New York State Department of Health

Advisory Council on Lead Poisoning Prevention

Report for
July 1, 2008 – December 31, 2008

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

David A. Paterson
Governor

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

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

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

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INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

NEW YORK STATE ADVISORY COUNCIL
ON LEAD POISONING PREVENTION

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

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

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

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

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

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

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

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

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

LEAD POISONING IN NEW YORK STATE: PROGRESS TOWARD ELIMINATION

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

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

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

Progress in Testing Young Children for Lead Poisoning

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

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

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

Data Highlights

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

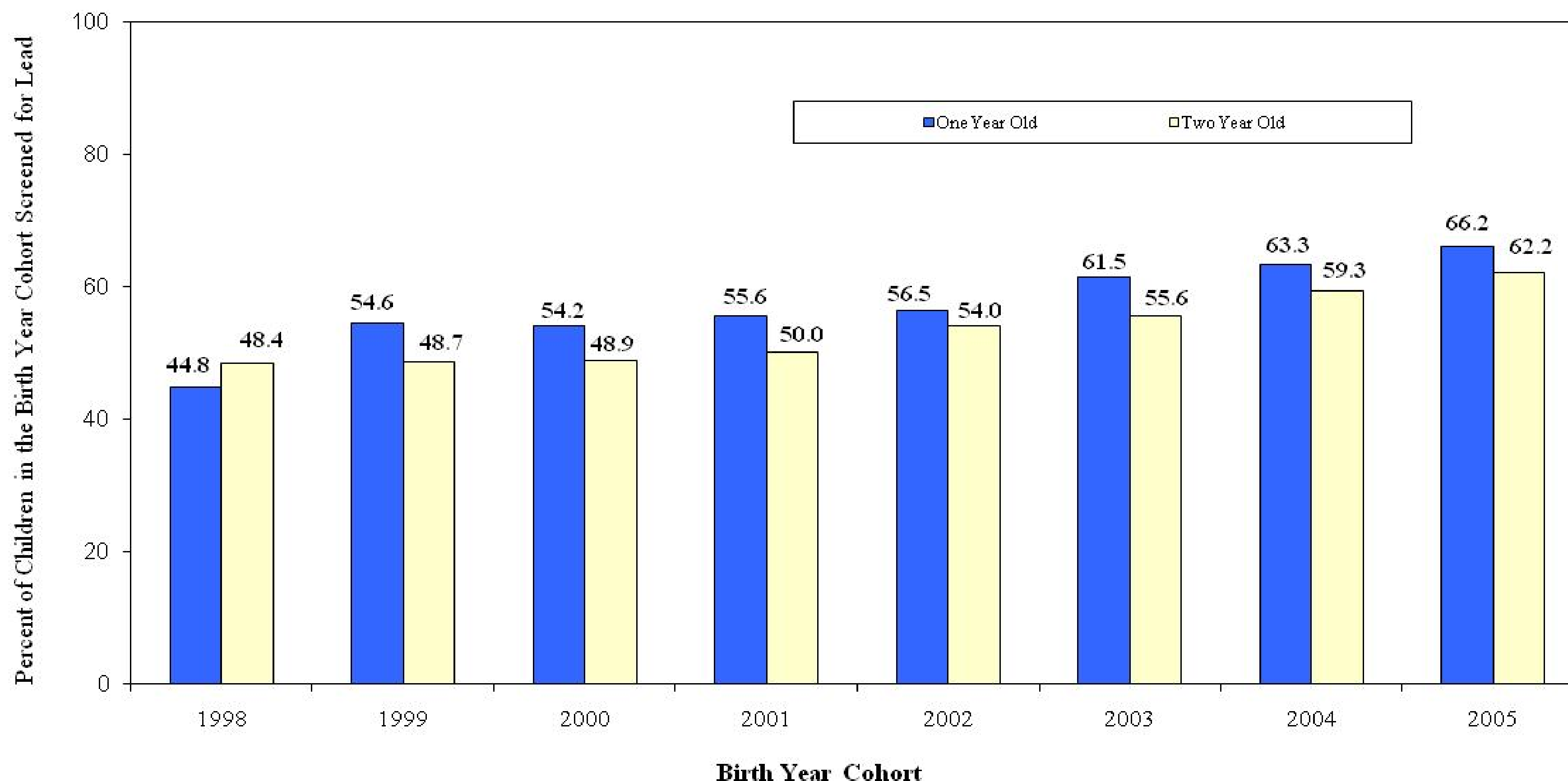
- **Lead testing rates for children at or around age two are also improving.** Preliminary analysis of lead testing data through 2008 demonstrate that in NYS (including NYC), blood lead testing rates for children at or around age two have increased by 29 percent over the last eight years. Sixty-two percent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

