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**OFFICE OF THE
NEW YORK STATE COMPTROLLER**

**DIVISION OF STATE
GOVERNMENT ACCOUNTABILITY**

DEPARTMENT OF HEALTH

**OVERSIGHT OF THE
CHILDHOOD LEAD
POISONING PREVENTION
PROGRAM**

Report 2004-S-49

AUDIT OBJECTIVE

Our objective was to determine whether the Department of Health (Department) has provided effective oversight of the Childhood Lead Poisoning Prevention Program (Program) to ensure that children under the age of six years are properly screened, that pregnant women are assessed for elevated blood lead levels, and that proper follow-up actions are taken when warranted.

AUDIT RESULTS - SUMMARY

We determined the Department and each of the counties we visited have developed outreach and education programs in the areas of screening, as well as pre-natal care and day care. For example, program information is presented at local health fairs and day care centers, and distributed via educational materials throughout the community. However, we conclude the Department can make better use of the resources available to it, to ensure that all children are screened for lead poisoning, as required.

We identified that 133,477 children (out of a population of 380,933 children) were not screened for lead poisoning. We also found approximately 99,000 children who were at least two years old and had received only one lead screening, although two screenings are required by age two. In addition, we found the screening rates reported by the Department are overstated and do not accurately reflect the number of children screened. [Pages 4-8]

We identified about 201,000 children whose blood lead results were not reported to the Department by the laboratories within five business days, as required. [Pages 8-9]

Overall, we found children identified as having high blood lead levels are receiving required follow-up activities. However, we did identify some instances in which specific activities were missing or were not conducted in a timely manner. [Pages 10-11]

Record reviews are conducted for Department programs targeting lower income women. However, no reviews are conducted of private providers and as a result, the Department has no assurance that these providers are risk assessing women for elevated lead blood levels as required. [Pages 11-12]

While the Department is responsible for overseeing the Program, county health departments play a major role in implementing the Program. We found the Department needs to better monitor county activities to ensure the Program is functioning as intended at the local level. [Pages 12-16]

We found the State Council on Lead Poisoning Prevention has not met its responsibilities as required under the Public Health Law. [Pages 16-17]

Our report contains 18 recommendations to improve the Program. Department officials generally agreed with our recommendations and indicated actions either planned or already taken to implement them.

This report, dated June 14, 2007, is available on our website at: <http://www.osc.state.ny.us>. Add or update your mailing list address by contacting us at: (518) 474-3271 or Office of the State Comptroller
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BACKGROUND

Lead is the leading recognized environmental poison for children in the State. Because of their normal hand-to-mouth behavior, children six years old and under may ingest lead from their environment and are at greatest risk for lead poisoning. Despite the elimination of lead from most gasoline and paint, children continue to be exposed to environmental lead from past uses. The principal source of lead exposure today is lead-based paint and the contaminated dust and soil it generates, principally in older dwellings. The irreversible effects of lead poisoning include lower IQ, growth problems, kidney damage, behavioral problems, hearing loss, anemia and death. In addition, lead poisoning in pregnant women has been linked with pregnancy-induced high blood pressure, miscarriage, preterm birth, and low birth weight.

Studies have also shown that immigrants to the United States, including foreign-born adopted children, appear to have an increased prevalence of elevated lead levels, reflecting a variety of environmental exposures in their countries of origin and/or a variety of cultural practices. The continued use of traditional folk medicines, cosmetics, ceramics, and foods all have been noted as sources of lead exposure among immigrant populations.

According to the State's Public Health Law, the Department is responsible for establishing and coordinating activities to prevent lead poisoning and to minimize the risk of exposure to lead. Specifically, the Department is required to: promulgate and enforce regulations for screening children and pregnant women and to follow up on those with elevated blood lead levels; coordinate lead poisoning prevention with other federal, State, and local agencies; and establish a

statewide registry of children with elevated blood lead levels.

The Department's Bureau of Child and Adolescent Health, Bureau of Community Environmental Health and Food Protection, and Bureau of Occupational Health, as well as the Department's four regional offices, are responsible for overseeing the Program. County health departments (counties) play a major role in implementing the Program. In addition, community-based organizations and regional lead poisoning prevention resource centers (resource centers) play an important role. Resource centers provide education and outreach to providers, hospitals and the public.

The Federal Centers for Disease Control and Prevention (CDC), along with the President's Task Force on Environmental Health Risks and Safety Risks for Children, have called for the elimination of childhood lead poisoning, defined as blood lead levels at or above 10 micrograms per deciliter (mcg/dl) among children aged six years and younger, by the year 2010. In June 2004, the Department issued "Eliminating Childhood Lead Poisoning in New York State by 2010" (Lead Elimination Plan). The plan has three priority focus areas: Surveillance, Targeting High Risk Populations, and Primary Prevention. This plan covers upstate New York. A companion strategic plan covering New York City was developed and issued in December 2005 by the New York City Department of Health and Mental Hygiene.

According to Department officials, in implementing the Program, they take a population based approach with an emphasis on education and cooperation. In 1994, 1995 and 2005, the Department sent letters to providers outlining their responsibilities pertaining to lead poisoning. Attached to each letter was a contact list of county health

departments and resource centers, and a list of available educational materials with an order form. According to Department officials, providers were also sent a *Physicians Handbook on Lead Poisoning Prevention*, which outlines a physician's responsibilities as they pertain to lead poisoning. Department officials also indicated that this and other lead poisoning prevention information is available free of charge on their website. In November 2004, the Department held a statewide lead screening roundtable discussion to identify challenges to achieving universal screening and promising strategies for improving screening rates.

The Department also has developed the Healthy Children New York program. Local county health nurses and other officials voluntarily attend a six-day training course to become child health promotion specialists in their communities. Lead poisoning is a core element of this training curriculum.

Each of the counties we visited has also developed outreach and education programs in the areas of screening as well as prenatal care and day care. Some examples of these programs are media campaigns, presentations at local health fairs and day care centers, and the distribution of educational materials at various locations throughout the community including libraries, hardware stores and pharmacies. Additionally, Onondaga County has a "Lead Bus" that visits neighborhoods identified as high risk. Officials go door-to-door to provide information about lead poisoning and will screen any child that has not had a lead screening.

AUDIT FINDINGS AND RECOMMENDATIONS

Screening of Children for Lead Poisoning

Public Health Law Section 1370-a requires the Department to set, distribute and enforce regulations for the screening of children for lead poisoning, the reporting of the results of laboratory analyses, and to follow up on children who have elevated blood lead levels.

Screening

Department regulations require primary health care providers to do the following as part of routine child care of children who are at least six months but less than six years old:

- Assess children for high dose lead exposure and arrange lead screening for high risk patients;
- Provide parents or guardians with guidance on lead poisoning prevention;
- Arrange lead screening or refer each child for blood lead screening at or around one and two years of age, preferably as part of routine well child care; and
- Contact the county in cases involving high lead levels and coordinate follow-up activities with the county.

To record and track results of blood lead level testing, the Department operates and maintains two databases: the Electronic

Clinical Laboratory Reporting System (ECLRS) and Leadtrac. Most clinical labs upload lead poisoning test results to ECLRS. (Some labs manually report test results to the counties.) Each county downloads its county's blood lead results from ECLRS on a daily basis using the LeadWeb system (formally the Leadtrac system). Counties access LeadWeb to obtain blood lead levels for children within their county and to carry out their Program activities.

We obtained downloads of ECLRS and Leadtrac databases for all children screened for lead poisoning between April 1, 2002 and December 31, 2004. We also obtained downloads of two other Department databases, the Medicaid Management Information System (MMIS) and the Statewide Immunization Registry¹, and identified 380,933 children born between June 1, 2001 and October 31, 2003. Children born between these dates would have required at least one lead screening during the period covered by our download of the ECLRS and Leadtrac databases. We matched the MMIS and the Statewide Immunization Registry databases against ECLRS and Leadtrac databases. We concluded that any children who appeared on either MMIS or the Statewide Immunization Registry, but not on either of the lead poisoning databases, were not screened for lead poisoning.

We then selected a statistical random sample of children we initially identified as not being screened. We verified this sample to the Department's lead poisoning databases to further determine whether these children had, in fact, been screened for lead poisoning but

¹ MMIS contains all Medicaid claim payments for recipients in the State. The Statewide Immunization Registry contains immunization records for children in the State, except for New York City. Participation in this registry is voluntary by the provider and the parent.

were not matched in our analysis due to differences in their names or dates of birth such as misspellings and data entry errors. Based on our sample results, we projected with 95 percent confidence, that between 113,704 and 153,249 children (with a mid-point of 133,477 children), or 35 percent, were not screened for lead poisoning.

Department officials expressed concern that children who may not have been in the State at the time a lead screening was required, and children who may have had their lead screening early or late, did not appear in our database downloads. To address the Department's concerns, we adjusted our analysis to include only children with dates of birth between June 1, 2001 and October 31, 2003. By adjusting the dates of birth within this range, we should have captured those children who may have had their screenings early or late. We believe the steps we took to ensure accurate results, minimize any such omissions and, therefore, have no material effect on the results of our analysis. Further, since the MMIS and Immunization databases contain limited populations of children, and not the total population of children statewide, the range of children not screened is conservative.

Currently the Department does not conduct data matches to identify specific children who are not screened for lead poisoning. Instead, in their most recent data report, released May 2004, Department officials calculated a percentage of children who receive at least one screening. The report breaks down the number of children who received screenings by age ranges ending with sixteen months, two years, three years and six years. According to Department officials, this screening rate is 66.1 percent for children born in 2001. Department officials stated that, as part of its methodology to complete this calculation, duplicate records are

removed based on an exact match to last name, first name and date of birth. However, there is no analysis to identify and remove records that are not exact matches but still represent duplicates. As a result, these duplicate records are included in the Department's calculation, thereby overstating the screening rate.

