New York State Department of Health

Advisory Council on Lead Poisoning Prevention

Report for
January 1, 2006 – June 30, 2008

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

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INTRODUCTION

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

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

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

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

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

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

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

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

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

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

NEW YORK STATE ADVISORY COUNCIL ON LEAD POISONING PREVENTION

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

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

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

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

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

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

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

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

LEAD POISONING IN NEW YORK STATE: PROGRESS TOWARD ELIMINATION

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

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

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

Progress in Testing Young Children for Lead Poisoning

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

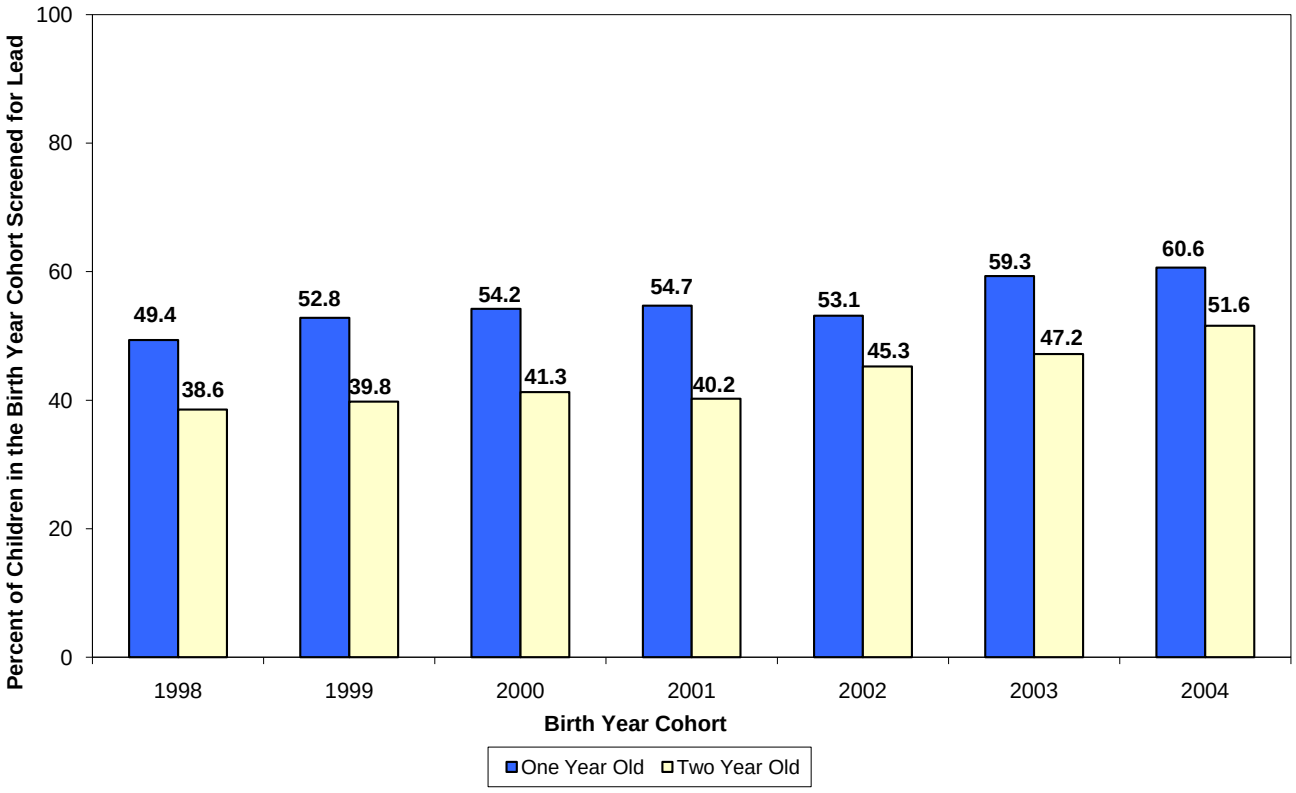
Blood lead testing rates are described for groups of children born in a given year (i.e., birth cohorts) because this is the most accurate way to estimate the number of children in a given age group who require blood lead screening tests. Testing rates for a group of children born in one and two for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

