HEALTH

HEALTH SYSTEMS BRANCH

DIVISION OF FAMILY HEALTH SERVICES

MATERNAL AND CHILD HEALTH SERVICES

CHILD AND ADOLESCENT HEALTH PROGRAM

Childhood Elevated Blood Lead Levels

Adopted Amendments: N.J.A.C. 8:51-1.1, 1.3, 1.4, 2, 3, 4, 7.1, 7.5, and 10.1

Adopted Repeals and New Rules: N.J.A.C. 8:51 Appendices A through K

Adopted New Rules: N.J.A.C. 8:51 Appendices L and M

Proposed: December 5, 2016, at 48 N.J.R. 2516(a).

Adopted: August 24, 2017, by Cathleen D. Bennett, Commissioner, Department of Health (in consultation with the Public Health Council).

Filed: August 24, 2017, as R.2017 d.175, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 26:2-137.2 et seq., particularly 26:2-137.7.

Effective Date: September 18, 2017.

Expiration Date: April 12, 2024.

Summary of Public Comments and Agency Responses:

The Department of Health (Department) received timely comments from the following commenters during the 60-day public comment period, which ended on February 3, 2017:

1. Annmarie Ruiz, Gloucester County Department of Health, Sewell, NJ

2. Annmarie Ruiz, Salem County Department of Health, Salem, NJ

3. Ben Haygood, Housing and Community Development Network of New Jersey, Trenton, NJ

4. Candice Davenport, Maplewood Health Department, Maplewood, NJ

5. Chris Merkel, Monmouth County Health Department, Freehold, NJ

6. Claudia Funaro, Camden County Department of Health and Human Services, Blackwood, NJ

7. Elizabeth Griffin, New Jersey Chapter, American Academy of Pediatrics, East Windsor, NJ

8. Holly Cucuzzella, Burlington County Health Department, Westampton, NJ

9. Jermaine Spence, Hackensack, NJ

10. Juliet Leonard, New Jersey Association of Public Health Nurse Administrators, Edison, NJ

11. Kevin McNally, President, New Jersey Public Health Association, Piscataway, NJ

12. Lisa Gulla, New Jersey Association of County and City Health Officials, Freehold, NJ

13. Marconi Gapas, Township of Union Health Department, Union, NJ

14. Maurie Brown, Middlesex County Office of Health Services, New Brunswick, NJ

15. Megan Sheppard, Cumberland County Department of Health, Millville, NJ

16. Patrick Dillon, Atlantic County Division of Public Health, Northfield, NJ

17. Peter Chen, Esq., Staff Attorney, Advocates for Children of New Jersey, Newark, NJ

18. Robert D. Roe, Health Officer, Maplewood Health Department, Maplewood, NJ

19. Robin Vlamis, MPH, CHES, Morristown, NJ

20. Sharon M. Winn, City of Trenton Health Department, Trenton, NJ

21. Stephanie Carrey, Montgomery Township Health Department, Belle Mead, NJ

22. William Bucci, Montgomery Township Board of Health, Belle Mead, NJ

23. Cecilia Zalkind, Esq., President & CEO, Advocates for Children of New Jersey, Newark, NJ

24. Staci Berger, President & CEO, Housing and Community Development Network of New Jersey, Trenton, NJ

25. Jeff Bienstock, MD, FAAP, President, New Jersey Chapter, American Academy of Pediatrics, East Windsor, NJ

26. Steven Kairys, MD, MPH, FAAP, Medical Director, New Jersey Chapter, American Academy of Pediatrics, East Windsor, NJ

27. Fran Gallagher, MEd., Executive Director, New Jersey Chapter, American Academy of Pediatrics, East Windsor, NJ

28. Deborah Gash, MS, PHCNS-BC, Co-President, New Jersey Association of Public Health Nurse Administrators, Edison, NJ

29. Ella Shaykevich, MSN, NPA, PHCNS-BC, Co-President, New Jersey Association of Public Health Nurse Administrators, Edison, NJ

30. Myles O'Malley, MA, Childhood Lead Poisoning Emergency Response, Inc., Maplewood, NJ

31. Elyse Pivnick, Director of Environmental Health, Isles, Trenton, NJ

32. Carol Biunno-Petscavage, Middlesex County Office of Health Services, New Brunswick, NJ

33. John D. Bogden, PhD., Professor, New Jersey Medical School, Newark, NJ

34. James M. Oleske, MD, Professor, New Jersey Medical School, Newark, NJ

A summary of the comments and the Department's responses follows (the numbers following the comments indicate the commenter making the comment).