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

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

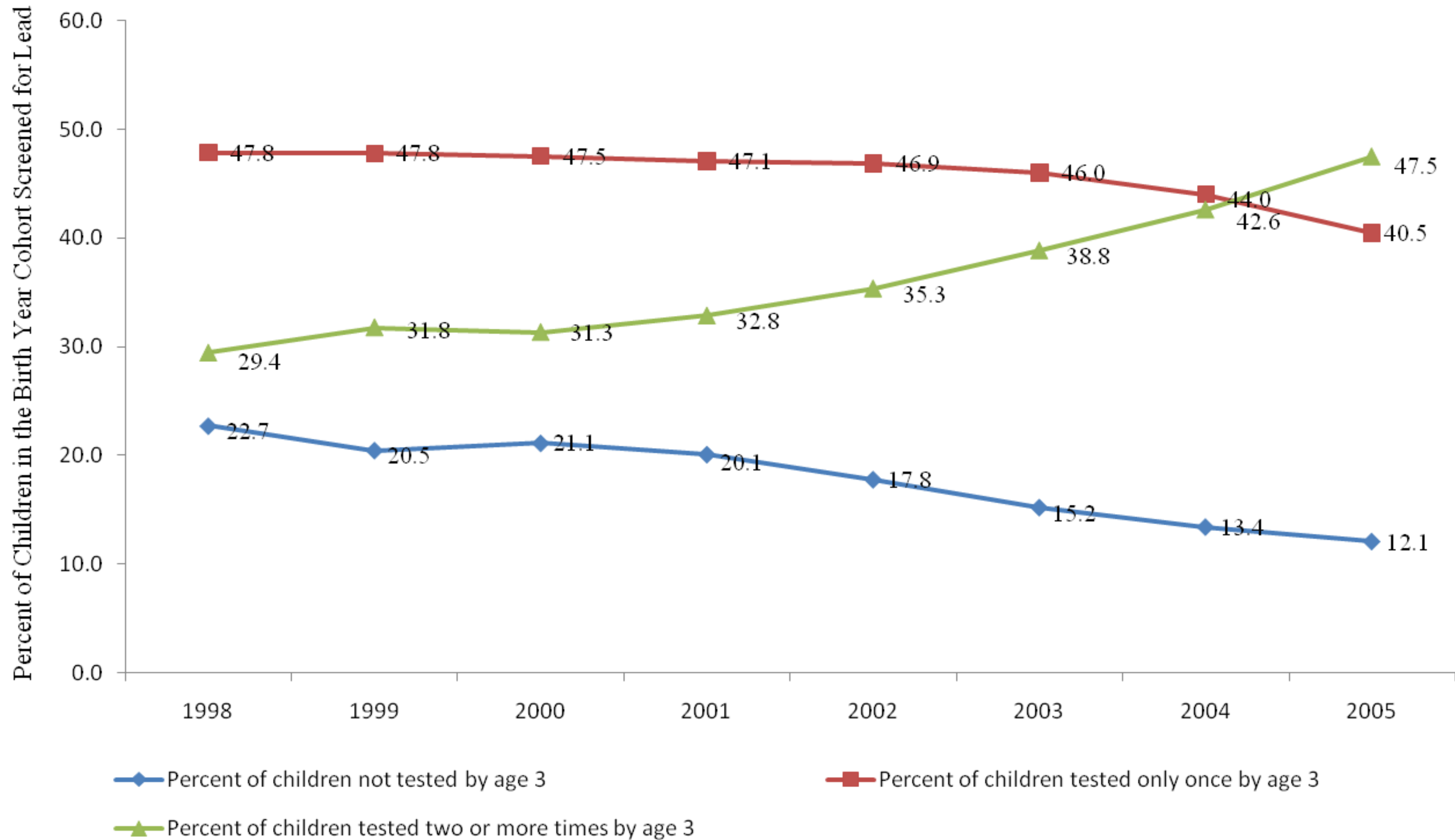
Figure 1: Percent of Children Tested for Lead At or Around Age One Year and At or Around Age Two Years[1]

