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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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