



February 1, 2017

Joy L. Lindo, Director
Office of Legal and Regulatory Compliance
Office of the Commissioner
New Jersey Department of Health
PO Box 360
Trenton, NJ 08625-0360

RE: PRN 2016-199

Dear Ms. Lindo,

Advocates for Children of New Jersey (ACNJ) is pleased to have the opportunity to present comments on proposed amendments to N.J.A.C. 8:51 as well as new proposed rules N.J.A.C. 8:51 Appendices L and M.

ACNJ is the premier statewide, multi-issue child advocacy organization in New Jersey. ACNJ's mission is to identify children's needs through research, policy and legal analysis, to raise awareness of those needs through strategic communications and to work with elected officials and other decision-makers to enact effective responses so that every child has the chance to grow up safe, healthy and educated. Our advocacy priorities are early care and education, health, nutrition, child welfare and juvenile justice. Lead exposure in children causes lifelong health, educational and developmental impacts, in particular for children exposed at a very young age. ACNJ has been at the forefront of statewide efforts to reduce and eliminate lead exposure and poisoning for more than a decade.

ACNJ welcomes and supports the long-needed changes to the blood-lead level requiring state action. Experts now recognize that even very low levels of lead in blood can affect IQ, ability to pay attention, and academic achievement. And the effects of lead exposure cannot be corrected. As a result, ACNJ is pleased to see that State regulations are conforming the State's definition of an "elevated blood lead level" to that of the U.S. Centers for Disease Control and Prevention (CDC), which adopted a five micrograms per deciliter reference level for elevated blood lead level in 2012.

ACNJ wholeheartedly commends the NJ Department of Health (NJDOH) on these much-needed regulatory changes. Given the opportunity being taken to revise the regulations,

however, ACNJ has additional recommendations on how to strengthen the regulations for children's health and education today and in the future.

References to CDC Levels Throughout the Proposed Regulations (notably definitions, proposed N.J.A.C. 8:51-1.4, case management, proposed N.J.A.C. 8:51-2.4, and environmental intervention, proposed N.J.A.C. 8:51-4.1)

ACNJ welcomes and supports the incorporation of CDC publications on low lead exposure. Given the continuously improving scientific knowledge of the impact of lead exposure on children even at very low levels, ACNJ commends the Department of Health for including the latest research from the CDC.

However, ACNJ also recommends revising the regulations in the definitions section (N.J.A.C. 8:51-1.4) and elsewhere in the regulations where reference is made to a five micrograms per deciliter level with clear language that the "elevated blood lead level" for young children will be "five micrograms per deciliter or other such amount as may be identified in the most recent recommendations from the federal Centers for Disease Control and Prevention, and that necessitates the undertaking of responsive action."

This change would reflect pending legislation (A3411/S1830) that identifies the CDC's recommendations as the guidepost for NJDOH interventions for children with lead exposure, specifically identifying five micrograms per deciliter but expanding that to include potential changes to the CDC's recommendations. The legislation has passed both houses of the Legislature.

Along those lines, ACNJ also recommends an additional subchapter stating that NJDOH will revisit the regulations to comply with CDC guidelines on an annual basis.

The CDC regularly changes its reference level based on the recommendations of a panel of experts and scientific consensus. Prior iterations of N.J.A.C. 8:51 included some language that specified that the level of intervention for local departments of health would be the CDC's reference level, rather than a specific number. The CDC's panel of experts has recently recommended that the CDC lower its action level to 3.5 micrograms per deciliter.

Between 2012 when the CDC modified its action level to 5 micrograms per deciliter and today when New Jersey lowered the blood lead level requiring action, an entire cohort of New Jersey children has for the past 5 years not received intervention for a blood level recognized to be unsafe. A nimbler response and regular revisiting of the appropriate level for intervention in accordance with CDC recommendations would reduce this lag time and ensure that children with unsafe levels of lead exposure requiring intervention receive it.

Interagency and Local Education Agency Data-Sharing (Proposed N.J.A.C. 8:51-3.2, 3.3, 10.1)

More data sharing and transparency will help target interventions and prevention across New Jersey. ACNJ welcomes the increased data sharing and recording within the LeadTrax system, specifically increased reporting requirements for environmental evaluation information.

