STATE OF NEW YORK
DEPARTMENT OF HEALTH

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Richard F. Daines, M.D.
Commissioner

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October 19, 2007

Hon. Thomas P. DiNapoli
Comptroller
State of New York
110 State Street
Albany, New York 12236

Dear Comptroller DiNapoli:

Pursuant to the provisions of Section 170 of the Executive Law, I hereby transmit to you a copy of the Health Department's comments related to the Office of the State Comptroller's final audit report (2004-S-49) on "Oversight of the Childhood Lead Poisoning Prevention Program."

Sincerely,

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

Enclosure

Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report
2004-S-49 on
"Oversight of the Childhood Lead Poisoning Prevention Program"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) final audit report on "Oversight of the Childhood Lead Poisoning Prevention Program", including general comments followed by responses to the specific recommendations included in the final audit report.

General Comments

The Department's Childhood Lead Poisoning Prevention Program ("CLPPP") is recognized as one of the most comprehensive and effective lead poisoning prevention programs in the Nation. Many of the New York State regulations and program components have served as models for other states. For over three decades, New York has been a national leader in developing and implementing evidence-based lead prevention public health programs and policies. New York continues to develop new program and policy approaches to address this critical public health problem.

The majority of the recommendations contained in the audit report represent ongoing or planned activities already included in the Department's comprehensive strategic planning and implementation efforts. The report often focuses on narrow aspects of certain activities without recognizing how they fit within the broader scope of comprehensive lead prevention, including ongoing program development and attention to emerging issues in the field. Nonetheless, the Department appreciates the opportunity to consider the issues raised in the audit and to report progress in addressing them.

The audit period corresponds to a period of significant and rapid development in the field of lead poisoning prevention in general, and for CLPPP specifically. In June 2004, in response to new guidance from the federal Centers for Disease Control and Prevention (CDC), the Department released its Lead Elimination Plan (LEP), a statewide strategic plan for the elimination of childhood lead poisoning by 2010. Emphasizing the strengthening of community and state-level partnerships, and targeting intensive efforts in the highest risk communities and populations, LEP outlines a multi-year agenda in the areas of surveillance and data analysis, lead screening of children and pregnant women, and primary prevention. During the past three years, the Department has implemented many new initiatives, developed and refined existing activities, and formed many new partnerships. The Department also developed and implemented LeadWeb, a new web-

based statewide data system containing up-to-date, real time lead test records. In addition, the Department implemented significant changes to the work plan requirements which all local health departments (LHDs) are required to complete annually as a condition of Department funding. These changes, effective with the April 2007 funding cycle, include the establishment of both minimum requirements and best practices to guide LHDs in implementing and operating various aspects of their lead programs, while allowing them the flexibility to select those approaches they consider most effective for their community needs, resources and existing relationships.

Based on the its extensive public health experience, the Department has chosen and implemented an evidence-based, public health approach to improving lead screening practices, through collaboration with professional medical organizations, insurers and other partners. Detecting problems as early as possible permits timely and comprehensive medical and environmental services to prevent further exposures. Utilizing a combination of population-based education and outreach, provider education and technical assistance and systems-based policy changes, the Department's comprehensive public health approach encompasses all aspects of lead poisoning prevention, including:

- Education to families, health care providers, professionals and the public;
- Surveillance, data analysis and laboratory reporting quality assurance;
- Promotion and assurance of childhood lead screening;
- Assurance of timely and comprehensive medical and environmental management for children with lead poisoning;
- Policy and program initiatives advancing primary prevention activities to reduce exposure before children become lead poisoned; and
- Responding to emerging lead-related public health issues, such as lead poisoning amongst refugee children and recalls of toys and other children's products contaminated with lead.