Data Highlights

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

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

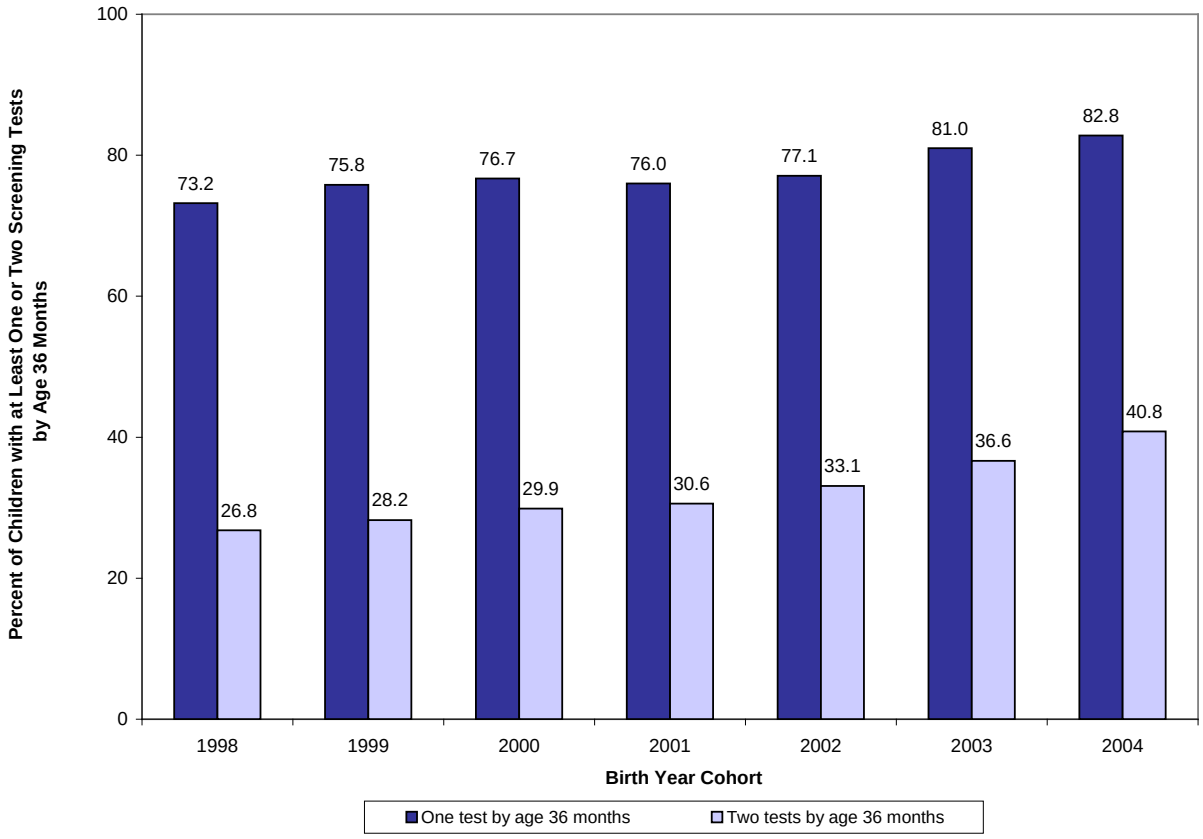
Figure 1: Percent of Children Tested for Lead at or Around Age 1 and at or Around Age 2; 1998 - 2004 Birth Cohorts (1998 to 2007 Blood Lead Test Data)[1,2]
New York State Excluding New York City