As part of our calculation of children who were not screened, we eliminated duplicates based on the same exact last name, first name, date of birth algorithm used by the Department. However, because we recognized that many additional duplicates existed in the data provided, we used software (WizSame program) to identify and remove records that are potential duplicates. Additional duplicates exist in the data due to transposition errors, spelling errors, the use of a middle initial or name suffix in one record and not in another and records containing lowercase letters. The WizSame program is used to identify and remove records that are potentially the same child but there are slight differences in the data records. When we used this program in our analysis, we identified and removed 7,215 potential duplicates.

Additionally, despite the requirement that children be screened at age one and two, Department officials do not routinely calculate screening rates for this mandate. Also, the Department's screening rates are not up-to-date, since the vital records data used to determine these rates is two years old. In August 2006, the Governor signed into law a mandatory immunization registry. This registry will be able to serve as a more comprehensive matching tool.

Our data matches were done using Department databases. If similar matches were conducted at the county level, thousands of children could be identified and screened

as required. For example, in August 2004, Onondaga County officials matched their Leadtrac database with the database of the County's Immunization Program and identified approximately 3,000 children who had no record of lead screening in their County. The County sent a letter to each provider explaining the importance of lead screening, and attached a listing of children identified in the match who were past or present patients of the provider. The Department could also use such data matches to monitor screening activity statewide and identify providers who are not screening children as required.

We also used the Department's lead poisoning databases to identify children who had received only one of their two required lead screenings. We identified approximately 99,000 children (out of a population of 1.4 million children) who were at least two years old and had received only one lead screening. The Department's Lead Elimination Plan shows that eight percent of the State's children who had non-elevated blood lead levels (<10 mcg/dl) on their initial screening, were found to have a newly elevated blood lead level at their second screening. This illustrates the importance of a second screening test even when an initial screening is negative. Despite the importance of this second screening, Department officials do not routinely conduct analysis to identify children who received only one of their required lead screenings.

The Department's Office of Managed Care collects managed care performance measures for commercial and Medicaid managed care plans. Lead screening measures are included in the report on a rotating basis to evaluate plan performance, not compliance with the law. These measures, based on a statistical sample, show the percentage of two-year olds who were screened for lead poisoning at least

once. As such, they are of limited use for overseeing the Program as they include only a measure of children who receive one lead screening by age two.

As part of our audit, we sent questionnaires to a random sample of 100 pediatricians (out of a population of 4,023 pediatricians) statewide to determine whether they were screening children as required. Of the 59 responses, four pediatricians stated they do not treat children in this age group or have recently retired; 53 stated they do complete these screenings; and two providers stated they do not screen children at ages one and two. In addition, 15 pediatricians stated they do not assess children six years of age or younger for the risks of lead poisoning, while 40 stated they do complete this assessment. Four pediatricians stated they do not test potentially exposed siblings, two do not contact their county for high lead levels, and three do not coordinate follow-up activities with their county. Three pediatricians also stated they practice in a low risk area and therefore feel screening should not be mandatory.

Under the Department's Provider Based Immunization Initiative (PBII), county lead and immunization officials review the files of health care providers to determine immunization and lead screening rates and identify missed opportunities. While this is a valuable means to ensure providers are screening children as required, provider participation is voluntary, and visits by county officials are done on a limited basis. According to Department statistics, from April 2003 through March 2006, a total of 782 PBII visits to providers were completed outside of New York City. However, in 12 of the 57 counties (21 percent), five or fewer providers were visited during this period. Additionally, in 22 of the 57 counties (39 percent), between 5 and 10 were visited. New

York City did not begin conducting PBII visits until July 2004. Between July 2004 and September 2005, only ten PBII visits have been completed in New York City. These visits should be further increased to include more providers.

According to Department officials, there are many challenges to achieving universal screening including:

- Beliefs among providers and/or parents that children are not at risk for lead exposure or lead poisoning, especially those children living in newer housing or generally low prevalence communities;
- Beliefs among providers and/or parents that lead exposure, particularly at low levels, is not associated with meaningful harmful clinical outcomes;
- Differences between the State's requirements for universal screening and national guidance from the American Academy of Pediatrics, which until October 2005, recommended targeted rather than universal screening for most children; and
- Parents do not take their child for lead screening after their provider gives them a prescription for lab testing.

While we recognize these challenges, the Department is nevertheless responsible for ensuring all children are screened for lead poisoning. We suggest the Department work with the counties to improve compliance with lead screening regulations.

In their June 2004 Lead Elimination Plan, Department officials state that in collaboration with New York professional medical academies, the Department "will establish a protocol for enforcing regulations

related to lead screening. Enforcement strategies will emphasize provider education, with targeted auditing, citation, or other penalties as needed in cases of significant non-compliance.”

Department officials stated they “do not have the authority to routinely access private physician medical charts without a subpoena or court order compliant with Health Insurance Portability and Accountability Act (HIPAA) and State Law related to patient confidentiality. Moreover, such a broad enforcement would be administratively and financially impractical in the context of finite resources dedicated to this and other public health priorities and thus is not the Department’s choice of methods to increase screening rates.” However, HIPAA would not require a subpoena or court order for the Department to review medical charts.

Timeliness of Lab Reporting

Department regulations require laboratories to report the results of blood lead analyses to the Department within five business days. If blood lead levels are excessively high (equal to or greater than 45 mcg/dl), and the child is up to 72 months of age, labs must notify providers within 24 hours. The Department is responsible for monitoring compliance with these regulations.

We did analyses using the Department’s ECLRS database to identify children whose blood lead results were not reported in a timely manner. We identified approximately 201,000 children (out of a population of 2,041,983 children) whose blood lead results were not reported to the Department within five business days, as required. To be conservative, we eliminated all results that took six and seven days to complete, as these tests would have included a weekend. We did not consider a result reported late unless it

took eight days or more to be reported. Lab results for 69 percent of the 201,000 children took between 8 and 20 days to be reported. The remaining results (31 percent) took 21 days or more.

Currently the Department cannot determine whether labs are reporting blood lead results for children with lead levels of 45 mcg/dl or higher, to providers within 24 hours as required. While laboratories are required to report results to the Department, they are not required to report within 24 hours. Without information showing when providers are notified, the Department cannot determine whether the timeframe for reporting to providers is being met. Children with these high lead levels require immediate medical attention due to the severity of the blood levels and potential health risks. As a result, it is imperative that providers be contacted with these results in a timely manner and that the Department is able to determine whether the timely notification occurred. The Department can obtain the needed information for monitoring laboratory timeliness by requiring laboratories to report results to them at the same time they provide the results to the providers.

We analyzed the data that is available to the Department and found 169 children (out of a population of 332 children) with blood lead levels equal to or greater than 45 mcg/dl were not reported to the Department within 24 hours of the analysis. As a result, the Department has no assurance that the provider was notified in a timely manner. To be conservative in our analysis, we eliminated those results that did not meet the timeliness test because the time period included a weekend.

According to Department officials, quality assurance activities related to laboratory reporting were developed and implemented in

2004. Officials stated the basic elements of this analysis include examining gaps in reporting, timeliness of reporting and completeness of reporting. Specifically related to timeliness, on a quarterly basis, the Department identifies those laboratories that report around 50 percent or more of their total submissions beyond nine business days from the analysis date. Laboratories identified as late reporters are sent a letter notifying them of reporting deficiencies. While we feel the quality assurance activities developed by the Department are a valuable tool, a laboratory has to report almost 50 percent of their tests late before they are contacted. In addition, as reflected above, our results show a number of laboratories do not comply with the reporting requirements. As a result, we feel the quality assurance activities should be expanded to a lower threshold of non-compliance.

Department officials advised us that labs that are repeatedly found to not report blood lead tests in a timely manner should be referred to the Department's Clinical Laboratory Evaluation Program, which oversees clinical laboratories. Staff from this program visit the laboratories to determine, among other things, why delays are occurring. When deficiencies are identified, program staff may issue citations and require a plan of corrective action. Chronic problems can result in administrative fines being imposed and/or the laboratory's permit being revoked.

Recommendations

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.
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.

3. Enforce lead screening and risk assessment requirements.
4. Require providers to follow up on those children for whom they do not receive lead screening results.
5. Work with the counties to expand the use of PBII visits statewide and increase these visits to reach more providers.
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.
7. Obtain necessary information to determine whether laboratories report the results of blood lead analysis equal to a greater than 45 mcg/dl to providers within 24 hours.
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.

Follow-Up for Children with High Lead Levels

Department regulations require counties to identify and track children with elevated blood lead levels to ensure appropriate follow-up. There are nine follow-up activities the county must ensure are completed. These activities include follow-up testing to confirm the child's blood lead level, explanation of test results to the family with information about risk reduction, nutritional counseling, developmental screening, advice on relocation

while lead hazards are removed, and testing of siblings under six years old. The other three follow-up activities are done as needed: medical treatment, environmental management, and referral to other agencies. It is up to the county to coordinate these activities with the primary care providers to determine how follow-up will be completed, as well as to develop policies and procedures for completion of these activities. Timeframes for completion of environmental inspections have been established by the Department.

Additionally, timeframes for confirmatory screening, follow-up screening, and initial contact with families have been developed by the CDC. No timeframes have been established for the remaining follow-up activities; therefore, it is up to the counties to determine these timeframes. For example, there is currently no regulatory requirement for re-inspections to ensure lead hazards have been abated. However, each of the counties we visited includes this as a step in their follow-up process. As a result, each county must determine how long after the initial inspection to conduct a re-inspection.

According to the Department, as of July 2006, case management guidelines including timeframes, have been developed but have not yet received final approval or been distributed to the counties. However, it is unclear whether these guidelines will contain timeframes for the remaining activities.