CLPPP is guided by New York State Public Health Law and regulations, standards and guidelines promulgated by the CDC, currently published peer-reviewed research, and ongoing input from the New York State Advisory Council on Lead Poisoning Prevention ("Lead Advisory Council") and other stakeholders. Work is undertaken in close partnerships with health care professional organizations and insurers, LHDs, other state, federal and city agencies, and various other Department programs. The effectiveness of the Department's approach is demonstrated by continued success in improving screening rates and dramatic declines in the number of children with elevated blood lead levels. Over the past decade, the number of children under the age of six diagnosed with lead poisoning (defined as blood lead level at or above 10 micrograms/deciliter) was reduced from over 22,000 children in 1996 to fewer than 5,000 children in 2005, nearly a five-fold decrease. During this same period, the proportion of children screened for lead poisoning before their third birthday increased from 71.6 percent of children born in 1994 to 77.1 percent of children born in 2002.

Recommendation #1:

Use available databases and/or other resources to identify children who have not been screened for lead poisoning and refer these children to their provider or county health department for screening.

Response #1:

The Department recognizes data analysis, and specifically the use of database matching, as important and useful tools for program improvement and is experienced with the technical complexities of conducting matches between unrelated data sets and the meaningful application of findings for improving programs and services. Under LEP, the feasibility of using data matching as a method for increasing lead screening rates is periodically assessed. Additionally, CLPPP utilizes database analysis and application for various purposes including to help assess the extent of the existing childhood lead poisoning problem, identify high-risk communities and populations with the highest need for interventions and monitor and evaluate the effectiveness of interventions. The results are helpful in targeting screening promotion and other prevention efforts, and as a basis for quality improvement activities.

Lead registry data matches have been performed or are being planned with the following Department programs:

- Early Intervention (EI) Program – As a major public health program serving at-risk children up to three years of age, EI has been identified as a key partner for assessing the effectiveness of promoting lead screening of young children, consistent with State requirements. An initial match of EI and lead registry data was performed to assess the lead screening rates for children enrolled in EI. The results of the match are being used to develop strategies for facilitating EI referrals of children for screening.

- Medicaid Managed Care – Discussions are underway with the Department's Office of Health Insurance Programs (OHIP) regarding performing new data matches to identify children who have not been tested, and in turn to work with their managed care plans and health care providers to ensure screening occurs within a specified time period. This project builds upon previous projects described in the Department's response to the draft audit report that tested the feasibility, accuracy and utility of matching lead registry and Medicaid data.

- Special Supplemental Food Program for Women Infants and Children (WIC) – With approximately 250,000 New York State children under three years of age active participants in WIC each month, work is underway on assessing the feasibility of conducting data matches to more effectively promote lead screening of children enrolled in the WIC program.

The application of these matching projects, including whether it is feasible and effective to apply findings for the purpose of identifying and referring individual children, will be determined based on the project outcomes.

A major emphasis of the Department's ongoing work and one of the central goals of LEP is to improve screening rates. Significant steps have been taken to improve understanding why some children do not receive required lead screening tests and to develop new program and policy initiatives addressing the barriers to screening. Some key examples of recent and ongoing strategies undertaken to improve screening rates include:

- Analysis and publication of surveillance data to assess screening rates and identify areas for improvement. Preliminary analysis of 2004 and 2005 data has been completed and is pending public release, including posting on the Department's website. Based on input from the Lead Advisory Council and other stakeholders, these reports include expanded analysis to include age-specific indicators for the number and proportion of children screened at or around one and two years of age. Additional demographic and geographic analysis underway will further examine age-specific screening practices amongst specific populations. These expanded analyses are a critical tool for guiding and monitoring ongoing public health activities at the state and local levels, and targeting efforts for improving compliance with screening requirements.

- Utilization of Quality Assurance Reporting Requirements (QARR) data as the basis for incentive approaches in the managed care system. Managed care plans that perform poorly in QARR are required to conduct root-cause analyses and develop action plans for measures that show negative trends or that are below the statewide average. These action plans are reviewed by the Department and help target interventions for quality improvement. Additionally, plans that perform well are eligible for the Quality Incentive, a program that provides up to 3 percent additional premiums. This approach is key because approximately 75 percent of all children in the State are enrolled in managed care plans, and because Medicaid children are enrolled on a mandatory basis, it reaches a high proportion of those children disparately impacted by lead.