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



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

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



Preliminary data – do not cite or publish as final

Progress in Reducing the Incidence of Childhood Lead Poisoning

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

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

Data Highlights

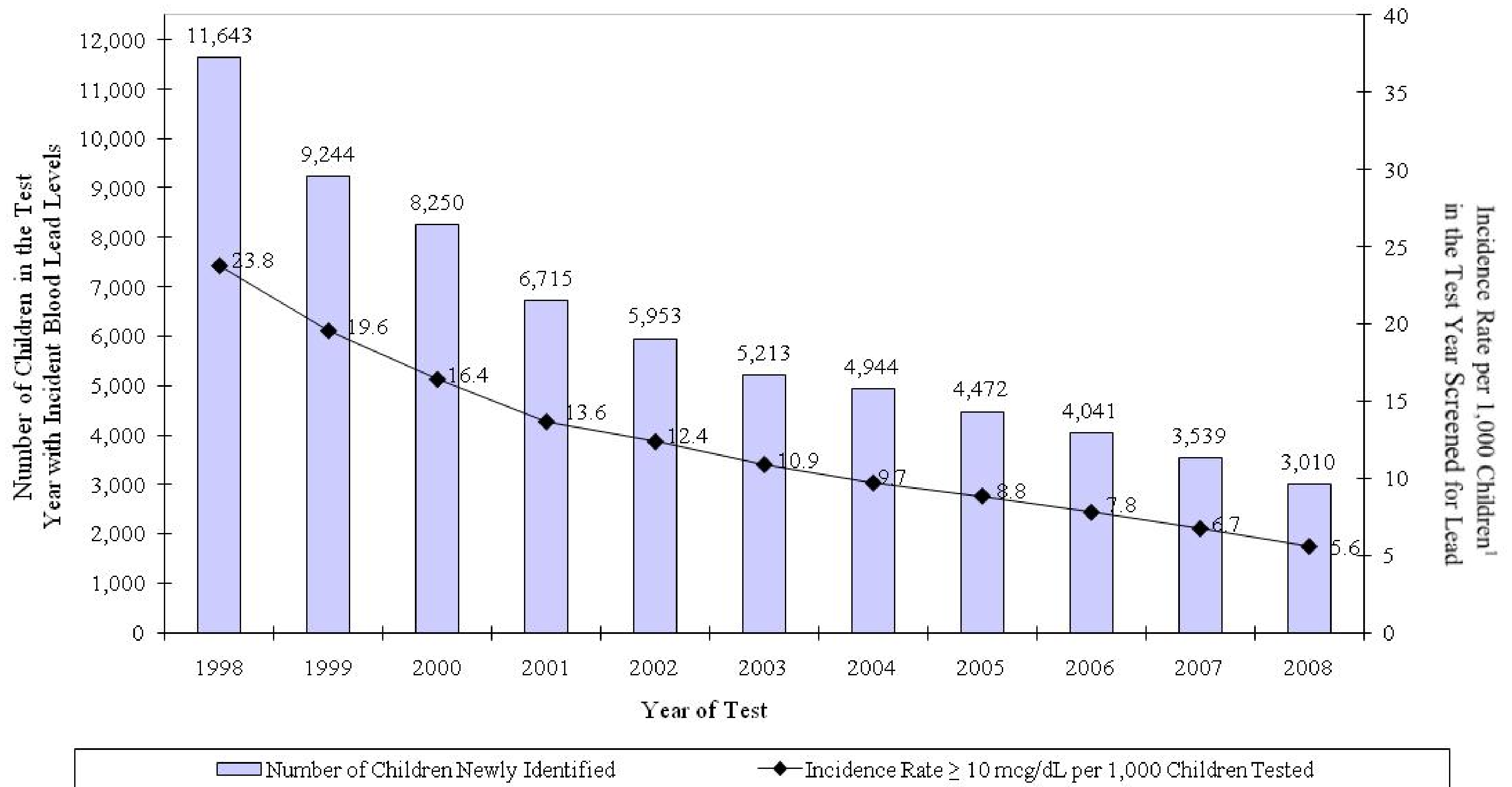
- **The number of children with EBLLs is steadily declining across all BLL categories.** Trend data for NYS (including NYC) show a dramatic reduction in the number of children identified with confirmed BLLs ≥ 10 mcg/dL, the current definition of lead poisoning established by the CDC. In 2008, 3,010 children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