1. COMMENT: Two commenters support the Department’s incorporation of Centers for Disease Control and Prevention (CDC) publications on the impact of lead exposure on children even at very low levels at N.J.A.C. 8:51-1.3. (17 and 23).

RESPONSE: The Department thanks the commenters for their support of the rule.

2. COMMENT: Three commenters state that the definition of “case management” at N.J.A.C. 8:51-1.4 should be amended to state that the public health nurse shall coordinate with an environmental specialist to identify lead sources, facilitate efforts to eliminate a child’s lead exposure, and to coordinate other services to reduce a child’s blood lead level to below five micrograms per deciliter of whole blood (µg/dL). (10, 28, and 29)

RESPONSE: The Department disagrees with the comment. Public health nurses coordinate with many different professionals during the course of case management. Accordingly, the Department has declined to limit the scope of case management by naming specific professionals with whom the public health nurse shall coordinate.

3. COMMENT: One commenter states that the definition of confirmed blood lead level at N.J.A.C. 8:51-1.4 is confusing with respect to whether it is a venous or capillary sample. (8)

RESPONSE: The Department disagrees with the comment. The notice of proposal does not change the existing definition of "confirmed blood lead level" at N.J.A.C. 8:51-1.4, and, therefore, the comment is beyond the scope of this rulemaking. The definition is a blood lead level obtained from a venous blood sample.

4. COMMENT: Two commenters state that the term "lead-burdened" should be changed to "lead poisoned" in the rules because it accurately describes a medical condition and is a severe term that properly emphasizes the severity of this condition. (14 and 32)

RESPONSE: The Department disagrees with the comment. While there is no safe level of lead in a person's bloodstream, there is no medical consensus regarding definitions of "lead burdened" and "lead poisoned." The Department is adopting the term "elevated blood lead level" to replace the phrases "lead burdened" and "lead poisoned" and to comport with the universally accepted term among lead experts that is also used by the CDC.

5. COMMENT: Several commenters state that the definition of "elevated blood lead level" should be permanently tied to CDC recommendations, so that when the CDC changes the reference level in the future the Department will automatically follow suit. (3, 7, 11, 17, 23, 24, 25, 26, 27, and 31)

RESPONSE: The Department disagrees in part with the comment and agrees in part with the comment. The Department disagrees that the definition of “elevated blood lead level” should be permanently tied to CDC recommendations so that when the CDC changes the reference level in the future the Department will automatically follow suit. Implementation of the reference level affects many sections of N.J.A.C. 8:51 and automatic adjustments to the rules, without consideration and vetting, may result in unintended and/or inappropriate public health actions. The Department agrees that the rules should follow CDC recommendations, however, and pursuant to N.J.S.A. 26:2-137.4e(2)(b), the Department will review these rules to ensure compliance with CDC recommendations on at least a biennial basis.

6. COMMENT: One commenter states that the definition for “lead based paint hazard” should be restated in full in the rule text at N.J.A.C. 8:51-1.4 in addition to citing to the location where the definition may be found in the statute, which is at N.J.S.A. 26:2Q-2. (2)

RESPONSE: The Department disagrees with the comment. It is preferable to use a citation without repeating a statutory definition in a rule because using the citation alone makes the rule more concise. In addition, if the statutory definition is changed by the Legislature in the future, the rule will automatically incorporate the change in the statute.

7. COMMENT: One commenter states that the definition for “lead based paint hazard” at N.J.A.C. 8:51-1.4 should include “friction and impact surfaces.” (2)

RESPONSE: The Department disagrees with the comment. The definition of "lead based paint hazard" is from N.J.S.A. 26:2Q-2 and means "any condition that causes exposure to lead from lead-contaminated dust or soil or lead-contaminated paint that is deteriorated or present in surfaces, that would result in adverse human health effects," which is very broad and would include friction and impact surfaces. By citing to the statutory definition, the Department intends to incorporate the Legislature's definition of "lead based paint hazard."

8. COMMENT: One commenter states that N.J.A.C. 8:51-2.1(b), which states, "If a local board of health determines that a child under six years of age, who is receiving service from one of its child health programs, is in need of lead screening, and it is not able to make arrangements for the child to be screened by a health care provider, the local board of health shall perform a lead screening of the child," should be changed. The commenter states that the word, "shall" in the rule should be changed to "may" because some local health departments do not have the necessary equipment to conduct screenings. (2)

RESPONSE: The Department disagrees with the comment. Every local health department in the State has access to lead screening kits free of charge by e-mailing the Department at clpp.fhs@doh.nj.gov to secure registration and order forms. The local health department then completes and submits the forms to the lead screening kit vendor and the vendor bills the Department initially for the cost of the kit and then later for the cost of the lab test after the kit is used.