- Revision of the WIC Medical Referral Form for Infants and Children that is completed by health care providers and is used to help determine children's WIC eligibility. The form was modified to add fields for reporting blood lead levels at one and two years of age, and to remove the word "optional" from the field utilized for reporting lead test results. The form's instructions were also modified to add the statement, "A blood lead test is required by law for all children at one and two years of age." These changes reinforce screening requirements and improve the collection of lead screening data for an entire population of low income and other at-risk children statewide. In follow-up to these key changes, as noted above, the Department is currently assessing the feasibility of

conducting data matches to more effectively promote lead screening of children enrolled in the WIC program.

- The Department distributed a letter outlining New York's lead screening requirements and rationale for universal screening in September 2005 to over 24,000 pediatric providers statewide, including pediatricians, family physicians, nurse practitioners, physician assistants and managed care organizations. The Department also sent the letter to LHDs and posted it on its public website for ongoing use in educating health care providers. The Department is planning to update and redistribute the letter to reinforce the screening requirements and rationale for universal screening.

- The Department included articles reinforcing the lead screening requirements in the December 2005 and December 2006 issues of Medicaid Update, a monthly Department publication disseminated to over 47,000 providers and medical institutions enrolled in the Medicaid program. An update is planned for 2007.

- Hospital-based Regional Lead Resource Centers (RLRCs) in each region of the State provide a statewide network of clinical expertise on lead poisoning prevention. RLRCs specifically assist in providing general and targeted consultation and education to health care providers in their communities on lead screening requirements and case management. The Department issued a Request for Applications in June 2007 for the next round of competitive funding that requires an even stronger role for RLRCs in providing education, consultation and technical assistance to health care providers.

Recommendation #2:

Develop a process to enable counties to use the databases available to identify children who have not been screened and to refer them to their providers.

Response #2:

The information resulting from the data matches described in Response #1 above will be made available to LHDs to assist in carrying out targeted screening promotion activities with health care providers and families. Additionally, new LeadWeb report functionality was added in February 2007 giving LHDs the ability to identify children listed in the registry who are due for second lead tests at or around two years of age. Using this data, LHDs are able to generate and send letters notifying parents and health care providers of the need to be tested, and to track and conduct additional follow-up. The Department has received positive feedback on this new functionality and will continue to work with the LHDs to refine existing reports and to develop additional reports to aide in identifying target groups for screening promotions and follow-up actions.

Recommendation #3:

Enforce lead screening and risk assessment requirements.

Response #3:

Improving lead screening compliance is a key objective of LEP, with a number of steps already undertaken to implement this element of the plan and additional activities underway. When a report of a non-compliant provider is received, the initial response consists of educating the provider by reinforcing the screening requirements and assessing the need for technical assistance. Should these initial efforts typically involving the LHD and regional office not succeed, expert clinicians at the RLRC are engaged to provide peer-to-peer education. The Department has found its educational approach successfully influences provider practice in most cases. Otherwise, the Department is authorized under Sections 12 and 206(4)(c) of the Public Health Law to assess penalties of up to $2,000 for each violation of Public Health Law, and the Department's Office of Professional Medical Conduct is authorized under section 230 of the Public Health Law to enforce cases of physician misconduct, which the Department would consider in situations warranting such actions. CLPPP will work with the Lead Advisory Council and professional medical organizations to document the current protocol into written policy, as part of the overall efforts to improve screening practices under LEP.

Recommendation #4:

Require providers to follow up on those children for whom they do not receive lead screening results.

Response #4:

As outlined in LEP, critical to the Department's approach to improved screening practices is development of strategies to address the specific barriers cited by providers and parents that often result in a lack of follow-through on written prescriptions for laboratory testing. A key strategy being pursued in this regard is to facilitate the appropriate use of office-based "point-of-care" technology, including in-office collection of capillary blood samples for analysis at outside laboratories, and the use of portable blood lead analyzers such as LeadCareII® to analyze blood samples in the office setting.