We visited five counties (Onondaga, Erie, Monroe, Schenectady and New York), and reviewed the documentation of follow-up activities for a sample of 25 children in each county. Each of the counties we visited has chosen to conduct all or almost all of the follow-up activities on their own, with input from health care providers. In determining whether a child received appropriate follow-

up activities in a timely manner, we measured against the Department's standards and those set by the counties.

Overall, we found that children identified as having high blood lead levels are receiving required follow-up activities. However, we found 38 specific activities (relating to 25 children) were missing or were not conducted in a timely manner. Thirty-one (relating to 19 children) of these 38 activities in Erie County.

During our visit to Monroe County, officials told us that as soon as children reach six years of age, they are discharged from case management unless otherwise requested by their provider, even if a child has been continuously receiving case management services. Monroe County was the only one of the five counties we visited that used this practice. Currently, regulations require screening and assessment for children six months to six years of age. However, follow-up is required for "each child with an elevated blood lead level." There is no age limit for follow-up included in the regulations. Additionally, according to the CDC's case management guidelines the case should be closed when the environmental lead hazards have been eliminated, the child's blood lead level has declined to below 15 mcg/dl for at least six months and the other objectives of the case management plan have been achieved. Further, the guidelines state that it often takes an extended period of time to complete all the elements in a case management plan. As a result, no child should be dropped from receiving case management services, simply for reaching their sixth birthday. Additionally, in some instances, children may not have health care providers to advocate for them. In other cases, they have been receiving case management for an extended period of time and have been unable to attain an acceptable blood lead level.

Dropping them from case management cannot provide any benefit to the child.

According to Department officials, each county is required to create and update a policy and procedure manual for implementing the Program, including the nine required follow-up activities. Officials stated these manuals are reviewed and approved as part of the regional office site visits to the counties. However, officials do not determine whether the counties are meeting the specific timeframes and steps set forth in their manuals. Instead, officials review children's files to determine whether or not follow-up was provided.

Recommendations

9. Require counties to follow up on children with elevated blood lead levels until levels fall to an acceptable level.
10. Monitor county performance toward meeting the specific timeframes for follow-up activities set forth in their policy and procedure manuals.

Prenatal Care

Public Health Law Section 1370-a requires the Department to set, distribute and enforce regulations for screening pregnant women for lead poisoning, and for following up in instances of elevated blood lead levels.

According to Department officials, a lead exposure risk assessment is completed for all women served by the Prenatal Care Assistance Program (PCAP) and the Women, Infants and Children Program (WIC). Both programs serve lower income pregnant or post-partum women. Neither the Department nor any of the counties we visited ensure all prenatal providers, including private providers, are risk assessing women as

required. As previously indicated, officials also stated they "do not have the authority to routinely mandate access to private physician office medical charts without a HIPAA compliant subpoena or court order." However, HIPAA allows a covered entity, including a physician, to disclose protected health information upon the request of the Department for purposes of enforcement or oversight of the Program without a HIPAA compliant subpoena or court order. In addition, we question why site visits similar to the PBII visits for children's providers are not conducted to provide some assurance risk assessments are being completed.

We sent questionnaires to a random sample of 100 prenatal care providers statewide (out of a population of 2,171 providers), and received 38 responses. Nine of the responses stated the provider was no longer practicing or was not currently practicing obstetrics. Twelve providers stated they do not risk assess pregnant women, and 17 stated they do complete this assessment. Of the 12 that do not risk assess, 2 providers stated they do not have any risk assessment materials, and 3 stated more literature is needed. In addition, of the 29 providers practicing obstetrics, 14 stated lead poisoning prevention is not discussed at the postpartum visit as required, 13 stated lead poisoning prevention is discussed, and 2 did not provide an answer.

Recommendation

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

Day Care Facilities

Department regulations state prior to or within three months of a child's initial enrollment, each day care provider must obtain and retain a copy of a certificate of lead screening for that child. When there is no documentation of lead screening, the child should not be excluded from attending. However, the facility must provide the parent or guardian with information on lead poisoning and lead poisoning prevention, and refer the parent or guardian to a primary care provider or to the county to obtain a blood lead test for the child.

Oversight of day care facilities outside of New York City is the responsibility of the State's Office of Children and Family Services (OCFS). In New York City, this oversight is the responsibility of the New York City Department of Health and Mental Hygiene's Bureau of Day Care. Officials from both agencies stated they visit day care centers on a regular basis, and as part of these visits they determine whether certificates of lead screening are being obtained. They also stated that they look for chipping paint or other possible lead hazards. However, OCFS officials stated they do not provide education and outreach regarding lead poisoning prevention because this is the Department's responsibility. OCFS officials also stated they expect to have more involvement with Department officials in the near future as a result of the Department's plan to eliminate lead poisoning by 2010. New York City Bureau of Day Care officials stated that if someone came to their office, they could get lead brochures. However, they have never done a mass mailing of brochures to day care facilities.

According to officials at two of the five counties we visited, Schenectady and Erie, they review children's files at day care

facilities to ensure certificates of screening have been obtained. Officials from all five counties we visited stated they provide outreach and education to day care facilities. However, Monroe County officials stated this outreach and education is only provided when specifically requested.

We sent questionnaires to a random sample of 100 day care facilities statewide (out of a population of 18,956 facilities) to determine whether the facilities were obtaining certificates as required, and received 36 responses. Four facilities indicated they either are no longer open, are not open yet, or do not serve children under the age of six. Fourteen facilities responded they do not require certificates of lead screening, while 18 indicated they do require these certificates. Six facilities requested information on the Program, including one facility that responded it did not know about the Program. Copies of these six questionnaires were provided to the appropriate county so that the requested information could be provided. In addition, one facility responded that obtaining the certificates of lead screening was recommended but not required, and six indicated that if a child did not have a lead test they do not provide information or education to the parents.

Recommendations

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

Oversight Provided to Counties

The Department provides oversight to the counties in a number of ways including regional and statewide meetings, teleconferences and local coalitions. We found improvements need to be made in some of their additional oversight methods including work plans and quarterly reports and regional office site visits to counties.

Work Plans and Quarterly Reports

Each county must complete and submit an annual work plan to the Department and its regional office to outline planned activities for the coming year. These work plans consist of goals in areas such as outreach and educational activities to be completed, target screening rates, the number of PBII visits to be conducted, and follow-up activities to be completed according to blood lead level. We found goals are often not quantified, especially in the area of outreach and education. For example, Schenectady County identified one of its goals as the “inclusion of lead pamphlets/information at health fairs or other community events attended by local health unit staff.” However, the work plan does not identify an approximate number of health fairs or other community events to be attended or the approximate number of pamphlets/information to be distributed. In contrast, for each item listed in the Onondaga County work plan, officials identify the number of possible encounters to be made, brochures to be distributed or presentations to be completed. In addition, county officials are not required to show the time frames in which the nine follow-up activities will be completed.

To show progress in relation to the work plan, each county is required to complete and submit quarterly reports to the Department and its regional office. These reports contain

a data and a narrative section. The data section includes statistical information such as the number of addresses requiring inspection, the number of those for which an inspection was completed, and the number at which lead hazards were found. During their site visits, regional office staff review case files to determine whether the counties are performing required follow-up activities. However, since Department officials indicated that work plans and quarterly reports are major monitoring tools, the information on these documents should be specific enough to be useful in assessing whether goals are being accomplished. For example, the data section does not show that all addresses for which lead hazards were found, were remediated. Including the above information in quarterly reports could assist regional office staff in focusing their site visits. The narrative section describes the steps the county has taken toward meeting the goals contained in the work plan. Each quarter, Department officials review the narratives against the work plans and reports from prior quarters to determine whether progress is being made toward each of the county’s goals. We found the counties are allowed considerable flexibility in meeting their goals. When Department officials cannot see progress being made, we noted that they will contact the county.

Regional Office Oversight

Regional offices are required to conduct site visits at each of the counties within their catchment area to ensure the Program is functioning as required at the local level. These site visits include interviews with county lead officials, a review of children’s files primarily for the purpose of determining whether children are receiving required follow-up activities, as well as a review of outreach and education materials and the policy and procedure manual required of each

county. Regional office staff also occasionally accompany inspectors on home visits. We determined the Department has not developed standardized, written procedures for regional office site visits to the counties. As a result, we noted inconsistencies in the way the regions conduct their site visits, and in some cases, county activities are not being adequately monitored.

Department officials have verbally recommended that regional offices perform site visits every one to three years. However, the regional offices determine the actual frequency of these visits since the Department has not set a formal, minimum requirement. Officials from each of the regional offices stated that each county is put on a site visit schedule of every one to three years, depending on the county. Using the criteria of each regional office, we found site visits were not conducted in a timely manner for 13 of the 57 counties outside of New York City. In addition, Department officials conducted a site visit to the New York City Department of Health and Mental Hygiene in October 2005. Regional office and Department officials could not document that a prior site visit had been conducted at the New York City Department of Health and Mental Hygiene since 1995, even though this agency is responsible for overseeing the lead screening and follow-up for all children in New York City.

At the end of each site visit, regional office staff are required to complete a report identifying areas where a corrective action plan is required. Department officials have provided only verbal guidance to the regional offices on the completion of these reports and state that many factors affect the timing of issuing the reports, such as the need to compile findings from multiple visits. Three regions, Capital District, Metropolitan Area and Western, indicated these reports are

completed within 30 days of the site visit. Central indicated it completes site visit reports within 60 days of the visit. We reviewed the completion of these reports according to each region's standards and found reports for 39 of the 58 counties were not completed in a timely manner, ranging from 33 to 983 days for completion. While we acknowledge there could be delays in producing these reports, 6 of the 39 reports took over two years to be completed and an additional 8 took over one year. Each of these 14 delays occurred in the Western region. It is important that site visit reports be completed in a timely manner so that counties can prepare their corrective action plans as needed.