9. COMMENT: A number of commenters state that a venous confirmation should be required by N.J.A.C. 8:51-2.3, 2.4, and 2.5 prior to initiation of case management services in all cases. The commenters generally state that a capillary test is not as accurate as a blood draw sample and, therefore, cannot justify initiation of case management. (1, 2, 5, 8, 10, 14, 20, 28, 29, and 32)

RESPONSE: The Department agrees with the comments. The Department is, therefore, not adopting proposed language that would have required local health departments to initiate case management following a capillary test only. Accordingly, the Department reinstates the word "confirmed" at N.J.A.C. 8:51-2.4(a) and will not adopt proposed new N.J.A.C. 8:51-2.4(b). The Department will not adopt proposed language at N.J.A.C. 8:51-2.4(c)3 that would have referred to N.J.A.C. 8:51 Appendix L.

10. COMMENT: One commenter states that the Department should not have removed the word "confirmed" from N.J.A.C. 8:51-2.4(a) because it makes the rule inconsistent with respect to what constitutes a confirmed blood lead level. (5)

RESPONSE: The Department disagrees with the comment. "Confirmed blood lead level" is a defined term at N.J.A.C. 8:51-1.4. The Department's intent in promulgating N.J.A.C. 8:51-2.4(a) is to require that each local health department begin case management at an elevated blood lead level equal to or greater than five µg/dL. However, the word "confirmed" is added back to subsection (a) pursuant to the Response to Comment 9.

11. COMMENT: One commenter states that under the proposed rule amendments, “two capillary samples would act as a confirmatory test.” The commenter states that since capillary tests are unreliable, only a venous blood test should be considered as a confirmatory test. (8)

RESPONSE: The Department did not propose that two capillary samples would act as a confirmatory test. N.J.A.C. 8:51-1.4 defines “confirmed blood lead level” as a blood lead level obtained from a venous blood sample. The Department agrees with the comment that only a venous blood test should be considered as a confirmatory test.

12. COMMENT: One commenter states that proposed N.J.A.C. 8:51-2.4(b)2 creates an inconsistency because it “allows the use of capillaries for the initial child, however, other children in the household (as well as pregnant clients) need to have venous laboratory blood tests.” (8)

RESPONSE: The comment is moot because the Department is not adopting N.J.A.C. 8:51-2.4(b)2 for the reasons set forth in the Response to Comment 9.

13. COMMENT: One commenter states that it is appropriate to initiate case management at a capillary blood lead level of five to nine µg/dL, however, it is not appropriate to initiate a home visit. The commenter recommends “contacting the parent or guardian and arranging a venous confirmation and providing educational materials about the prevention of exposure to lead hazards.” (5)

RESPONSE: The Department agrees in part with the comment and disagrees in part with the comment. The Department agrees that it is not appropriate to initiate a home

visit based upon a capillary test. The Department further agrees that the local health department should contact the parent or guardian and arrange for a venous confirmation. The Department does not agree that it is appropriate to initiate case management at a capillary blood lead level of five to nine µg/dL. This is because a capillary test is generally not as reliable as a venous test and, therefore, should not be used to justify the initiation of case management. Accordingly, the Department is not adopting proposed language at N.J.A.C. 8:51-2.5(a) that would have established that a local health department must conduct an initial home visit at a capillary blood lead level of five to nine µg/dL.

14. COMMENT: Several commenters state that the Department needs to clearly define "public health staff member" as it is referenced at N.J.A.C. 8:51-2.4(b). The commenters state that the Department should specify the qualifications and training required for the public health staff member with regard to the various duties and aspects of case management within the context of N.J.A.C. 8:51-2.4(b). (5, 13, 17, 23, and 31)
One commenter states that a public health nurse should be designated as a case manager within the context of N.J.A.C. 8:51-2.4(b). (13)
RESPONSE: The comments are moot because the Department is not adopting N.J.A.C. 8:51-2.4(b) for the reasons set forth in the Response to Comment 9.

15. COMMENT: Several commenters state that a preliminary environmental evaluation should not be performed based upon a single confirmed elevated blood lead level. The commenters generally state that the preliminary environmental evaluation does not

provide useful guidance to the homeowner concerning potential lead hazards and how to address them. The comments also generally state that the preliminary environmental evaluation is of little value compared to an environmental intervention because it does not identify specific lead hazards and it does not provide for any follow up or enforcement action by the local health department. The commenters generally recommend the Department not adopt the preliminary environmental evaluation proposed at N.J.A.C. 8:51-4.1(g). The commenters generally support an environmental intervention after two confirmed elevated blood lead levels. (2, 5, 8, 16, and 20) Two commenters state that proposed N.J.A.C. 8:51-4.1(h)6, which would require a local health department to distribute educational materials to other units in a multi-unit dwelling where a local health department conducted a preliminary environmental evaluation in one unit, is not helpful because no environmental sources of lead would have been identified at that point in time. (14 and 32)

