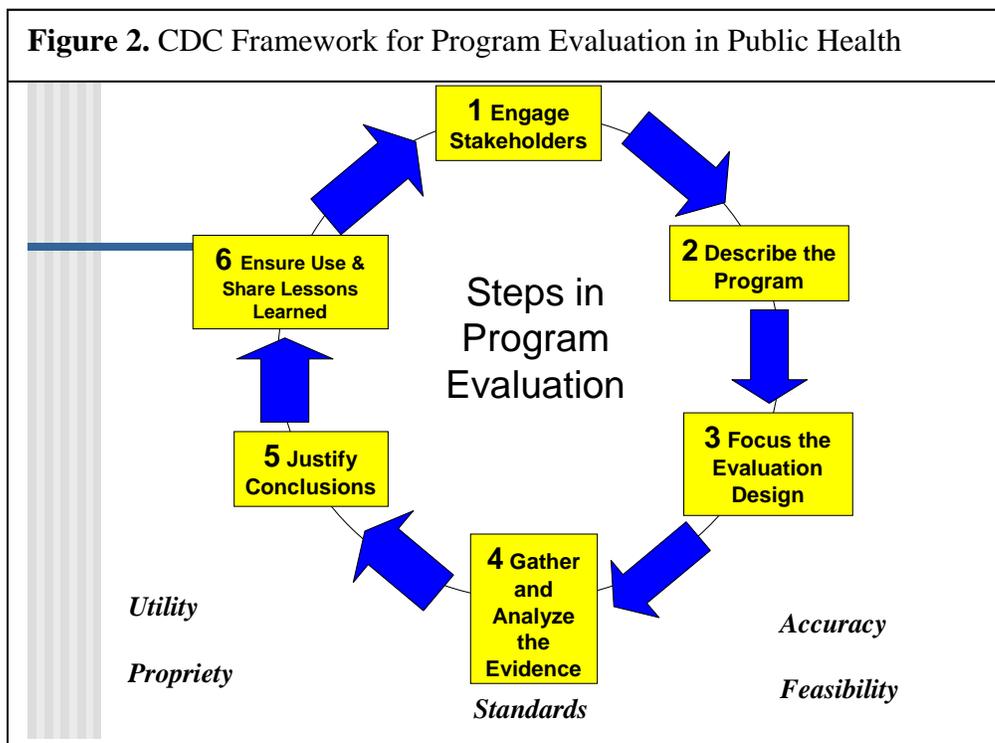
**Objective 2:** To ensure that all DOH Guidance Document to field staff are consistent with federal requirements.

**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.<sup>41</sup>



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.

## VII. References

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