The Department also does not have written guidelines for the timely completion of corrective action plans. Officials from three regions, Capital District, Metropolitan Area and Western, stated corrective action plans are required within 30 days of the receipt of the site visit report. The Central region requires corrective action plans be submitted within 60 days. Of the 21 counties required to complete a corrective action plan based on their most recent site visit, we found five instances in which corrective action plans were not completed in a timely manner, ranging from 61 to 196 days for completion. In one additional instance, the Central regional office could not provide us with a corrective action plan. According to officials from the Western regional office, corrective action plans are not always required because in general, anything found are "things that need to be tweaked, not deficiencies." However, during our review we found that counties in the Western region were cited for untimely lead inspections, incomplete or lack of documentation of follow-up activities (8 of 17 counties), a passive stance taken in the home visit process, and policies and procedures that need to be updated, revised or

have specific items added (15 of 17 counties). Yet, only one county (which needed to revise its policy and procedure manual) was required to complete a corrective action plan. We identified instances in the other regions where counties were cited for similar deficiencies and a corrective action plan was required.

The Department requires regional offices to follow up with the counties with regards to the deficiencies identified in their corrective action plans. There are no required methods or timeframes for this follow-up. According to Capital District, Central and the Metropolitan Area regional office procedures, follow-up visits are made only if major problems are found during the site visit; otherwise, follow-up is conducted by phone or email. According to officials from the Western regional office, follow-up is conducted with the next quarterly report. Of the 21 counties that were required to complete a corrective action plan, no evidence of follow-up could be provided for 14 counties. Additionally, 15 counties from the Western region were cited for deficiencies, but no corrective action plan was required. Evidence of follow-up to ensure deficiencies were corrected could not be provided for any of these counties.

Overall, we noted that the Western regional office needs to be more proactive. Some areas that specifically should be addressed include: physicians not screening children; parents refusing inspections; obtaining work plans and quarterly reports; the development of a standardized site visit tool and report; understanding the data section of quarterly reports; and obtaining a clear, comprehensive understanding of the Program.

We did not find similar issues in the other regions we visited. As a result, we conclude Western regional office officials should consult with the Department and possibly

other regional office officials to resolve these issues. In response to our preliminary report, Western regional office officials agreed that they “will consult with Central office and other regional office staff to resolve these issues.”

Recommendations

14. Require that work plans include quantifiable goals and that counties make substantial progress toward meeting their goals.
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.
16. Develop and implement standardized written procedures for site visits to counties to be used by all regions.
17. Work with Western regional office officials to ensure Department expectations are clear and regional officials are meeting those expectations.

New York State Advisory Council on Lead Poisoning Prevention

In 1992, Public Health Law Section 1370 (b) created The New York State Advisory Council on Lead Poisoning Prevention (Council) within the Department. The Council is to be chaired by the Commissioner of Health or his or her designee.

Council Responsibilities

The Council is required to meet as often as necessary to fulfill its responsibilities which include, among other things, to: develop a

comprehensive statewide plan to prevent lead poisoning and minimize the risk of exposure; recommend the adoption of policies regarding detection and elimination of lead hazards as well as the identification and management of children with high lead levels; and report on or before January first of each year to the Governor and the Legislature concerning the development and implementation of the statewide plan and operation of the Program, together with recommendations as necessary.

We found that the Council does not issue the required annual reports. The last annual report was issued in 1998 covering the 1995-1996 accomplishments of the Program; recommendations made by the Council, status of recommendations made in 1994; extent of lead poisoning in the State; progress in developing a State plan to prevent lead poisoning; and the future direction of the Council. Since that time, the Department has issued three public lead poisoning reports. However, these reports were not completed by the Council and do not contain the same types of information as the report issued in 1998.

The Council had not been holding meetings on a consistent basis. Six meetings were held during our audit scope: June 22, 2004, September 22, 2004, April 18, 2005, July 28, 2005, October 20, 2005 and March 13, 2006. However, the last meeting prior to these meetings was held on September 23, 1997. Department officials could not explain why meetings had not been held during this time period. In addition, the period of lack of activity from the Council caused some regional and county officials to question whether the Council still exists.

Membership

Section 1370-b of the Public Health Law states the Council shall consist of the Commissioners of the following agencies, or their designees: Health; Labor; Environmental Conservation; Housing and Community Renewal; and Social Services. In addition, 15 public members are to be appointed by the Governor.

The Council members currently consist of 6 required commissioned members and 11 of the 15 required public members. Since the Council's inception, the New York State Department of Social Services has been dissolved and the Office of Temporary and Disability Assistance and the Office of Children and Family Services have taken its place, bringing the required commissioned members up to six. The Local Housing Authority and Environmental Group designees for the public members are currently vacant and there are two other non-specific public member positions that are vacant. Of the 11 public members currently in the Council, the Hospital member term has been expired since 1999 and the existing member continues to serve in this position. In addition, completion of the reappointment process for the Community Group member took a year and five months and it took eight months for the Professional Medical Organization member.

When vacancies are not filled in a timely manner, there is a loss of input from member agencies during meetings, including ideas and recommendations for implementing the Program. Department officials explained the appointment and reappointment process can be lengthy in nature, involving determinations of any conflicts of interest and a review of a candidate's qualifications.

Recommendation

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

AUDIT SCOPE AND METHODOLOGY

We conducted our performance audit in accordance with generally accepted government auditing standards. We audited the Department's oversight of the Program for the period April 1, 2002 through March 13, 2006. To accomplish our objective, we reviewed applicable laws, rules, regulations, policies and procedures, and we interviewed Department, regional, and county officials.

We obtained downloads of the MMIS and Immunization Registry databases and identified 380,933 children born between June 1, 2001 and October 31, 2003. We also obtained downloads of ECLRS and Leadtrac lead poisoning databases for the period April 1, 2002 through December 31, 2004. We then determined if any of the 380,933 children appeared on the ECLRS and Leadtrac databases. Based on our analysis, we initially concluded that 194,082 children were not screened for lead poisoning. This number was further reduced using the WizSame program, which identifies possible duplicates, resulting in 186,867 children not screened. From this population, we selected a statistical random sample of 70 children, using a 95 percent confidence level. We verified this sample to the Department's lead poisoning databases to further determine whether these children had, in fact, been screened for lead poisoning. The Department's lead databases were also used to identify children who had only been screened for lead poisoning once and to determine the timeliness of lab reporting.

We visited the Department's four regional offices, as well as the local health departments (referred to as "counties") in Erie, Monroe, Onondaga and Schenectady Counties, and New York City. These locations were selected based on geographic location, incidences of high lead levels in children and their use of the Leadtrac system. At each of the counties, we reviewed work plans, quarterly reports and a random sample of 25 files for children under the age of six with elevated blood lead levels equal to or greater than 15 mcg/dl (the blood lead level at which the counties we visited perform follow-up activities). The total population of children at the counties we visited was 2,767 and ranged from 39 to 1,300 children per county. Our file review focused on the documentation of follow-up services provided to children including: the timeliness of initial contact by the county with the family and health care provider, environmental inspections, letters to property owners and re-inspections, educational services provided, reminders for follow-up screening, and the screening of possibly exposed siblings. The education and outreach provided by the Department and each county was also reviewed. We also reviewed the membership, meetings and reports produced by the Council.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State, several of which are performed by the Office of Operations. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of whom have minority voting rights. These duties may be considered management

functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

AUTHORITY

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

REPORTING REQUIREMENTS

A draft copy of this report was provided to Department officials for their review and comment. Their comments were considered in preparing this report, and are included as Appendix A. Appendix B contains State Comptroller Comments which address certain matters in the Department's response. Department officials generally agreed with our recommendations and indicated actions either planned or already taken to implement them. However, they took issue with the methodology and manner in which we developed the data matching results, and

conducted our survey of health care providers. We maintain that our data matching and data analysis was a valid methodology to determine the number of children not screened for lead poisoning. Regarding our survey, we did not use the results as a basis for making any recommendations but only as a means to validate our audit findings.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

CONTRIBUTORS TO THE REPORT

Major contributors to this report include William Challice, David R. Hancox, Albert Kee, Sheila Emminger, Todd Seeberger, Vicki Wilkins, Andrea Inman, Dennis Buckley, Doug Abbott, Michael Asencio, Michael D'Amico, Jennifer Mitchell, Amanda Strait, John Karwacki, and Paul Bachman.

APPENDIX A - AUDITEE'S RESPONSE



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

December 14, 2006

William P. Challice
Audit Director
Division of State Services
State Audit Bureau
123 William Street – 21st floor
New York, New York 10038

Dear Mr. Challice:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report on "Oversight of the Childhood Lead Poisoning Prevention Program" (2004-S-49).

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

cc: Ms. Anderson
Ms. Astin
Mr. Boxley
Mr. Cambridge
Dr. de Long
Mr. Griffin
Mr. Howe
Dr. Jenny
Ms. McTague
Ms. Mesler
Mr. Murphy
Ms. Ryan
Ms. Riser
Ms. Silver

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

The following is the Department of Health's response to the Office of the State Comptroller's (OSC) draft audit report 2004-S-49 on "Oversight of the Childhood Lead Poisoning Prevention Program."

General Comments:

The New York State Department of Health Childhood Lead Poisoning Prevention Program is recognized as one of the most comprehensive and effective lead poisoning prevention programs in the nation. For over three decades, New York has been a national leader in developing and implementing evidence-based lead prevention public health programs and policies. Many of New York's regulations and program components have served as national models for other states.