RESPONSE: The Department agrees with the comments that a preliminary environmental evaluation does not identify specific lead hazards for the homeowner and how to address them, nor does it provide actionable information enabling follow up and enforcement by the local health department. Accordingly, the Department is not adopting proposed N.J.A.C. 8:51-4.1(g), (h), or (i), which would have established the preliminary environmental evaluation, and related proposed language throughout the chapter referencing the preliminary environmental evaluation. This includes a reference at N.J.A.C. 8:51 Appendix G that would have required the Department to change the singular word “form” into its plural configuration “forms” at the top of the first page of Appendix G. In addition, the Department is not adopting N.J.A.C. 8:51 Appendix L,

which contains the form that would have been used for the preliminary environmental evaluation. The Department is reserving N.J.A.C. 8:51 Appendix L. The Department agrees with the comment that an environmental intervention should be performed following two confirmed elevated blood lead levels. Accordingly, the Department is not adopting proposed references to a preliminary environmental evaluation at N.J.A.C. 8:51 Appendix M. In addition, the Department is not adopting proposed Category One interventions at N.J.A.C. 8:51 Appendix M, is recodifying proposed Category 2 interventions as Category 1 interventions, proposed Category 3 interventions as Category 2 interventions, and proposed Category 4 interventions as Category 3 interventions. The Department is not adopting or recodifying references to rules in N.J.A.C. 8:51 Appendices K and M, as appropriate, based upon proposed rules that are not being adopted at N.J.A.C. 8:51-2.4. The Department provided details of the rationale for each change to N.J.A.C. 8:51-2.4 in the Response to Comment 9.

16. COMMENT: One commenter states that at N.J.A.C. 8:51-4.2(b), the requirement to perform a limited hazard assessment “and dust sampling” is redundant because a limited hazard assessment includes dust sampling as defined at N.J.A.C. 8:51-1.4. (2) RESPONSE: The Department agrees with the comment and is making this technical change upon adoption by removing the phrase “and dust sampling” from N.J.A.C. 8:51-4.2(b).

17. COMMENT: One commenter states that the cross-reference at N.J.A.C. 8:51-8.2(c) to N.J.A.C. 5:23-2 should be changed to N.J.A.C. 5:23-2.23(p) regarding obtaining a clearance certificate. (2)

RESPONSE: The Department disagrees with the comment. The Department's intent is for lead abatements to comply with all of the requirements of the New Jersey Uniform Construction Code, Subchapter 2. N.J.A.C. 5:23-2.1(a) states that the subchapter may be referred to as N.J.A.C. 5:23-2. A more narrow citation to N.J.A.C. 5:23-2.23(p), as suggested by the comment, would not, for example, cover lead abatements by demolition, which would not require the homeowner to obtain a clearance certificate. See N.J.A.C. 5:23-2.1(c).

18. COMMENT: One commenter states that the Department needs to clarify when a hazard assessment needs to be completed but the commenter does not state what rule needs to be clarified. (8)

RESPONSE: The Department disagrees with the comment. N.J.A.C. 8:51-4.2(a) states when a hazard assessment shall be performed in the case of a child up to 72 months of age.

19. COMMENT: The Department should offer additional guidance on what the appropriate public health actions should be when non-paint sources of lead are identified. (5)

RESPONSE: The Department disagrees with the comment. N.J.A.C. 8:51-7.1(b) and (c) together provide that an owner is only responsible for non-paint hazards that are under

his or her control and N.J.A.C. 8:51-6.5 authorizes a local health department to order the abatement and/or interim controls of any other condition that it considers to be a lead hazard. Exercise of this authority, as with all government authority, requires knowledge and discretion. Appropriate public health actions include resident education and/or lead hazard removal. Lead sources can be from a variety of consumer products and goods, including, but not limited to, lead crystal glasses, cultural remedies, spices, toys, imported pottery, and numerous others. The Department intends the above rules to provide a range of appropriate public health actions to local health officials in the exercise of professional discretion.

20. COMMENT: One commenter states that the Department should amend N.J.A.C. 8:51-1.3(d)1 to make use of N.J.A.C. 8:51 Appendix F optional by changing the word "must" to "may" to allow local health departments flexibility to deviate from the template and include elements from the Federal Housing and Urban Development (HUD) Guidelines. (2)

RESPONSE: The Department disagrees with the comment. N.J.A.C. 8:51 Appendix F only requires a minimum data set to be used in notification letters. The instructions at N.J.A.C. 8:51 Appendix F do not prohibit additional information, such as elements from HUD Guidelines, from being included. N.J.A.C. 8:51-1.3(d)1 makes use of N.J.A.C. 8:51 Appendix F mandatory, so that notification letters have a minimum data set that is uniform throughout the State.