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

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

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

New York State, 1998 to 2008 Blood Lead Test Data



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

Preliminary data – do not cite or publish as final

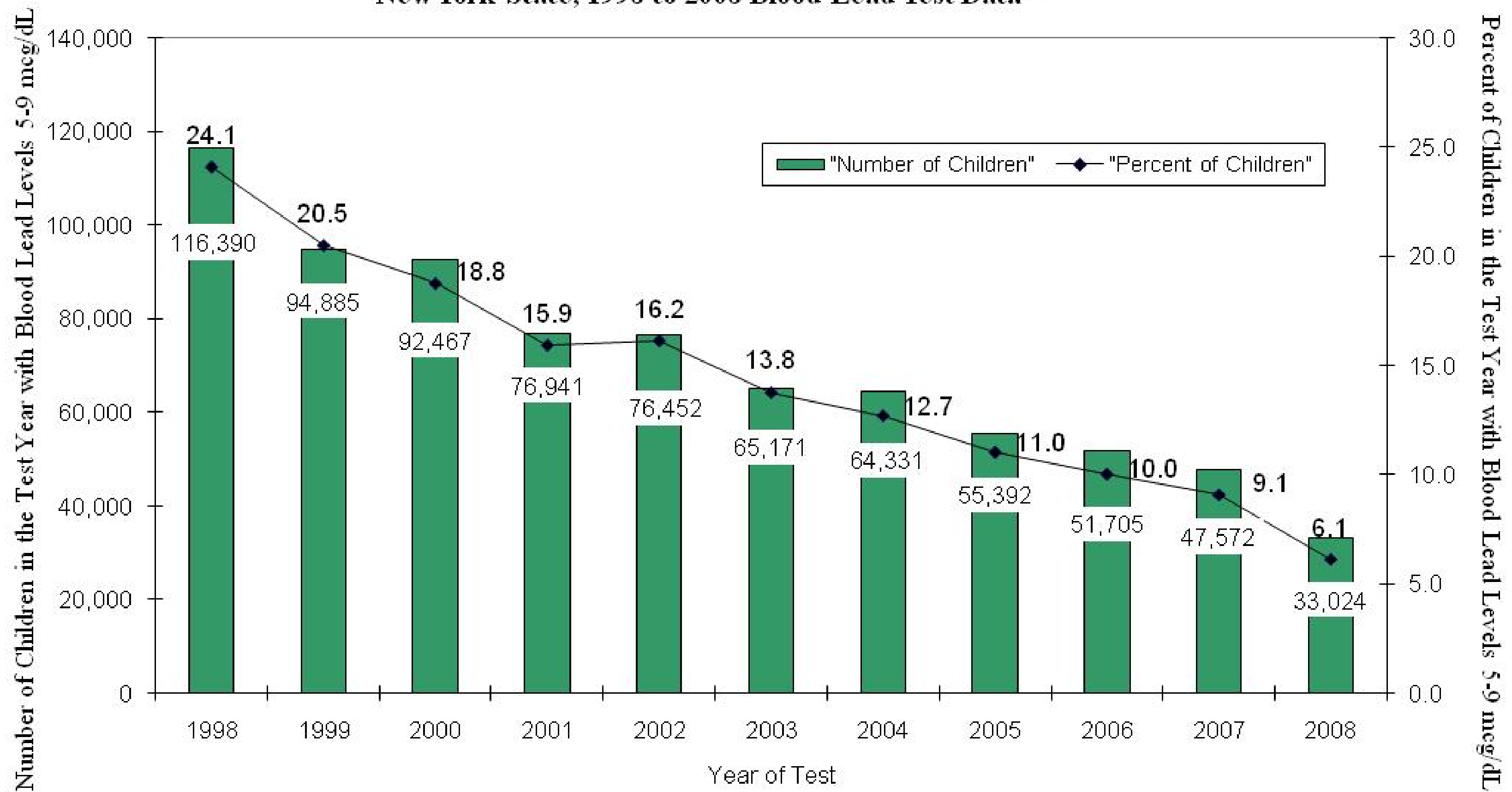
Children with Blood Lead Levels Below 10 mcg/dL