A comprehensive public health approach is implemented in New York to prevent and eliminate the problem of childhood lead poisoning in the State. An effective public health approach emphasizes broad population-based outreach, education, policy, and systems changes, with more intensive assurance efforts targeted to the populations at highest risk for lead poisoning. This multi-pronged approach to addressing public health needs is consistent with the expert national consensus outlined by the Institute of Medicine in its landmark report (1988) *The Future of Public Health*, and is also consistent with the current guidance specific to lead poisoning prevention provided to New York from the federal Centers for Disease Control and Prevention (CDC).

New York's comprehensive public health approach addresses 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, comprehensive medical and environmental management for children with lead poisoning; and
- Policy and program activities to advance primary prevention of lead poisoning to reduce exposure before children become lead poisoned.

New York's work is guided by the Public Health Law and regulations; standards and guidelines promulgated by CDC; current published peer-reviewed research; and ongoing

input from New York's Lead Advisory Council and other stakeholders. Work is undertaken in close partnership with health care professional organizations and insurers, local health departments, other state and federal agencies, and many other programs within the Department of Health.

The success of New York's public health approach is evidenced by the dramatic declines in childhood lead poisoning over the past several years. Between 1998 and 2003, the number of children newly identified with lead poisoning (defined as blood lead levels at or above 10 mcg/dL) decreased by 57%, from 16,308 children in 1998 to 7,039 children in 2003. This decline translates to a 44% decrease in incidence rates from 2.9 cases of lead poisoning per 100 children tested in 1998, to 1.6 cases per 100 children tested in 2003. Over the same period, the prevalence rate (which includes both new and ongoing cases of lead poisoning) declined by 54%, from 5.3 per 100 children tested in 1998 to 2.5 per 100 children tested in 2003. These recent data highlight ongoing steady declines in both the incidence and severity of childhood lead poisoning, within New York and nationally, over the past three decades. This decline in children's blood lead levels has been noted as one of the most significant public health successes of the last half-century.

The effectiveness of New York's approach is further evidenced by continued success in screening children at risk for lead poisoning to assure that problems are detected as early as possible, and that children with elevated blood lead levels receive timely, comprehensive medical and environmental services to prevent further exposures. New York is one of only a few states with a law requiring screening or with a requirement for universal childhood screening, and is among the states with the highest lead screening rates in the nation. Lead screening rates have increased steadily over the past several years. Over 66% of children born in New York (excluding New York City) in 2001 were screened for lead poisoning at least once by the age of 24 months, up from 62.6% of children born in 1996. Lead screening rates among children enrolled in Medicaid Managed Care plans – who represent one of the highest risk groups of children in the state – increased from 70% in 1998 to 86% in 2005. These screening rates are much higher than national screening rates for Medicaid-eligible children reported by CDC, which show that nationally only 43% of Medicaid eligible children ever receive a blood lead screening test.

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The time period during which OSC conducted their audit of our lead program corresponds to a period of significant and rapid development in the field of lead poisoning prevention in general, and within our lead program specifically. In June 2004, in response to new federal guidance from CDC, the Department released a statewide strategic plan for the elimination of childhood lead poisoning in New York by 2010. This plan reflects cutting edge research related to lead poisoning, as well as collaborative input from a variety of stakeholder groups, including professional medical organizations, the New York State Association of County Health Officials, the Maternal Child Health Block Grant Advisory Council, and New York's Lead Poisoning Prevention Advisory Council. The plan outlines a new multi-year agenda for lead poisoning prevention in New York in the areas of surveillance and data analysis, lead screening of children and pregnant women, and primary prevention. The plan emphasizes strengthening of community and state level

partnerships, and targeting intensive efforts in the highest risk communities and populations, as key approaches to achieving goals and objectives.

Since its publication in June 2004, the elimination plan has served as a living document to guide the further development and implementation of previous and new lead prevention activities. As implementation of the plan has progressed over the past two years, many new partnerships and initiatives have been initiated, and many steps taken to further develop, refine, and improve longstanding components of our program. As noted in this response to OSC's recommendations, many of the areas addressed by OSC in this draft audit report are areas in which changes were already made or initiated as part of New York's comprehensive strategic planning and implementation efforts. However in many instances, the OSC audit focuses only on specific narrow aspects of the program, and does not recognize how those activities fit within a broader scope of comprehensive lead prevention activities and ongoing program development. The Department welcomes the opportunity the audit process has provided to further consider these issues and to share information about progress in addressing them.

Response to Audit Results – Summary *(Draft Report page 2)*

This section does not present a balanced summary of the full draft report. The full report includes descriptions of both perceived positive and negative findings. There are many places throughout the draft report where OSC acknowledges current program activities, strengths, and accomplishments related to the areas covered in the audit. However, this summary only summarizes the perceived negative findings. Without reference to these positive findings, the audit summary presents an unbalanced synopsis of the overall audit findings that will mislead readers who do not review the entire detailed report. We request that this section be revised to reflect a more balanced summary in the final report.

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Response to Audit Findings and Recommendations *(Draft Report pages 4-17)*

Screening

In the draft report, OSC describes the analysis they conducted to estimate the number of children not screened for lead in New York. As discussed extensively with OSC throughout the audit process, the methodology OSC used to conduct their analysis is not rigorous enough to justify their conclusions. Data matching between unrelated data sets is a complex undertaking that requires development and testing of sophisticated matching algorithms, which include application of multiple rounds of matching using varying criteria and a non-match rate, to produce valid results. In light of the many methodological flaws in OSC's comparison of the Medicaid, Immunization and Lead databases, we do not agree with OSC's conclusion that failure to identify a match between databases analyzed equates to lack of lead screening for those children.

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As a key example, OSC's use of strict matching criteria with only a single round of matching very likely resulted in many potential data matches not being identified, and therefore an understatement of the number of children screened for lead poisoning. Only

a single round of very strict matching criteria of exact spelling of last name, exact spelling of first name and exact date of birth was used by OSC to identify matches between databases. The Department uses multiple rounds in any matching process that is conducted, which is recognized among researchers as necessary to achieve optimal matching levels and attain valid findings. This is often followed by a manual review of matching results. As another key example, OSC did not restrict their analysis to children who had been continuously enrolled in Medicaid during the time period in which lead test(s) would have been required. Without this important restriction, OSC cannot confirm that children without a matching record in the lead database resided in New York at the time a lead test would have been conducted. This is an important consideration for the highly mobile Medicaid population, and results in a further understatement of the number of children screened for lead poisoning.

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The lack of consistency between OSC's findings and comparable established screening rates arrived at with nationally accepted methods confirms skepticism with OSC's methodology. Because OSC's analysis used the Medicaid database as the major comparison population for matching with the lead registry, it is most appropriate to compare their results to other known screening rates for the Medicaid population. In New York, approximately 40% of all children are eligible for Medicaid, with the vast majority (approximately 75%) of these children enrolled in Medicaid Managed Care plans. Because of the importance of screening children for lead poisoning, the Department has incorporated lead screening as a performance measure for Medicaid and other managed care plans within the Quality Assurance Reporting Requirements (QARR). Data for the QARR Lead Screening measure is collected through a systematic review of a representative sample of enrollee medical charts, and represents a rigorous gold standard measurement of lead screening rates for Medicaid Managed Care enrollees. The most recent report of these measures shows that 86% of children enrolled in Medicaid Managed Care plans received at least one lead test by the age of 24 months in 2005, up from 70% in 1998. In contrast, the proportion of Medicaid-enrolled children screened for lead reported by OSC based on their data analysis appears significantly lower. Although OSC does not present their results in terms of a screening rate (i.e. a percentage of eligible children who were screened for lead), based on the numeric results reported by OSC in their report, their estimated lead screening rate is approximately 65%, in contrast to the established screening rate of 86% described above. New York's screening rates are especially impressive in comparison to recent information provided by CDC that the national average lead screening rate for the Medicaid population was 43%, far below New York's rate.

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OSC also describes the results of a survey they conducted with a sample of 100 pediatricians. The methodology used by OSC does not support the audit findings or recommendations. For example, the questions included in the survey were vaguely worded and were not validated prior to conducting the survey. Moreover, OSC obtained a very low response rate to this survey, which is likely to result in a significant response bias.

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The Department does not agree with OSC's comment that the screening rates published by the Department are overstated, nor is this comment substantiated by any data analysis performed in conjunction with this audit. The Department has worked extensively, in conjunction with the CDC, the National Center for Quality Assurance (NCQA), and with colleagues in other states to define valid, standardized, robust, scientifically accepted methods for estimating screening rates and other lead-related indicators. To estimate the number of children tested for lead, a matching algorithm is used that accounts for the possibility of similarity in names and minor common errors such as misspelling of a child's first or last name, or an incorrect birth date. In addition, local health department staff, who are familiar with their county's records, review incoming lead test records, and can account for errors by manually matching incoming records to existing child records, thus further decreasing duplicate records. The Department's new LeadWeb data system contains additional system improvements that will further decrease the occurrence of duplicate records.

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Finally, OSC's statement that the Department does not routinely calculate screening rates for the requirement that children be screened at one and two is not correct. The most recent comprehensive lead surveillance data report includes a specific analysis to estimate the rate of second screening tests for children born between 1994 and 1999. The data analysis plan for the next comprehensive lead surveillance report, which is currently under development with input from the Lead Advisory Council, will include an expanded analysis of lead screening rates at or around both one and two years of age.

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The following are the Department's comments on specific OSC recommendations:

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:

Improving lead screening rates is one of the central goals of New York's lead elimination plan. Significant steps have been taken to improve understanding of why some children do not receive required lead screening tests and to develop new program and policy initiatives to address the barriers to screening. Data analysis has always been and will continue to be an important tool to help assess the extent of the existing childhood lead poisoning problem statewide, to identify high-risk communities and populations with the highest need for interventions, and to monitor and evaluate the effectiveness of our interventions.