Providers using LeadCareII® can collect a blood sample in their office and obtain results within a few minutes. (Because LeadCareII® is appropriate for screening but not diagnostic lead testing, elevated results must be confirmed using a venous sample analyzed through established reference methods, typically at an outside laboratory.) In 2006, the Federal Food and Drug Administration (FDA) approved use of LeadCareII® as a Clinical Laboratory Improvement Amendment (CLIA) waived device, allowing for widespread distribution to sites performing other types of CLIA-waived laboratory

testing, including physician offices, public health clinics, WIC programs and schools. Recognizing the potential for LeadCareII® to remedy some of the most common barriers to screening, the Department formed a workgroup comprised of broad participation from Wadsworth Center, OHIP and Environmental Health in January 2007 to assess the use of LeadCareII® and similar technology. The workgroup members have been collaborating extensively to identify issues, evaluate options and develop recommendations in several important areas, including:

- LeadCareII® performance and accuracy for pediatric screening;
- Quality assurance and oversight of LeadCareII® and other CLIA-waived testing technology in non-traditional laboratory settings;
- Reporting of results to assure surveillance and appropriate follow-up; and
- Regulatory barriers to the use of CLIA-waived technology for lead screening.

Several key documents are currently under development including new practice guidelines for LeadCareII® use, and proposed regulation changes expanding authority to conduct lead testing in point-of-care settings and assuring reporting of those test results.

In addition to enhancing the appropriate use of office-based point-of-care technology, the following strategies for addressing barriers to screening have been or are being incorporated into screening promotion activities:

- The April 2007 changes to the work plan requirements incorporated a stronger emphasis on effective education strategies for working with health care providers to improve screening practices. Relevant activities highlighted in the work plan changes which were developed in collaboration with the New York State Association of County Health Officials (NYSACHO) include public health detailing and provision of education and technical assistance related to collection of capillary samples in providers' offices.

- Development and distribution of updated, evidence-based educational messages for parents to increase the "demand" for lead testing and to encourage parents to obtain lead screening tests when ordered. In July 2007, two new educational pamphlets were completed and made available statewide. The pamphlets address key information for pregnant women and parents of young children regarding the risk of exposure, risk reduction behaviors and the importance of routine screening. These updated materials incorporate state-of-the-art health education guidelines, including low literacy text and layout, modeling of desired risk reduction behaviors using real photographs and use of theory and evidence-based messages. The pamphlets are available to LHDs, health care providers, child care providers, consumers and others at no cost, and will also be posted on the Department's website.

- Development is underway on a clinical lead prevention toolkit that will assist providers in implementing requirements for screening, risk assessment and

clinical management. When finalized, the toolkit will include up-to-date guidance on office-based lead testing options to help address many of the barriers to testing, as well as updated practice guidelines, office reference materials, patient education and counseling materials and other resources.

- Development of incentives for managed care providers to increase lead screening rates within their practices, including follow-up on "missed opportunities" to be identified through data matching.

- Collaboration with sister agencies and partners to reinforce child care providers' responsibility to assess the lead screening status of children and to refer those whose records do not contain information on lead screening to their health care provider or LHD for screening.

Recommendation #5:

Work with the counties to expand the use of PBII visits statewide and increase these visits to reach more providers.

Response #5:

The Provider Based Immunization Initiative (PBII) visits cited are dependent on record review, tailored data analysis and education. This resource intensive approach may not be the most effective or efficient means for improving screening practices in all communities, but is more appropriate for targeted assurance activities associated with case management. Given limited public health resources, the Department must be selective regarding when intensive record review activities are warranted.

Working with LHDs is a top priority because they are critical in promoting lead screening and other lead prevention practices in their communities, including conducting provider outreach and education. The April 2007 changes to the work plan requirements include requiring LHDs to propose specific local activities focused on achieving measurable increases in lead screening rates. The Department's central and regional offices work closely with LHDs in implementing the revised work plan requirements, including the following initiatives:

- In May 2007, the Department conducted all-day training on implementation of the new work plan for LHDs in each region of the State and also initiated or responded to requests for further individualized technical assistance from a number of LHDs.