21. COMMENT: One commenter states that the case closure criteria at N.J.A.C. 8:51 Appendix K appears to be incorrect, but does not state in which respect. (5)

RESPONSE: The Department agrees with the comment. The Criteria for Case Closure chart at N.J.A.C. 8:51 Appendix K, number 1, reads “Single, capillary, BLL 5 µg/dL or greater,” which would have applied too broadly and created confusion. It should have read “Single, capillary, BLL 5 to 9 µg/dL.” Therefore, the Department is not adopting the proposed phrase “Single, capillary, BLL 5 µg/dL or greater” in N.J.A.C. 8:51 Appendix K.

22. COMMENT: Several commenters state that the Department of Community Affairs (DCA) is not providing adequate funding to assist homeowners in meeting the cost of lead abatement. The commenters generally state that funding is needed and should be made available. (1, 2, 5, 12, 15, 16, 18, 20, and 30)

RESPONSE: This comment is outside of the scope of this rule proposal. The Department acknowledges the comments. The Department’s authority is limited to addressing the health of children with elevated blood lead levels. Authority for ensuring the safety of buildings is vested in the DCA.

23. COMMENT: One commenter states that lead abatement is not needed in all cases. The commenter states that lead safe work practices are very effective at removing lead hazards and are much less costly. (18)

RESPONSE: The Department agrees with the comment that interim controls are generally less costly than abatement. Nevertheless, it is important to note that interim controls, by definition, are temporary in nature. See N.J.A.C. 8:51-1.4. It is also

important to note that interim controls can only be used on the exterior of homes pursuant to N.J.A.C. 8:51-6.2(a). Abatement, by definition, is permanent. See N.J.A.C. 8:51-1.4.

24. COMMENT: Two commenters state that the Department should amend N.J.A.C. 8:51-7.1(a)2 to remove the requirement that if the owner fails to perform abatement or interim controls following an order, the local board of health shall perform, or arrange for the performance of, the required activities, and then take legal action to recover the costs thereof from the owner. The commenters generally state that this is not a practical solution due to the difficulty of obtaining recovery of costs through the legal system. (2 and 16) One commenter states that the Department has never addressed the legal justification for placing this burden on local health departments. (16)
RESPONSE: The Department disagrees with the comment. The requirement for local health departments to perform abatement or interim controls if the owner fails to perform them following an order is statutory. See N.J.S.A. 24:14A-9. The rule reflects the intent of the statute.

25. COMMENT: Several commenters state that due to the increased case load that local health departments anticipate from the proposed amendments and new rules, the State will need to provide additional funding because local health departments will face budget shortfalls. (2, 4, 5, 6, 8, 11, 12, 15, 16, 17, 18, 19, 20, 21, 22, 23, and 31)
RESPONSE: The Department agrees with the comments that additional funding would help with the increased caseload in situations where local health departments face

budget shortfalls. The Department is receiving an additional $10 million from the 2018 budget. The Department is appropriating $12.2 million in State funding from the Maternal, Child, and Chronic Health Services Block Grant, $1.7 million in Federal funding from Lead Abatement and Enforcement programs and the Federal Maternal and Child Health Block Grant, and $160,000 in dedicated revenue from Lead Abatement Certification.

26. COMMENT: Three commenters state that the Federal Medicaid program does not adequately reimburse local health departments for expenses related to implementing the provisions of N.J.A.C. 8:51 in connection with public health services provided to children who are enrolled in Medicaid. (2, 5, and 15)

RESPONSE: The Department acknowledges the comments. Enforcement of this chapter has imposed, and would continue to impose, costs on local health departments for the investigation of reported cases of elevated blood lead levels in children and the provision of case management. The Division of Medical Assistance and Health Services of the New Jersey Department of Human Services has established a reimbursement process for local health departments for inspections performed in response to a report of an elevated blood lead level in a child who is enrolled in Medicaid. See N.J.A.C. 10:77. This revenue partially offsets the costs created by the requirements of this chapter.

27. COMMENT: One commenter states “What happened to Subchapters 5-6? What happened to sub chapters 8-9?” (5)

RESPONSE: The Department did not propose any changes to those subchapters, therefore, there was no need to publish those subchapters in the rulemaking.