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

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

Data Highlights

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



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

KEY ACCOMPLISHMENTS AND STRATEGIES FOR CONTINUED SUCCESS

A Continued Commitment to the Elimination of Childhood Lead Poisoning

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

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

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

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

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

Achieving Elimination: Progress and Priorities for the Future

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

New York's Primary Prevention of Childhood Lead Poisoning Pilot Project and *New York State's Primary Prevention of Childhood Lead Poisoning Pilot Program: Year One Implementation Final Report*. Both reports are available on the NYSDOH public website. Highlights of the first year of the pilot program include:
  - Reaching 6,290 households through direct outreach and referral and nearly 26,000 additional individuals through informational meetings and other events;
  - Conducting home visits for 1,289 children age six and under, with 582 children referred for blood lead testing;
  - Investigating 1,514 housing units for lead-based paint (LBP), of which 699 units were found to have deteriorated paint or LBP dust hazards;
  - Creating at least 215 lead-safe housing units, with many planned; and
  - Training 518 property owners, contractors and do-it-yourselfers in Lead-Safe Work Practices, with over 12,000 others trained through prior agreements between these LHDs and other programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

Facilitating strategic partnerships to advance the elimination of childhood lead poisoning

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

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

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

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

Appendix A

Abbreviations

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

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

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

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

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

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<td>Welcome and Introductions</td>
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The meeting was convened at 10:05 a.m.
Dr. Birkhead opened the meeting, welcomed special guest Larry Franklin from the Centers for Disease Control and Prevention (CDC), and the Council members.
Dr. Birkhead provided opening remarks regarding compliance with relevant executive orders:

In accordance with Executive Order #3 and the Open Meeting Law, this meeting is being made available on the internet. The meeting notice and links to the webcast are at http://www.nyhealth.gov/events. (Note: this webcast is archived until November 19, 2008 and all future webcasts are anticipated to be announced at this website and will be archived for one month following the meeting.);
In accordance with Executive Law, section 166, members of the public who appear before the Council and represent any agency regulated by the Department of Health must fill out a record of attendance, provided at the registration table.

Dr. Birkhead noted that this meeting falls within National Lead Poisoning Prevention Week. The theme for this year is, “Let’s Wipe Out Lead Poisoning – Renovate Right!” The theme was first developed by the NYS Lead Poisoning Prevention Program (LPPP), and then adapted by the CDC for national use. The Department of Health (DOH) LPPP sent local health departments (LHDs) a sample press release, public service announcements, sample proclamation for local jurisdictions, a list of activity ideas for the week, and a media kit developed by the Environmental Protection Agency (EPA). DOH is also distributing a poster for the week, developed by the CDC. A copy of the folder was circulated for council members to view. The LPPP will be surveying counties to learn what awareness activities they conducted for this week, and to share among LHDs.

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<td>Overview of Agenda</td>
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Dr. Birkhead provided an overview of the meeting.
The scheduled presentation on the Renovation and Remodeling Outreach Campaign, by Dr. Eileen Franko, Director, Bureau of Occupational Health, had to be cancelled, and will be presented at a future meeting.
In the afternoon, Larry Franklin from the CDC will be presenting on the topic of healthy housing promotion. CDC has increasingly emphasized healthy housing as a holistic approach to addressing lead and other environmental health hazards and has initiated discussions with states and other grantees about transitioning from lead-specific primary prevention activities towards a healthy housing approach. Healthy housing is an approach New York has been a national leader in developing with our own Healthy Neighborhoods Program.

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

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

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

	and activities, including an expanded health care provider tool kit that is in development. **Lab Reports** – DOH is adding a requirement for new comment language on laboratory reports for BLL results <10 mcg/dL. Within DOH, Wadsworth is responsible for certifying and setting standards for labs. All reports must have some sort of interpretation, a reference range for abnormal results. Wadsworth has proposed to add required comment language on the test reports that highlights the concern for BLLs under 10 mcg/dL, without changing the established reference range. • Following the standard process for adding new requirements, Wadsworth sent a letter to all laboratories holding a NYS permit for toxicology-blood lead that included proposed new comment language for lead test reports for BLL results < 10 mcg/dL. • Detailed comments were received from 12 lab directors. Comments reflected a consensus on the need to alert health care providers about dangers of BLLs under 10 mcg/dL, along with concerns about perceived inconsistency with the established intervention level established by CDC, concerns about attributing adverse effects to blood lead levels below the typical limit of detection of 5 mcg/dL given the allowable error window of plus/minus 4 mcg/dL, and concerns about changing laboratory report language without simultaneous education for physicians. • To address the comments received, Wadsworth has revised the proposed comment language to read: "Blood lead levels in the range 5-9 µg/dL have been associated with adverse health effects in children aged 6 years and younger." Implementation of the new standard will be coordinated with the distribution of educational materials to health care providers.	
Council Discussion	Council discussion took place on several issues, including: • **Incorporating the new surveillance data into educational messages/materials to reinforce the importance of two year old lead tests.** Preliminary data for 2007 indicate that only about 41% of children are tested for lead at both ages one and two, and improving two-year-old testing rates is a specific objective. • **Completeness and quality of data for children with BLLs 5-9 mcg/dL to support additional analysis.** Obtaining complete, accurate laboratory data is a constant challenge. Address information is needed to support sub-county geographic analysis, but completeness of address data is more challenging for BLLs under 10 mcg/dL because there is not as much follow up. Similarly, information about the	