- In June 2007, the Department sponsored a second annual provider meeting for LHDs to share updates and information on best practices. Dr. Thomas Schlenker, a published researcher and public health physician from Wisconsin with expertise in working effectively with health care providers to improve lead screening, presented a plenary session and a workshop on lead screening, both

of which were well attended and generated excellent feedback. LHD staff commented on evaluations that Dr. Schlenker's presentation offered practical information on specific outreach measures that would enable them to effectively partner with physicians in their communities.

- Beginning June 2007, quarterly conference calls are conducted with LHD lead program staff to facilitate ongoing communication, exchange of information and sharing best practices.

Recommendation #6:

Identify laboratories who do not report results of blood lead analysis to the Department within five business days as required and follow-up to ensure the laboratories comply in the future.

Response #6:

As the report acknowledges, CLPPP already identifies the laboratories that do not report the results of blood lead analysis within the required five business days, and follows-up to ensure these laboratories comply in the future, as part of its comprehensive quality assurance protocol. As demonstrated by the extensive documentation provided to the OSC during the audit process, the timeliness of laboratories' reporting has significantly improved. The following ongoing activities are additionally undertaken by CLPPP to further improve timeliness:

- Quarterly analysis to identify specific laboratories deficient in complying with the reporting requirements, followed by generation of non-compliance notifications documenting the deficiencies and requiring written corrective action plans within specified timeframes, and follow-up with Laboratory Directors to provide additional guidance as needed;

- In collaboration with the Wadsworth Clinical Laboratory Evaluation Program (CLEP), cite laboratories with significant and/or repeated deficiencies, and monitor subsequent performance for improvement. Recent activities included reviewing the current protocols with CLEP, and CLEP formally citing several laboratories with repeated significant reporting deficiencies;

- Annual notification to all laboratories of the required elements and timeframes that must be followed for lead test reporting;

- Ongoing communication with LHD lead coordinators to troubleshoot laboratory reporting concerns; and

- Coordination with Electronic Clinical Laboratory Reporting System (ECLRS) staff to resolve any reporting transmission problems that result in late reporting of lead test results or omission of critical data fields.

Recommendation #7:

Obtain necessary information to determine whether laboratories report the results of blood lead analysis equal to or greater than 45 mcg/dl to providers within 24 hours.

Response #7:

CLPPP has collaborated with CLEP to develop a protocol for determining if laboratories are reporting all blood lead levels ≥ 45 mcg/dL to health care providers within the required 24 hour timeframe. Under the arrangement, CLPPP provides CLEP with sample results ≥ 45 mcg/dL every six months which are utilized by CLEP surveyors during laboratory site visits to assess whether the laboratory complied with the regulatory reporting requirement. Follow-up actions will be pursued with the laboratories determined to be non-compliant.

Recommendation #8:

Lower the threshold of non-compliance used in its quality assurance analysis and refer those laboratories repeatedly identified as not reporting timely to the Clinical Laboratory Evaluation Program for follow-up.

Response #8:

Improving lead surveillance data quality is an objective of LEP, with expanded quality assurance activities already implemented. In November 2006, the late reporting threshold triggering program action for non-compliance of timeliness in reporting lead results was changed from 50 percent to 15 percent. For laboratories not meeting the revised standard, a letter is sent to the Laboratory Director, with a copy to CLEP, citing the deficiency and outlining the requirements for a corrective action plan. Laboratories with significant and/or repeated deficiencies are referred to CLEP for further action. The timeliness of laboratories' reporting has improved significantly with implementation of these changes.

Recommendation #9:

Require counties to follow up on children with elevated blood lead levels until levels fall to an acceptable level.