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

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

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



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

Progress in Reducing the Incidence of Childhood Lead Poisoning

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

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

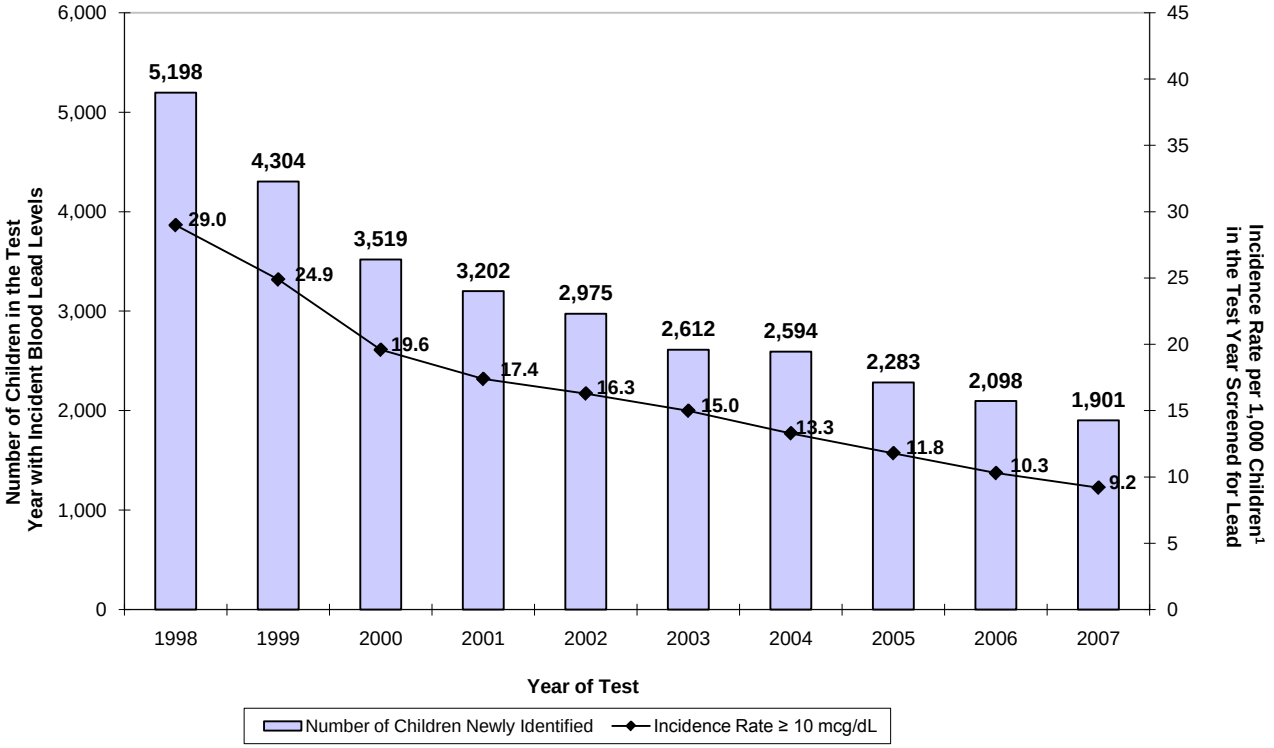
Children with EBLLs receive follow-up services to minimize the adverse effects of lead and to reduce further exposure to lead in their environments. Health care providers, families, and local health departments (LHDs) work together to assure that children with EBLLs receive these services. The specific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

Data Highlights

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

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

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



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

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

Children with Blood Lead Levels Below 10 mcg/dL

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

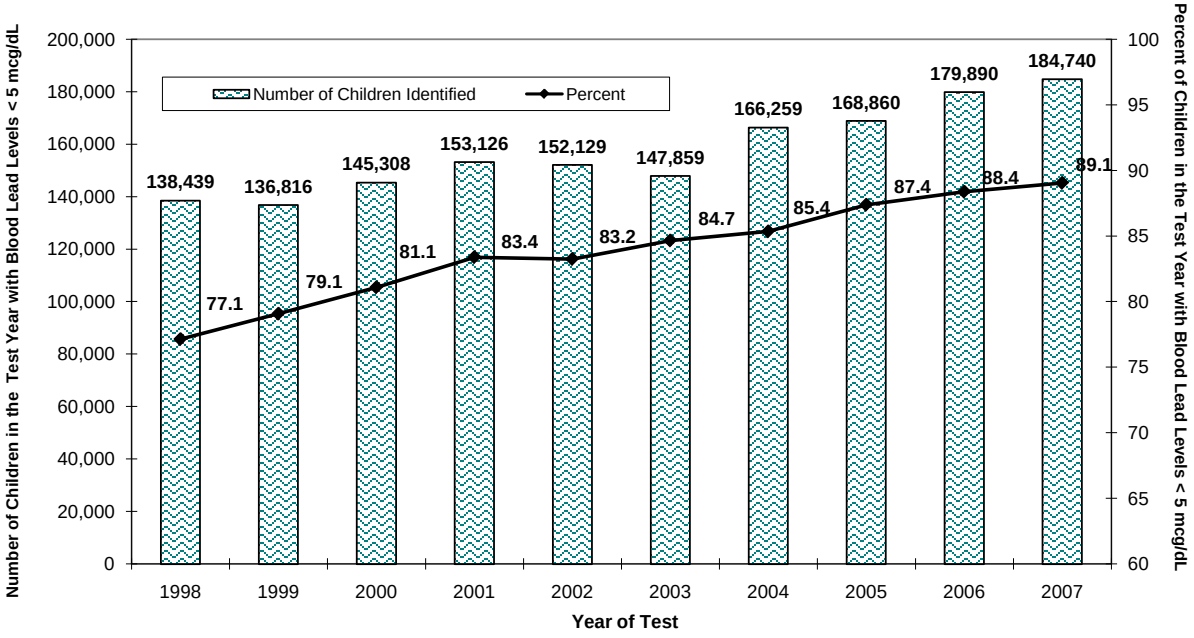
Under current NYS Public Health Law and implementing regulations, as well as national CDC guidelines, all parents should be provided with anticipatory guidance on the major causes of lead poisoning and means for preventing lead exposure as part of routine health care, with consideration of