The Department is very familiar with the potential for using database matching as a tool for program improvement. As part of our implementation of the lead elimination plan objective related to improving surveillance of lead screening rates, the feasibility of using data matching as a method for increasing lead screening rates is periodically assessed.

We have performed lead screening data matches with both the Medicaid Managed Care and the Early Intervention Programs, and the results have been helpful for the purpose of identifying high-risk areas and populations for targeted lead screening promotion efforts. However, using data matching for the purpose of identifying and referring individual children for lead testing, as recommended by OSC, has a number of significant limitations. Lead testing information in the registry would have to be real time data to effectively intervene with individual children. The LeadTrac database is not a real time database. Therefore, it has not been feasible to use this type of dated analysis to identify and act on results related to individual children in a timely manner. This is illustrated by the fact that OSC's own analysis focused on lead tests that occurred several years before the analysis was conducted, and thus after the timeframe for clinical opportunity. It would not be helpful to use these results to follow-up on individual children, since the opportunity to test those children within the required timeframes would be past.

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The Department has developed a new lead registry, LeadWeb, which provides up-to-date real-time lead test records. As part of our ongoing work to achieve our elimination plan goals for universal screening, we have begun working with the Office of Managed Care to test new data matches to identify children who have not been tested for lead, and work with those children's managed care plans and health care providers to assure that lead screening occurs within a specified time frame. We anticipate that this initiative will be tested within the next 12 to 18 months.

Recommendation #2:

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

Response #2:

As described in Response #1, additional data matching efforts are being tested to identify children who have not been screened for lead, and to work with health plans and providers to assure testing is pursued. Information from these data matches also will be made available to the local health departments to assist them in carrying out targeted screening promotion activities with health care providers and families in their counties.

In addition, to assist local health department (LHD) staff in screening promotion activities, the Department created report capability within the new LeadWeb system, which allows LHD staff to identify all children in their counties who are due for second lead tests at or around age two years. Using this report, LHDs will be able to generate and send letters to both the parents and health care providers notifying them of the need for the lead test, and conduct additional follow-up for those children who do not get tested. This new reporting function is being implemented in December 2006.

Recommendation #3:

Develop and implement regulations that contain penalty and enforcement provisions that enable the Department and the counties to enforce lead screening and risk assessment requirements.

Response #3:

As noted by OSC, improving compliance with current lead screening regulations is one of the key objectives described in the Lead Elimination Plan (LEP). We have already taken a number of steps to implement this element of the plan, with additional activities planned.

When reports of non-compliant providers are received by the Department, the initial response consists of education to the provider to reinforce screening requirements and to assess their need for technical assistance. If initial educational efforts by LHD and regional office staff are not successful, expert clinicians at the Regional Lead Resource Centers are engaged to provide peer-to-peer education to providers. In most instances this type of educational approach is successful in influencing provider practice. The Department has authority under Sections 12 and 206(4)(c) of the Public Health Law to assess penalties of up to \$2000 for each violation of Public Health Law, and the State Board of Professional Medical Conduct has authority under section 230 of the Public Health Law to enforce cases of physician misconduct, which the Department would consider in situations warranting such an approach. As described in our LEP, we will work with the Lead Advisory Council and professional medical organizations to document this current protocol in a written policy, as part of our overall efforts to improve lead screening practices.

Current regulations for lead screening requirements and enforcement penalties are clear. Based on the Department's extensive public health experience, an evidence-based public health approach to improving lead screening practices has been chosen and implemented through collaboration with professional medical organizations, insurers, and other partners, using a combination of, population-based education and outreach activities, education and technical assistance to providers, and systems-based policy changes. The steady increase in lead screening rates, both among the general population and the Medicaid population specifically, is a testament to the success of this approach.

Key examples of recent and ongoing strategies undertaken to improve lead screening rates include:

- Utilization of QARR data (described above) for a variety of systemic 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 are below the statewide average. The action plans proposed by managed care

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plans are reviewed by Department staff and help target plan interventions for quality improvement. Managed care plans that perform well on QARR are eligible for the Quality Incentive, a program that provides up to 3% of additional premiums to Medicaid managed care plans that perform well on quality. This approach is key because approximately 75% of the children in New York are enrolled in managed care plans. Because the state enrolls Medicaid children on a mandatory basis, this approach reaches a high proportion of children disparately impacted by lead.

- Revision of the Women, Infants and Children (WIC) Medical Referral Form for Infants and Children to add fields for reporting blood lead levels at ages one and two years, and to remove the word 'optional' from the previous field for reporting lead test results. In addition, the accompanying instructions for health care providers completing the form were modified to add the statement: "A blood lead test is required by law for all children at one and two years of age". This form is completed by health care providers to help determine eligibility of children referred to WIC. These changes are effective because they reinforce screening requirements and improvement in collection of lead screening information for an entire population of low income and other at-risk children statewide. Approximately 250,000 children under the age of three are active participants in WIC each month.
- In September 2005, a letter outlining lead screening requirements and rationale for universal screening was distributed to over 24,000 pediatric providers statewide, including pediatricians, family physicians, nurse practitioners, physician assistants, and managed care organizations. This letter was jointly signed by the Commissioner of Health and the Presidents of the American Academy of Pediatrics District Office II, the New York State Academy of Family Physicians, and the Medical Society of the State of New York.
- The Department contracts with Regional Lead Resource Centers in each region of the state. These hospital-based centers provide a statewide network of clinical expertise and physician education related to lead poisoning prevention. The centers specifically assist in providing both general and targeted education to health care providers within their communities about lead screening requirements and case management of children with elevated blood lead levels.
- The Department, in collaboration with the Regional Lead Resource Centers and medical academies, is in the process of developing a comprehensive clinical lead prevention toolkit to assist providers in implementing requirements for screening, risk assessment, and clinical management in their practices. This toolkit will include practice guidelines, office reference materials, patient education materials, and other resources to help providers incorporate lead screening requirements in their practices. The toolkit

specifically will include up to date guidance on in-office lead testing options that can help address many of the barriers to lead testing identified by health care providers and parents.

- In December 2005, an article reinforcing lead screening requirements was included in the *Medicaid Update*, a monthly publication disseminated by the Department to over 47,000 providers and medical institutions in the Medicaid program statewide. The article will again be published in the December 2006 *Medicaid Update*.

Recommendation #4:

Develop and implement regulations requiring providers to follow up on those children for whom they do not receive lead screening results.

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Response #4:

As described above in Response #3, the Department does not agree that additional lead screening regulations related to this issue are needed. It is agreed that health care providers play a critical role in encouraging families to follow through on lead screening. A multi-faceted approach to improving lead screening, as outlined in the elimination plan and in responses above, includes a variety of approaches targeting both providers and families to improve screening practices. Many of these approaches include specific strategies to address the barriers cited by providers and parents that result in lack of follow-through on written prescriptions for lab testing. Specific strategies related to these barriers that will be incorporated in our ongoing and planned screening promotion activities include:

- Updated, evidence-based educational messages for parents to increase the 'demand' for lead testing and encourage parents to obtain lead screening tests when ordered;
- Additional guidance for local health departments to provide education and technical assistance to health care providers regarding practical strategies for improving screening rates within their practices, including effective strategies for follow up of tests that are ordered;
- Promotion of office-based testing methods that allow for lead screening within the office, including capillary testing and use of LeadCare® (a portable blood lead analyzer manufactured by ESA) technology;
- Dissemination of a clinical toolkit for providers that includes practical materials and resources related to patient education and counseling, office reminder systems and appropriate use of office-based testing; and

- Continued incentives for managed care providers to increase lead screening rates within their practices, including follow-up of “missed opportunities” identified through future data matching exercises.

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 Department agrees that LHDs play a key role in promoting lead screening and other lead preventive practices within their communities. LHDs are responsible for conducting outreach and education to health care providers as part of their lead program work plans. Working with LHDs to build their capacity for achieving elimination of lead poisoning is one of the top priorities of the Department’s lead program. As part of the workplans all LHDs complete each year in conjunction with their grant funding from the Department, additional guidance and technical assistance will be provided to LHDs regarding effective strategies for working with health care providers to improve lead screening. Record review, with tailored data analysis and education, is a very resource intensive activity that may not be the most effective or efficient means of improving screening practices in all communities. Record review is more appropriate for targeted assurance activities associated with case management for children with lead poisoning. Given limited resources for public health work, the Department must be selective regarding when intensive record review activities are warranted. Because there are a number of effective approaches LHDs can carry out to improve lead screening practices within counties, LHDs will have the flexibility to choose from amongst a set of best practice approaches to pursue those that are most effective in their own communities based on the specific needs, resources, and relationships that exist. Department central office and regional office staff will work with LHD staff to assure that all counties are carrying out effective lead screening promotion activities that result in measurable improvements in lead screening rates. An updated LHD workplan is currently being finalized and will go into effect for most counties in April 2007.

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 described in the report, the Department’s Lead Program already has established a comprehensive quality assurance protocol to identify laboratories that are not in compliance with regulations for laboratory reporting, including requirements for timeliness

of reporting. The Program currently works directly with laboratories to educate laboratory staff on the regulatory reporting requirements. A letter is sent to all current permitted lead laboratories each year to remind them of the required elements and timeframes that must be followed for lead test reporting. Department program staff communicate with lead coordinators in local health departments on a continuous basis to troubleshoot laboratory reporting concerns, and coordinate with Electronic Clinical Laboratory Reporting System staff to resolve any reporting transmission problems that result in late reporting of lead test results or omission of critical data fields. In addition, on a quarterly basis, staff conduct an analysis of laboratory reporting to identify specific laboratories with deficiencies in meeting reporting requirements. A letter is then mailed to all laboratories that are not in compliance with laboratory reporting requirements describing the deficiency and requiring a written corrective action plan. If a corrective action plan is not received within the timeframe stated, program staff contact the laboratory director to provide additional guidance if needed. The Program works with the Wadsworth Clinical Laboratory Evaluation Program (CLEP) to cite laboratories with significant and/or repeated deficiencies in complying with laboratory reporting regulations. Reporting is tracked in subsequent quarters to assure that performance has improved. As demonstrated by extensive documentation previously provided to OSC during the audit, this process has resulted in significant improvement in timeliness of reporting by laboratories. We will continue to implement these procedures to assure timeliness of lab reporting.