Response #9:

Case closure criteria will be more clearly defined for LHDs in forthcoming case management guidelines developed by the Department. These guidelines, consistent with the most recent CDC recommendations, will state that a case can be closed when two consecutive venous blood levels are ≤ 15 mcg/dL, or one is ≤ 10 mcg/dL for at least 6 months, and all required follow-up activities consistent with the child's blood lead level have been completed. The guidelines will also allow case closure based on specific

administrative criteria, such as refusal of service or transfer to another county or state program, and will additionally advise LHD case managers to discuss with health care providers and parents/caregivers provisions for long-term developmental follow-up following discharge from LHD management. In addition, the appropriate criteria for discharge is periodically reinforced with individual LHD staff, and was discussed in May 2007 at a joint meeting of the NYSACHO maternal child health and environmental leadership committees.

Recommendation #10:

Monitor county performance toward meeting the specific timeframes for follow-up activities set forth in their policy and procedure manuals.

Response #10:

The Department carries out a full range of monitoring activities to ensure LHD compliance with requirements for follow-up activities. Each LHD is required to develop and maintain a lead program policy and procedure manual, which must be submitted to the Department for review and approval. Following Department approval, ongoing monitoring is accomplished via routine Department review of required LHD quarterly submissions. Any issues or concerns noted during these reviews are acted upon as appropriate, either immediately or at a subsequently scheduled review, depending on the severity of the matter. Additional ways the Department monitors LHDs compliance include the following:

- As part of their annual work plans, LHDs are required to explain how they intend to accomplish required program objectives and activities, including how they will ensure appropriate follow-up activities are undertaken. Each work plan is reviewed by the Department for consistency with Public Health Law and regulations, work plan guidance, and current medical and public health standards. Where warranted, LHDs are required to incorporate plan modifications necessary to ensure satisfactory fulfillment of program requirements.

- The Department regularly conducts LHD site visits to provide more in-depth monitoring of LHD activities. During these visits, LHD policies and procedures are reviewed to ascertain compliance with Department requirements. In addition, reviews of random samples of records of children with elevated blood lead levels are performed to confirm all required follow-up activities occurred timely. Because the specific processes undertaken by individual LHDs to communicate with health care providers and families often vary, these record reviews provide an objective standardized approach to determining whether specific required elements of follow-up care occurred. It is surprising that the report would describe this record review in a negative light, since the review of records is considered the most rigorous monitoring method for determining if standards of care have been met.

Recommendation #11:

Develop an initiative similar to PBII to ensure all prenatal care providers, including private providers, are risk assessing women as required.

Response #11:

New York is one of only a few states with specific guidelines or regulations related to lead screening during pregnancy, and New York's guidelines have served as a model for the development of guidelines by other states. The PBII initiative cited is an intensive, individualized approach that is dependent on record review, tailored data analysis and education, which may not be the most effective or efficient approach given limited public health resources. Instead, the Department's approach to work within the existing systems is consistent with a basic tenet of public health: change systems and leverage resources to achieve public health impacts that could not be realized through individual contacts.

The April 2007 changes to the work plan requirements include requiring LHDs to propose specific local activities to increase prenatal care providers' knowledge and to encourage favorable attitudes and the practice of lead poisoning prevention requirements, risk assessment and targeted blood lead testing for pregnant women. The Department's central and regional offices works closely with all LHDs on the prenatal screening aspects of the new requirements, including the following specific initiatives:

- All-day training was conducted for LHDs in each region of the State, as well as further individualized technical assistance provided to numerous LHDs.

- In June 2007, the Department sponsored a second annual provider meeting for all LHDs to share updates and information on best practices. Dr. Morrie Markowitz, a published researcher and expert clinician from Montefiore Medical Center, provided an overview of lead exposure during pregnancy, including risk factors for lead exposure on the mother, effects of lead exposure on the fetus, and recommendations for maternal blood lead testing during pregnancy. The presentation was well attended and LHD staff expressed significant interest in the topic.