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

Data Highlights

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

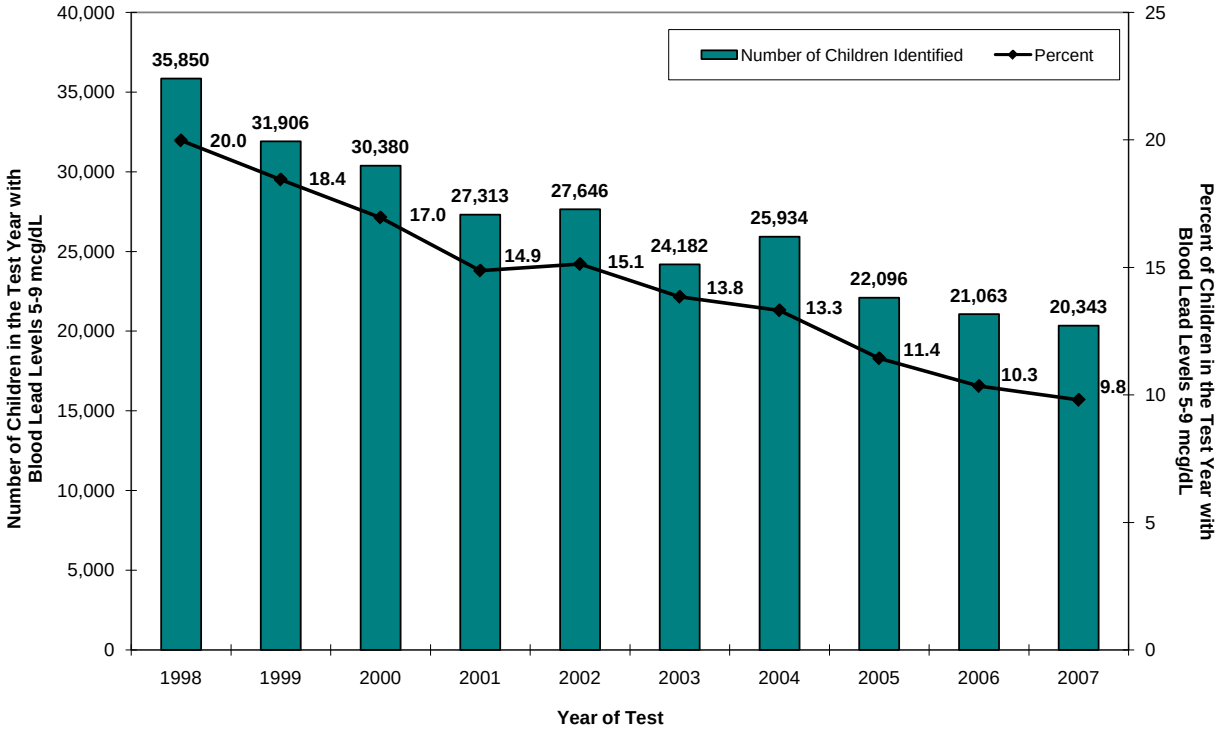
Figure 4: Number and Percent of Children Under Age 6 with Blood Lead Levels below 5 mcg/dL;[1] 1998 to 2007 Blood Lead Test Data, New York State Excluding New York City



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

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

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



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

KEY ACCOMPLISHMENTS AND STRATEGIES FOR CONTINUED SUCCESS

A Continued Commitment to the Elimination of Childhood Lead Poisoning

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

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

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

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

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

Achieving Elimination: Progress and Priorities for the Future

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix A

Abbreviations

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

Appendix B

2006 Advisory Council Meeting Minutes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix C

2007 Advisory Council Meeting Minutes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Topics/Speaker	Discussion	Follow Up

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

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

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

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

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

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

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

Appendix D

2008 Advisory Council Meeting Minutes

March 6, 2008
June 19, 2008

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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