28. COMMENT: Two commenters state that the Department should eliminate the age limit on childhood lead screening. (14 and 32)

RESPONSE: There is no age limit on childhood lead screening. At N.J.S.A. 26:2-137.2, the New Jersey Legislature expresses concern about the effects of lead exposure on children under age six, but it does not state that the Department shall limit the age above which a child should not be screened for elevated blood lead levels. Accordingly, the Department has not established an age limit on childhood lead screening.

29. COMMENT: One commenter states that health care providers should be aware that blood lead screening is vital if there are changes to a child's primary residence. (4)

RESPONSE: The Department agrees with the comment. N.J.A.C. 8:51-2.1(a) requires local health departments to coordinate with health care providers to ensure that all children less than 72 months of age are appropriately screened in accordance with N.J.A.C. 8:51A, including if there are changes to a child's primary residence.

30. COMMENT: Two commenters state that the Department should not refer to the age of children in terms of months (72) and should instead refer to the age of children as five years and 364 days in order to avoid confusion and eliminate the need to convert years to months. (14 and 32)

RESPONSE: The Department disagrees with the comment. The Department proposed expressing the age of children in terms of months because it is easier to understand and less confusing than referring to the age of children in terms of years and days. Previously, when the Department referred to the age of children as “under six years of age,” the regulated community sometimes misunderstood the term to be inclusive of the age of six. The Department intends the change to avoid this confusion.

31. COMMENT: One commenter states that the Department failed to calculate the increased number of children with elevated blood lead levels greater than or equal to five µg/dL that would require case management under the proposed rules. (11)
RESPONSE: The Department disagrees with the comment. In the Social Impact of the notice of proposal published on December 5, 2016, the Department estimated that approximately 6,000 children under the age of 17 were identified in fiscal year 2015 with blood lead levels greater than or equal to five µg/dL. See 48 N.J.R. 2516(a).

32. COMMENT: One commenter states the Housing Affordability Impact Analysis in the notice of proposal at 48 N.J.R. 2516(a) is incorrect. The commenter states the Department’s estimate that less than one percent of housing will be affected by the notice of proposal and, therefore, there is an extreme unlikelihood that the proposed amendments, repeals, and new rules would evoke a change in the average costs associated with housing is in error. The commenter states “The number of pre 1978 housing units is approximately 2.4 million. Dividing 2.4 million by 3.5 million results in

68% of the homes in N.J. being affected." The commenter does not state how this calculation affects the average cost associated with housing in the State. (18)

RESPONSE: The Department disagrees with the comment. The Department calculated the percentage of houses that are affected by the rulemaking by using 2015 data from the Childhood Lead Information Database that projected approximately 6,000 children under the age of 17 would be under case management with blood lead levels greater than or equal to five µg/dL if the proposed rules were in effect in 2015. Approximately 5,500 of these children would have been new cases. Assuming that each child lived at a separate residence, which is not the case, slightly greater than one percent of all housing would have been affected by this rulemaking. This number is statistically insignificant when considering its impact on the affordability of housing in the State. Assuming the 2.4 million house figure is correct, the comment advances a calculation that does not reflect the actual number of houses that would be affected by the proposed rulemaking; it rather calculates the number of houses that may contain lead-based paint. The comment does not explain how this has affected the affordability of housing in New Jersey.

33. COMMENT: Several commenters state that the Department should share lead data with State and local education agencies. This data would include the number and percentage of children screened, the number and percentage of children with elevated blood lead levels, and the number of inspections and abatements within a school district or school catchment area. (3, 17, 23, 24, and 31)

RESPONSE: The Department agrees that it is useful to share de-identified lead data with State and local education agencies. The Department shares de-identified lead data with State and local health agencies through the Childhood Lead Information Database pursuant to N.J.A.C. 8:51-10.1. The Department's annual report, Childhood Lead Exposure in New Jersey, aggregates data by municipality, not school district or school catchment area. The reason for this is because local health departments have jurisdiction over their own political subdivisions only and the data is, therefore, useful to them for public health activities if it is aggregated by municipality. School districts and school catchment areas do not necessarily follow the same political boundaries.

34. COMMENT: Two commenters state that the Department should consider entering into a Memorandum of Agreement (MOA) with the New Jersey Department of Education (DOE) to create a comprehensive monitoring system for lead exposure to be used by local education agencies. The commenters also state that the Department should provide guidance for local health departments on how to collaborate with schools to take advantage of the monitoring system. (17, 23, and 31)

RESPONSE: The Department agrees with the comment insofar as it suggests the concept of a comprehensive monitoring system and will consider the merits and strategic planning implications of such a system. The process of entering into an MOA with the DOE, however, is outside the scope of this rulemaking. The Department already encourages local health departments to make referrals to appropriate community resources including, but not limited to, educational services. N.J.A.C. 8:51-

2.4(b)15 requires case managers to monitor follow-up activities to ensure that educational interventions are delivered in a timely and coordinated manner.