The Department continues to regularly monitor LHD activities and quarterly reporting to ensure education and outreach activities promoting lead assessments and screening of pregnant women remain effective and are consistent with Department requirements and guidelines. Ongoing population-based and targeted activities related to lead poisoning prevention during pregnancy and assuring pregnant women at risk are identified and receive appropriate testing and follow up services include the following:

- Updating the existing prenatal care provider guidelines associated with risk assessment, lead testing and follow-up actions for pregnant women. Building on

the Department's work with the New York City Department of Health and Mental Hygiene (NYCDHMH) and the Mt. Sinai Center for Children's Health and the Environment, an update to the current guidelines, incorporating new research findings and best practice recommendations, has been drafted and is currently undergoing Department review. The Department will work with key partners to finalize the update and disseminate the revised guidelines to all prenatal care providers statewide.

- Continuation of the more intensive assurance strategies targeting the populations of pregnant women at the highest risk for lead exposure. Risk assessment of pregnant women for possible lead exposure, with provision or referral for blood lead testing as indicated, is a specific required component of the Department's Prenatal Care Assistance Program (PCAP) and WIC. Both of these programs serve low-income women, including immigrant women. Additionally, all adult blood lead laboratory results, including all pregnant and postpartum women 16 years of age and over, are reported to the Department's Heavy Metals Registry. Results greater than 15mcg/dL are followed-up with a structured telephone risk assessment and risk reduction counseling. Counseling specific to pregnancy and newborn care is provided for all women who are pregnant or potentially pregnant, and all women of childbearing age are educated on the need for ongoing biomonitoring and ways to reduce their sources of exposure.

- The Department's Bureau of Occupational Health provides education and outreach to companies with the potential for occupational lead exposure. These activities include educating employers on the need for biological monitoring of all employees, and consultation regarding lead exposure and the need for lead testing during pregnancy.

Recommendation #12:

Work with officials from the OCFS and the New York City Department of Health and Mental Hygiene's (NYCDOHMH) Bureau of Day Care to determine whether day care facilities are obtaining certificates of screening as required.

Response #12:

As stated in the report, both of these agencies are already monitoring whether day care facilities are obtaining certificates of lead screening as part of their ongoing activities. When either agency reviews child records containing no information on lead screening, the child care provider is asked if the child's parents were given information on lead poisoning prevention and referred to the child's health care provider or LHD for screening. These criterion are specifically included on the inspection checklist utilized by licensing staff during reviews. The Department is currently working with the Office of Children and Family Services (OCFS) on developing and implementing additional child care provider guidance that would require providers to document in the child's file, when

no record of lead screening is noted, that educational materials and referral for lead screening have been provided.

Recommendation #13:

Provide each day care facility with educational materials pertaining to lead poisoning to be used for their own knowledge and to be given to parents.

Response #13:

in April 2007, the Department and OCFS collaborated on a joint mailing to all child care providers in the State regulated by OCFS. The mailing included a letter reinforcing the responsibilities of child care providers in assessing children's lead screening status and promoting lead screening, samples of current educational materials, specific information on how child care providers can order additional materials for distribution to families, and LHD contact information. A similar mailing to all additional New York City child care providers that are overseen by the NYCDOHMH is underway.

OCFS regional offices will maintain a current supply of Department lead prevention publications for distribution to providers during on-site licensing and renewal inspections, as well as for distribution to regional office "walk-ins." In addition, the Department is working with OCFS on developing updated continuing education lead prevention training materials for both child care providers and child care licensing staff. The Department and OCFS, in conjunction with OCFS' training contractor, the State University of New York Training Strategies Group, are in the process of assessing child care providers' lead training needs and identifying effective strategies for building lead information within the existing training networks. As a result of this collaboration, several training and education opportunities have been implemented or are under development. Updated lead prevention information has been incorporated into OCFS' Health and Safety training materials distributed to new child care providers as well as into its Safety First materials available to all providers. In addition, three specific lead training formats are being developed for child care providers: a lead education curriculum for new child care providers as part of OCFS' mandated 15-hour child care provider training; a segment for use in one of the monthly video conferences for child care providers; and a section devoted to lead issues as part of the mandated biennial child care provider certification renewal. Additionally, a videoconference dedicated to environmental hazards that will include extensive information on lead is being planned for next year.