Recommendation #7:

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

Response #7:

Laboratories are currently required to report blood lead test results that are greater than or equal to 45 mcg/dL directly to the ordering health care provider, who is responsible for carrying out medical follow-up treatment, within 24 hours of the date of analysis. The health care provider is responsible in turn for notifying the local health department within 24 hours of the date of analysis. These communications typically are accomplished by telephone where the urgency of the report can be communicated directly to the provider who is responsible for that patient's care, and in turn to the local health department to coordinate provision of follow-up activities. Because the Department does not carry out follow-up activities directly, regulations do not require reporting of these blood lead level results to the Department within this shorter timeframe, but rather within the standard five business days required for all blood lead test results. For the vast majority of laboratory results, this notification occurs via the electronic reporting system.

The Lead Program will work with CLEP to develop a protocol to survey laboratory reporting to health care providers of all blood lead levels ≥ 45 mcg/dL to assure that these results are reported to health care providers within 24 hours from the date of analysis.

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 the quality of lead surveillance data is one of the objectives of the lead elimination plan. As part of ongoing work to implement this multi-year plan, steps already have been taken to expand laboratory quality assurance activities, based on the success of previous quality assurance procedures described in Response #5. The threshold of non-compliance for timeliness of reporting of lead results triggering program action has been changed from 50% late reporting to 15% late reporting (i.e. less than 85% reporting within required timeframes). Laboratory performance against this benchmark is monitored quarterly through the program's laboratory quality assurance procedures. For those laboratories that do not meet this reporting standard, a letter is sent to the laboratory director citing the deficiency and outlining requirements for a corrective action plan. A copy of each letter is also sent to CLEP. Lead program staff communicate with the laboratories to discuss plans of correction. Laboratories with significant and/or repeated deficiencies in complying with laboratory reporting regulations are referred to CLEP for further action. We will continue to implement these procedures to assure timeliness of lab reporting.

Recommendation #9:

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

Response #9:

The Department agrees that discharge from case management should be on the basis of accepted medical criteria, and should not occur on the basis of age alone. To address this concern, case closure criteria have been more clearly defined in the forthcoming case management guidelines for LHDs developed by the Department. These guidelines are consistent with the most recent CDC recommendations for case closure, which state that a case can be closed when the environmental lead hazards have been controlled, the child's blood lead level (BLL) has declined to below 15 µg/dL for at least 6 months, and other objectives of the plan have been achieved. The criteria also state that the LHD case manager should discuss with the health care provider and child's parent/caregiver provisions for appropriate long-term developmental follow-up after discharge from LHD management.

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 agrees that overall children with elevated blood lead levels (EBLLs) are receiving required follow-up activities. The Department already carries out a full range of monitoring activities to assure that LHDs are taking the necessary steps to assure provision of timely and appropriate follow up services for all children with EBLLs. Under the Public Health Law and regulations, LHDs are responsible for assuring that children with EBLLs receive timely and appropriate follow-up services. As described in the report, there are nine specific follow up activities that may be required for each child, depending on the BLL and other case-specific considerations. In practice, LHDs communicate and coordinate with health care providers and families in a variety of ways to assure these follow-up activities occur.

Department central and regional office staff work together to provide oversight, guidance, and technical assistance to LHDs, and to monitor their performance in assuring that children with EBLLs receive timely and appropriate follow-up services. The Department provides LHDs with specific guidance regarding follow-up services through the annual workplan, dissemination of CDC guidelines, annual meetings, and other ongoing program updates.

County performance is monitored by the Department in several key ways. Each LHD completes and submits a work plan to the Department on an annual basis describing how they will accomplish the required program objectives and activities, including assuring appropriate follow up of children with EBLLs. Department staff review the completed LHD work plans for consistency with Public Health Law and regulations, work plan guidance, and current medical and public health standards. If needed, revisions to work plans are required prior to approval to assure satisfactory fulfillment of program requirements. In addition, each LHD must develop and maintain a lead program policy and procedure manual, which is reviewed and approved by the Department. Ongoing monitoring of LHD program activities is accomplished through the submission of quarterly reports, which are reviewed by the Department. Any issues or concerns are noted and followed up as appropriate, either immediately or at subsequent scheduled reviews, depending on the nature of the concern noted.

Site visits to LHD programs are conducted regularly by the Department to provide more in-depth monitoring of LHD program activities. As part of site visits, the policies and procedures for the municipality are reviewed to determine compliance with Department requirements. In addition, reviews of random samples of children's records with EBLLs are performed to ensure that all required follow-up activities take place on a timely basis. Because the specific processes taken by each LHD to communicate with health care

providers and families vary, these record reviews allow for an objective standardized review of whether specific required elements of follow-up care have occurred. It is surprising that OSC describes 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.

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As part of our ongoing efforts to achieve elimination of lead poisoning, activities to strengthen and monitor local health department capacity for lead prevention activities will continue. As noted above, the Department currently is finalizing case management guidelines that synthesize and update previous guidance for LHDs in a single document, which will be disseminated to all LHDs. In addition, the new LeadWeb registry will provide LHDs with a new tool for case management by enabling them to complete electronic case management modules for each child with EBLs. These modules will allow for recording information on all required elements of case management, including risk reduction education, developmental screening and nutritional assessment. LHDs will have the ability to generate reports that include those children that have received these required assessments and those assessments that still need to be done. Training and technical assistance will be provided to all LHDs to assist them in effectively using these tools. In addition, as described below in Response #15, the Department will explore new methods of monitoring follow-up services through analysis of data from the new LeadWeb case management modules.

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 that have developed specific guidelines or regulations related to lead screening during pregnancy, and these guidelines have served as a national model for the development of guidelines by other states.

The Department currently provides guidance to prenatal care providers in New York, in conjunction with the American College of Obstetricians and Gynecologists (ACOG), District II, through the *Lead Poisoning Prevention Guidelines for Prenatal Care Providers*. These guidelines outline clear clinical protocols and tools for risk assessment of all pregnant women for exposure to lead, targeted blood lead testing, and follow-up as required by Public Health Law and regulations. When these guidelines were initially developed, a joint letter from the Commissioner of Health and ACOG was mailed to all prenatal care providers statewide with a copy of the guidelines included. Accompanying educational materials designed for patients and the public were also developed. The guidelines and educational materials are available to providers and the public at no charge through the Department's website and upon request from the Department's Distribution Center. LHD lead programs also distribute these guidelines to prenatal care providers in their counties. Neither the CDC nor the ACOG have developed guidelines on

this topic. The development of consensus guidelines and specific clinical tools for risk assessment by the Department and the ACOG was a notable achievement of national significance that should be noted in the draft report. These prenatal guidelines recently were updated to incorporate new research findings and best practice recommendations, building on the Department's work with the New York City Department of Health and Mental Hygiene (NYCDOHMH) and the Mt. Sinai Center for Children's Health and the Environment. In the upcoming year, work with ACOG and other key partners will finalize the updated guidelines and disseminate them to all prenatal care providers statewide.

The Department also will continue more intensive assurance strategies targeted to the populations of pregnant women at highest risk for lead exposure, including the Prenatal Care Assistance Program (PCAP), the Special Supplemental Nutrition Program for WIC, and the Heavy Metals Registry. The draft report references some of these activities, but does not accurately describe their importance as systematic approaches to assure care for the highest risk populations of pregnant women. 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 both the PCAP and WIC programs, which serve low-income women, including immigrant women. In addition, all blood lead laboratory results for adults, including all pregnant and postpartum women age 16 years and older, are reported to the Department's Heavy Metals Registry. All blood lead results greater than 15mcg/dL are followed up by a structured telephone risk assessment and risk reduction counseling, including counseling specific to pregnancy and newborn care for all women who are pregnant or potentially pregnant. The Department's Bureau of Occupational Health also provides education and outreach to companies with potential occupational lead exposure, including consultation regarding lead exposure and the need for lead testing during pregnancy. The Department will continue to carry out all of these important activities to assure that pregnant women at risk for lead poisoning are identified and receive appropriate testing and follow up services.

As described above in Response #5, LHDs play a key role in promoting lead screening and other lead preventive practices within their communities. LHDs are responsible for conducting outreach and education to health care providers regarding lead poisoning prevention in both children and pregnant women as part of their lead program work plans. Improving risk assessment, targeted screening, and follow up care for pregnant women are some of the goals of the lead elimination plan.

As part of the annual workplans LHDs complete in conjunction with their lead grant funding, the Department will provide additional guidance and technical assistance regarding effective strategies for working with prenatal health care providers to improve the provision of counseling and assessment of all pregnant women for high dose lead exposure, and blood lead testing for those women found to be at risk. Medical record review is a resource-intensive activity that may not be the most effective or efficient strategy for improving risk assessment and testing activities in all communities. Record review is more appropriate for targeted assurance activities associated with case management for children with lead poisoning. Due to the need to prioritize public health activities, the Department must be selective regarding when intensive record review

activities are warranted. Because there are a number of effective approaches LHDs can carry out to improve lead screening practices within their counties, LHDs will have the flexibility to choose from among a set of best practice approaches to pursue those that are most effective in their own community based on the specific needs, resources, and relationships that exist. Department staff will continue to work with LHD staff to assure that all counties are carrying out effective lead screening promotion activities that result in measurable improvements in lead screening records. The updated LHD workplan is being finalized and will go into effect for most counties in April 2007. The Department will continue and expand ongoing activities related to lead poisoning prevention during pregnancy, including population-based education activities and more intensive assurance activities targeted to the highest risk populations.