35. COMMENT: One commenter states that our elected officials and educators have no information about children who have been exposed to lead in their communities. Therefore, the public sector's interest in serving the health, safety, and welfare of its residents is thwarted. (31)

RESPONSE: The Department disagrees with the comment. The Department publishes an annual report, Childhood Lead Exposure in New Jersey, which details screening rates, elevated blood lead level rates, completed inspections, and completed abatements. It is available at www.nj.gov/health/childhoodlead to provide this information to the public. The Department launched its #kNOwLEAD campaign in October 2016, a measure aimed at primary prevention through public awareness. The #kNOwLEAD campaign focuses on distributing information through social media and Department stakeholders.

36. COMMENT: Several commenters state that the public needs to be made more aware of the importance of lead screening and how to prevent elevated blood lead levels in children, which is consistent with a preventive approach. The commenters generally state that the proposed rules do not adopt a primary prevention approach. (4, 11, 18, and 30)

RESPONSE: The comment that the public needs to be made more aware of the importance of lead screening and how to prevent elevated blood lead levels in children,

which is consistent with a preventive approach, is outside the scope of this rulemaking. The purpose of the rules, as stated at N.J.A.C. 8:51-1.2, is to protect children from adverse health effects due to exposure to lead hazards in their homes and in the environment. The rules are focused on protecting each child who has already been exposed to lead. Outside of the legislative directive of N.J.S.A. 26:2-137.2 et seq., however, the Department agrees that efforts can and should be made in the area of primary prevention. In order to prevent children from being exposed to lead initially, the Department launched its #kNOwLEAD campaign in October 2016, a measure aimed at primary prevention through public awareness. The Department also established Regional Lead Poisoning Prevention and Healthy Homes Coalitions in January 2003. The Coalitions conduct public education and training for professionals to enhance their knowledge and skills that support primary prevention. In addition, the Department's Office of Population Health established a Population Health Action Team in September 2016. The Team includes representatives from eight State departments. The Team's Lead Work Group focuses efforts toward prevention and community engagement with an emphasis on high-risk populations and geographic regions.

37. COMMENT: One commenter states that while he supports the rule amendments, New Jersey needs a long-term initiative to slowly but surely replace old pipes and eliminate other known lead hazards. The commenter generally states that the best policy is to remove lead from our communities. (9)

RESPONSE: The Department agrees with the comment that lead should be removed from our communities, however, the comment is outside of the scope of these proposed

amendments, which were authorized to fulfill the legislative intent expressed at N.J.S.A. 26:2-137.2 et seq., particularly 26:2-137.7.

38. COMMENT: Four commenters state that lead paint testing of houses built before 1978 should be required prior to the sale or occupancy of those houses. (16, 20, 33, and 34)

RESPONSE: The Department acknowledges the comment. The comment is beyond the scope of these rules, however. The Department's authority is limited to addressing the health of children with elevated blood lead levels. See N.J.S.A. 26:2-137.2 et seq., particularly 26:2-137.7.

39. COMMENT: Three commenters state that the questions on page 6 of N.J.A.C. 8:51 Appendix G are not appropriate for a registered professional nurse case manager to answer. The commenters state that questions requiring the case manager to assess the structural soundness of the home, to determine whether gas appliances are properly vented, and to determine whether the carbon monoxide detectors are working are outside of the education and experience of case managers. The commenters state that these questions should be reassigned to the homeowner or the parents/guardians of the child with an elevated blood lead level to answer. (10, 28, and 29)

RESPONSE: The Department disagrees with the comment. The questions on page 6 of N.J.A.C. 8:51 Appendix G are general public health assessment questions that the Department intends to document issues not captured through the Lead Hazard Assessment Questionnaire (N.J.A.C. 8:51 Appendix A). This may lead the case

manager to identify additional home hazards that contribute to poor health outcomes. The case manager is familiar with this assessment and, in the event he or she has a question, the case manager has access to other officials, such as a lead inspector/risk assessor or local construction code inspector for consultation. The parents and/or guardians of the child with an elevated blood lead level do not have this training or access to additional resources.