In August 2007, in response to major recalls of children's toys found to be contaminated with lead paint, the Department worked with OCFS and NYCDOHMH to rapidly develop and distribute educational messages and materials to all child care providers in the State, including lead screening recommendations for children who were exposed to the affected toys. All materials reinforced the importance of universal blood lead screening at one and two years of age, and risk assessment with targeted blood lead screening up to the age of six. Also included was Information on how child care providers can order updated educational materials at no charge for distribution to parents.

Recommendation #14:

Require that work plans include quantifiable goals and that counties make substantial progress toward meeting their goals.

Response #14:

Strengthening LHD capacity for lead poisoning prevention is a major emphasis of LEP. The April 2007 changes to the work plan requirements include requiring LHDs to propose specific measurable activities for a number of defined program objectives that address program management, education, surveillance, screening, case management and primary prevention. LHDs are required to describe how they plan to implement minimum required activities for each objective and to propose additional activities within each objective; all activities must meet CDC criteria. In addition, required LHD quarterly reporting to the Department was modified to align with the new work plan requirements. LHDs are required to report quarterly on specific progress in achieving work plan activities, any major changes that might have occurred and any specific barriers or challenges to effective implementation. The new reporting format incorporates each quarter's activities year-to-date, facilitating Department review of the progress trends in comparison to the work plan expectations.

Recommendation #15:

Revise the data section of the quarterly reports to require more specific information that will allow for determining whether follow-up activities were completed for all addresses.

Response #15:

LHD quarterly reports are not the best source for obtaining the most up-to-date data on follow-up activities. LeadWeb permits Department and LHD staff to track follow-up activities, and ensure all activities are completed. The system includes several modules, including specific case management modules for nursing/education and environmental follow-up services. The environmental module, for example, was deployed in July 2006 and permits Department and LHD staff to track all lead inspections and environmental remediation and abatement activities. Currently, additional LeadWeb management reports are being developed for use at both the state and local level for tracking completion of required follow-up activities.

Recommendation #16:

Develop and implement standardized written procedures for site visits to counties to be used in all regions.

Response #16:

Updated site visit protocols have been developed and implemented, providing specific

uniform timeframes for conducting reviews and follow-up activities, and formalizing the extensive ongoing monitoring practices in place at the central and regional office levels and described to the OSC during the review. Also included is a standardized written site visit tool for monitoring LHD lead programs. The tool includes assessment of the LHD's policies and procedures to assure compliance with Department requirements, as well as structured review of a random sample of the records of children with elevated blood lead levels to assure timely and appropriate follow-up services have occurred.

Recommendation #17:

Work with Western regional office officials to ensure Department expectations are clear and regional officials are meeting those expectations.

Response #17:

The Department's central office works closely with all regional offices, including the Western Regional Office (WRO). WRO has incorporated lead program requirements and key indicators into its Community Health Quarterly Operations Plan, with WRO administrators meeting quarterly with the Community Health Program Director to discuss program performance. Additionally, the Department's central office has provided orientation training for new WRO staff, and has accompanied a new staff person on a LHD site visit.

The Department conducts monthly conference calls with the regional offices to discuss lead program oversight issues, and additionally communicates with staff in each region on an ongoing basis as issues arise between calls. In addition, regional office staff were included in the annual educational conference for LHD lead programs and assisted in carrying out the regional trainings for LHD staff associated with the revised work plan. These ongoing forums provide the opportunities necessary to ensure expectations are clear and are being met.

Recommendation #18:

Monitor Council activities and membership to ensure all Council obligations are being met.

Response #18:

The Lead Advisory Council is currently meeting all its obligations, and conducts regular meetings including meetings held in April 2007, June 2007 and September 2007. The annual report for 2005 was completed with input from Council members, and the report for 2006 is currently being finalized. The Department will continue to work closely with the Council, an important resource for the ongoing implementation, refinement and evaluation of LEP.