However, additional steps must be taken to ensure that data sharing goes to other professionals who can provide intervention for families and children affected by lead exposure, notably educators. As the proposed rule's economic impact statement notes, many of the costs of lead hazards fall on the education system. Although no intervention can reverse the harm of lead exposure, educational interventions such as early intervention services, special education, and behavior management plans can help lead-exposed children live up to their full potential.

In November 2016 the Education Research Section and the Center for Health and Wellbeing of the Woodrow Wilson School at Princeton University and Isles, Inc. organized a conference on the impact of lead exposure on students and the role of schools in designing effective interventions. One consistent theme throughout the conference was the need for better linkages between health providers and case managers on one side and educators and school nurses on the other.

For example, once a child has tested at an elevated blood lead level, there may be confidentiality concerns if the child's status is sent to other agencies, such as Early Intervention Services, local school districts, etc. Similarly, if a child has had an elevated blood lead level in his or her past, school districts and health care providers may not coordinate to provide a seamless plan for the student that combines health and educational interventions.

Other states have shown how linking health and education data sets can improve outcomes. For example, Rhode Island has linked its lead elimination surveillance system and health data systems with its education department's enrollment data to produce district-level screening and elevated blood lead level reports for each school district in the state.

ACNJ recommends clarifying the circumstances under which the number and percentage of children who have received mandated blood lead tests, the number of children with elevated blood lead levels, the number of abatements or inspections within a school district or school catchment area, or other relevant data can be shared with state and local education agencies. Additionally ACNJ recommends that in cases when a child is under three years of age, case management as defined by N.J.A.C. 8:51-2.4 should include information and referral when appropriate to New Jersey Early Intervention Services.

ACNJ recommends that NJDOH begin exploring an interagency agreement with the Department of Education to create a comprehensive monitoring system for lead exposure for local education agencies.

Barring an additional amendment to the existing regulations, ACNJ recommends that NJDOH write clarifying guidance for local health departments about how best to collaborate with school efforts to intervene on behalf of lead-exposed children.

Capillary vs. Venous Testing (Proposed N.J.A.C. 8:51-2.5)

Given that the CDC does not distinguish between capillary or venous blood tests for what constitutes an elevated blood lead level, ACNJ recommends that all children with an elevated blood lead level (i.e. five micrograms per deciliter or more), regardless of method of testing, receive at least the home visit schedule laid out in proposed N.J.A.C. 2.5. Primary prevention remains the most important element of a lead prevention plan across New Jersey, and the more that local departments of health can begin to identify homes with lead hazards within them, the quicker we can end this public health crisis forever.

Case Management for Children with Blood Lead Levels 5-9 µg/dL (Proposed N.J.A.C. 8:51-2.4)

Under the current regulations, a parent of a child with a single blood lead level of five to nine micrograms per deciliter does not receive intervention from their local department of health in the form of case management or housing abatement. ACNJ applauds the change to require action once the child's blood lead level exceeds 5 µg/dL.

However, as these children begin referral to local health departments, caseloads and abatement orders will necessarily increase. The NJDOH estimates that an additional 4,000 children annually may be identified as having elevated blood lead levels. Currently the workforce at local health departments may not have the capacity to meet these demands.

Proposed N.J.A.C. 8:51-2.4(b) attempts to alleviate some of this staffing pressure by authorizing a "public health staff member" to perform case management for children with a single capillary blood lead test of 5-9 µg/dL. The proposed rules do not define what a "public health staff member" is, their qualifications and training, or who may provide this vital case management.

Understanding that local health departments need discretion in assigning this responsibility while also recognizing the need for well-informed case managers, ACNJ recommends defining what requirements are needed to be a "public health staff member" for the purposes of N.J.A.C. 8:51-2.4(b). In order to ensure that adequate

information is delivered to parents in accessible language and that this information be consistent from county to county, ACNJ recommends that NJDOH in collaboration with the local health departments and the New Jersey Interagency Task Force on the Prevention of Lead Poisoning develop a set of standards for public health staff members tasked with delivering this information and the content of the information to be delivered (both verbally and written).

Conclusion

ACNJ reiterates its strong approval of this regulatory proposal. ACNJ welcomes this step forward for New Jersey's children.

Thank you for the opportunity to provide these comments. If I can provide you with any further information, please contact Peter Chen at ACNJ via email to pchen@acnj.org or at 973-643-3876.

Very truly yours,

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