	likely sources of exposure would not be available. Dr. Greenberg noted that Nassau County DOH might have more data than is typical because it conducts home visits for children with BLLs 5 to 9 mcg/dL who are under one year of age. • **Feedback on draft parent education materials.** A member of the work group praised the work group process. It was noted that the recommendations on the parent handout will also be reflected in updated guidelines for health care providers, and that the materials would be updated when proposed regulations to expand requirements for comprehensive follow-up services from 20 mcg/dL to 15 mcg/dL are adopted. It was suggested that the expanded toolkit include a poster to prompt parents to discuss lead testing with the provider. Use of the term "doctor" vs. "health care provider" was discussed, noting that the work group had recommended the use of the term "doctor" in the new parent handout to reduce the literacy level, while some Council members preferred the use of the term "health care provider" because it is more inclusive and generic. It was noted that it might be resolved this through rephrasing. It was recommended that the material be translated into multiple languages, which is planned. • **Application of the new reporting standard to lead tests conducted in physician offices.** Physician Office Laboratories may utilize new office-based "point of care" technology to analyze blood samples for lead within their offices. As private practices, there is no additional lab interpretation provided with these results, and the state does not have regulatory authority over those labs, which are overseen by the federal government. However, Wadsworth has been distributing standards of practice guidelines, and the Department is proposing regulations that would require that the results of office-based testing be reported to the state. Currently, a very small percentage of doctors conduct these tests, about 100 providers statewide, compared to over 20,000 total providers statewide. **Lab language for BLLs 10-14 mcg/dL**. This level gets flagged as "abnormal." The language for this is not changing. • **Interpreting results of under 5 mcg/dL.** There was a concern that providers might assume that anything under 5 mcg/dL is perfectly safe, and that is not known for certain. Dr. Parsons noted that a result below 5 mcg/dL will mean different things to different labs. Some labs have higher accuracy, while others will not report quantitative results below 5 mcg/dL, other than to say results are "less than 5	Dr. Greenberg will provide DOH with additional information about the information collected through Nassau County home visits.

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

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

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<td>Council Discussion</td>
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Discussion took place on several issues, including:

• Use of the X-ray Fluorescence XRF Analyzer to detect lead in home inspections. The XRF instrument provides quantitative elemental lead analysis. There was discussion about whether there was too much reliance on the XRF, which can detect the presence of lead inside an object, even if it is not accessible on the surface, leading to a false identification of a health hazard. It was noted that the inspection does not completely rely on the XRF, but also on visual inspection for peeling paint. DOH has found that the XRF, used with visual inspections, is reliable.

• Amount of evidence that remediation will lower a child's BLL. The initiative is collecting and analyzing this kind of data. This project, however, is focused on primary prevention, and is not directed towards reducing individual children's BLLs. A Nassau County study on abatement found that there was a decrease in BLLs both with abatement and without abatement. They concluded that other factors influenced BLLs, such as education and clean-up.

• Matching requirement for the pilot grant. There is no matching requirement for this initiative, but it is encouraged. Counties are knowledgeable about how to access HUD and other funding sources.

• Criteria for selection of new counties. The criteria are the same as the original eight pilot counties.

• Analysis of geographic data. DOH is doing geocoding and will be able to conduct additional analysis. The goal is to do sub-ZIP code geographic analysis, which should be available within the next year. In the old data system, DOH was limited by the completeness of address level data. Also, each county had its own system, and had to link BLL results with addresses. Now DOH is geocoding all addresses, to enable analysis of BLLs at every geographic level. DOH will have this analysis soon.

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

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

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

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

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

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