Recommendation #12:

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

Response #12:

As noted in the report, the Office of Children and Family Services (OCFS) and the NYCDOHMH Bureau of Day Care Services already monitor whether day care facilities are obtaining certificates of lead screening as part of their ongoing licensing activities. In addition, child care providers are required to complete an environmental hazard attestation form. As part of our lead elimination plan, the Department is working with OCFS to develop and implement additional collaborative activities to increase the number of children receiving blood lead screening and families that receive basic lead prevention education consistent with current regulations. A joint letter will be mailed to all regulated child care providers in New York, including child care centers, group family day care, and family day care providers upstate and family and group family day care providers in New York City. A similar mailing for New York City day care centers which are licensed by the NYCDOHMH will be implemented in cooperation with their Lead Program and Bureau of Day Care. These mailings will remind child care providers of the lead screening requirements related to child care, reinforce the important role that child care providers play in promoting blood lead testing for all children in New York, and ensure that all child care providers are aware of how to obtain lead educational materials to distribute to families enrolled in care. Work with OCFS is underway to develop updated continuing education and training materials for both child care providers and child care licensing staff. As part of these efforts, we will work with OCFS to have child care providers incorporate additional practices to note that parents of children without documented lead screening have received educational materials, and that they make referrals to LHDs when additional assistance or referrals for lead testing are needed.

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:

As described above, the Department is working with OCFS and the NYCDOHMH to distribute a letter to all licensed child care providers reinforcing the importance of lead screening and lead screening requirements, requirements specific to child care health records, and educational materials and other resources available to assist child care providers. The purpose of this letter is to increase the knowledge, favorable attitudes, and practices of child care provider staff to improve lead education of families and referral of children for screening blood lead testing, consistent with current screening regulations. The letter will include sample educational materials for child care providers, along with specific information about how additional copies can be ordered at no charge from the Department's distribution center, how materials can be accessed through the Department's website, and contact information for LHDs.

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 prevention is a major emphasis of our elimination plan implementation activities. As part of this effort, changes to the annual LHD workplan already have been initiated, with additional changes planned for the upcoming project year. The Department made changes to the current LHD work plan to require them to provide additional quantifiable information for the activities identified for each objective, including the number of educational encounters planned, the target groups for activities, and the number of individuals to be reached. LHDs also must set specific objectives for improving lead screening rates at both one and two years of age within their counties, and describe specific plans for achieving those objectives. At the end of the grant year, LHDs are required to submit progress reports to describe their attainment of their county-specific objectives from the prior grant year. The Department is currently finalizing the new LHD workplan for 2007-2008, which will include further changes to make all objectives and activities even more quantifiable and measurable. Department staff will provide training and technical assistance to LHDs to support them in completing and implementing these updated workplans, and will continue monitoring activities to assure that LHDs are making substantial progress in achieving workplan objectives.

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:

Data should be available to determine whether required follow-up activities for children with lead poisoning have been completed. As part of our ongoing efforts to improve the LHD workplan described above in Response #14, the quarterly report form was revised to capture additional quantifiable information for each workplan objective completed by the LHD, and to provide a mechanism for them to describe any barriers encountered in completing their objectives. Quarterly reports are sent to both regional and central office staff for review and follow-up. Staff are responsible for working with the LHDs to resolve any issues identified through the quarterly reports.

The new statewide LeadWeb data system will be the most accurate and timely source of this data. As noted by OSC, LHDs submit quarterly reports to the Department to describe their progress in reaching the goals and objectives of their annual workplans. In the past, because the LeadTrac data system relied on submission of data from each county, these reports included local data provided by each LHD to the Department.

The new LeadWeb data system is a statewide web-based database that will allow the Department and LHDs to track follow-up activities, and ensure all activities are completed. The environmental portion of LeadWeb has recently been deployed for use by all environmental staff in the LHDs and state district offices. This will allow environmental health staff to track all lead inspections and environmental remediation and abatement activities. Trainings have been conducted statewide for all environmental health staff in the use of this system. Through LeadWeb, reports will be completed at the state and local level to allow for tracking of lead hazards and sources of exposure at individual addresses.

Recommendation #16:

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

Response #16:

An updated written site visit protocol is currently being finalized. This protocol outlines specific uniform timeframes and formalizes the extensive monitoring practices that already are in place by staff, as described to OSC. As part of this protocol, the Department has developed an updated standardized written site visit tool to be used in monitoring LHD lead programs. The updated site visit protocol and tool are currently being used in the Western, Central and Metropolitan regions. A pilot period began in October 2005 in the Metropolitan region, and use of the protocol and tool have expanded

to the Central and Western Regions. Regional office staff are using the site visit protocol and tool, and providing feedback to DOH central office. Regional office staff in each of these regions have been oriented on the use of the protocol and tool, and central office staff have accompanied them on site visits. Regional office staff provide a copy of the completed site visit tool with the report of findings to the LHD with a copy to the central office. Future changes to the site visit protocol or site visit tool may be made based on feedback provided from regional office staff. The tool also will be updated annually as needed to reflect changes in annual LHD workplan.

Recommendation #17:

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

Response #17:

The current schedule of monthly conference calls with regional office staff to discuss issues related to oversight of the lead program will continue. In addition, Department central office lead program staff will continue to provide orientation for new regional staff. A new Western Regional Office staff person recently received training regarding lead program expectations. Central office staff accompanied the new staff person on a LHD site visit to orient her to the expectations of the site visit process.

As noted above in Response #16, Western Regional Office staff are currently using the updated written site visit protocol and will provide feedback regarding the protocol and any additional needs for training.

Recommendation #18:

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

Response #18:

The New York State Advisory Council on Lead Poisoning Prevention is currently meeting all its obligations. The Council will continue to meet regularly, with three meetings already scheduled for 2007. OSC's statement that the last annual Council report was issued in 1998 is not correct, as a Council report for 2004 activities was published and distributed in July 2006. A subsequent report covering 2005 activities is currently being finalized and will be distributed within the next several months. The Department will continue to work closely with the Lead Advisory Council as an important source of ongoing input on the implementation, refinement, and evaluation of the Department's Lead Elimination Plan.

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APPENDIX B - STATE COMPTROLLER COMMENTS ON AUDITEE RESPONSE

1. We note that the 43 percent screening rate referred to by the Department is from a 1999 report issued by the U.S. General Accountability Office. Therefore, it is misleading to use it as a comparison to 2005 data.
2. To address the Department's concerns, we added some of the positive aspects of the program to the audit summary.
3. In addition to the matching of the databases, our testing included three rounds of analysis. We first cleansed the data provided by the Department. We then used WizSame software to eliminate potential duplicates. From the resulting population of children identified as not being screened, we selected a statistical sample. We conducted a manual review of this sample to validate that they were, in fact, not screened and projected the results to our findings. Despite the Department's objections, our results show almost the same screening rate as theirs, 65 percent versus 66.1 percent.
4. We did not restrict our sample to children continuously enrolled in Medicaid because a lack of continual Medicaid enrollment does not indicate that a child has left the State and does not eliminate the requirement for lead screening. Additionally we note that these children would have had to leave the State within a very small window (within the first year) to avoid the need for a lead screening and the probability of a large number of children leaving within this timeframe is low.
5. There are reasons for the differences between the rates calculated by OSC and the QARR reports. First, in addition to the Medicaid database, we used the Statewide Immunization Registry. This resulted in us identifying many non-Medicaid children as not being screened. Also, QARRs include only children who were continually enrolled in Medicaid for 12 months or more. The Registry includes all children, including those enrolled in Medicaid, even for less than 12 months. As a result, there are children who would have been included in our match but not in the QARR.
6. Contrary to the Department's contention, we did not make any recommendations based on the results of the survey. The results of the survey were used to confirm our finding that some doctors are not screening children for lead poisoning, as required.
7. The description of the matching algorithm provided in the Department's response is not consistent with that provided to us during the audit. At that time, Department officials stated that duplicates are removed using an exact match to last name, first name and date of birth. When we questioned how additional duplicates were picked up (such as those with spelling errors), Department officials stated "that would be really hard." As indicated in the Department's response, its new Lead Web data system should decrease the occurrence of duplicate records.

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| <p>8. The cited report represents the only time the Department calculated these rates.</p> <p>9. We, on several occasions, offered the Department the listing of children we identified as not being screened. They were not interested in receiving it. It seems to us, that as a public health body, the Department would want to follow through on the list, and ensure that the children on it, even though some have aged out, would be screened and treated if necessary. It should also be noted that the timeliness of our data analyses was impacted by the Department not providing us with the data until nearly one year after it was requested.</p> <p>10. We revised the body of our report and Recommendation 3 to reflect additional information provided in the Department's response. We are pleased that the Department has outlined a series of actions it plan to take to improve compliance of lead screening regulations. We urge the Department to carry out these planned actions timely. Although the LEP</p> | <p>referred to was released in 2004, the protocol has still not been completed over two and one-half years later.</p> <p>11. We revised this recommendation based on additional information provided in the Department's response.</p> <p>12. Our point was that the record reviews test only whether or not follow-up was completed but not whether all of the follow-up steps were taken as prescribed in the manual.</p> <p>13. The statement by the Department that the Advisory Council report released in July 2006 covering 2004 activities is partially accurate. The Council did issue a report labeled, "Annual Report 2004", however, this report did not meet the Council's reporting requirements, as outlined in our report. It is, instead, primarily a reissuance of the Department's report entitled "Eliminating Childhood Lead Poisoning in New York State by 2010."</p> |
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