40. COMMENT: One commenter states that the Environmental Intervention Report form, found at N.J.A.C. 8:51 Appendix B, does not allow for reporting of all conditions that constitute a lead hazard. The commenter states that this deficiency causes confusion for property owners and lead abatement contractors because they do not understand every lead hazard that must be abated. The commenter does not identify specific changes the Department should make that would improve the form. (2) RESPONSE: The Department disagrees with the comment. N.J.A.C. 8:51 Appendix B allows documentation of all components tested and contains a column for the inspector to note whether the component tested resulted in a violation. Pursuant to N.J.A.C. 5:17-3.2(a)1, all testing and evaluation services shall be conducted in accordance with Chapters 5, 7, and 15 of the HUD Guidelines. Chapter 7 of the HUD Guidelines specifies testing combinations and documentation standards that inspectors are required to follow to determine the location and extent of lead hazards in single-family and multi-family dwellings. Chapter 7 requires that all testing combinations must be classified as either positive or negative, and lead inspectors and abatement contractors are trained in HUD guidelines. N.J.A.C. 8:51 Appendix F contains a template letter

which sets forth the minimum information that a local health department must provide to a homeowner in its notice of violation. If the local health department believes that something is unclear concerning the location of a lead hazard following inspection, the local health department should clarify and resolve the matter in its formal notice of violation letter.

41. COMMENT: Three commenters state that N.J.A.C. 8:51-2.4(b)14 should include information and referral, when appropriate, to New Jersey Early Intervention Services. (3, 24, and 31)

RESPONSE: The Department disagrees with the comment. N.J.A.C. 8:51-2.4(b)14 states that the case manager shall refer cases to appropriate community resources including, but not limited to, Special Child Health Services. Early Intervention Services are included within the ambit of Special Child Health Services.

42. COMMENT: Two commenters state that for confirmed venous whole blood lead levels of five to nine µg/dL, the evidence that intervention will improve health and education outcomes is less convincing than that for whole blood lead levels of 10 µg/dL. The commenters do not state what action the Department should take with regard to this evidence, however. (33 and 34)

RESPONSE: The Department acknowledges the comment. The Department is required by N.J.S.A. 26:2-137.1a to follow CDC recommendations, which currently require intervention at a blood lead level of five µg/dL or higher.

43. COMMENT: Two commenters state that the Consent to Participate form for the Childhood Lead Poisoning Program should be available in other languages, especially Spanish. (14 and 32)

RESPONSE: The Department has not promulgated a Consent to Participate form or a template for such a form under N.J.A.C. 8:51. The Department's intent with respect to signed release forms is that each local health department develop and approve a release form that meets the needs of the constituents of that local health department. The Department intends for the release to authorize case management referrals as set forth at N.J.A.C. 8:51-3.3(a)1.

44. COMMENT: One commenter states that the definition of "hazard assessment" at N.J.A.C. 8:51-1.4, which states that the lead inspector/risk assessor should take dust samples of window sills and floors or areas where a child is most likely to come in contact with dust, wrongly implies that dust samples should only be taken in rooms identified on the Hazard Assessment Questionnaire, found at N.J.A.C. 8:51 Appendix A. The commenter states that the definition of "hazard assessment" should be amended to delete this implication. (2)

RESPONSE: The Department disagrees with the comment. The Hazard Assessment Questionnaire does not limit the areas where dust wipe samples should be taken. The lead inspector/risk assessor, after satisfying minimum dust sampling requirements, has the discretion to determine whether and where additional dust samples should be taken. See N.J.A.C. 8:51-5.1(b).

45. COMMENT: One commenter states that the definition of “hazard assessment” at N.J.A.C. 8:51-1.4, which means, in part, testing of the soil if no lead-based paint is found in either the interior or the exterior of the residence, unnecessarily postpones the testing of soil near the child’s residence. The commenter states that soil testing should occur simultaneously with interior inspection. The commenter points out that contaminated soil can be brought into the house on shoes or pets and could contribute to the lead dust found on floors. (2)

RESPONSE: The Department disagrees that the definition of “hazard assessment” at N.J.A.C. 8:51-1.4, which includes the completion of the Hazard Assessment Questionnaire, found at N.J.A.C. 8:51 Appendix A, unnecessarily postpones the testing of soil near the child’s residence. N.J.A.C. 8:51 Appendix A gives broad discretion to the lead inspector/risk assessor to determine when to test soil.

46. COMMENT: One commenter states that additional clarification is needed concerning when a child can be discharged from case management. The commenter states that a child’s case should be closed when the child no longer lives in the residence encumbered by an outstanding abatement order if the child’s blood lead level has declined below five µg/dL. (2)

RESPONSE: The Department disagrees with the comment. The Department’s intent in promulgating N.J.A.C. 8:51-2.4(e) is to ensure case management of the highest quality. By keeping a child’s case open in the circumstances described by the commenter, the Department intends to protect a child who may move back to his or her previous residence, which still presents a lead hazard.

47. COMMENT: Several commenters expressed support for the Department's proposed revision of the definition of elevated blood lead level to five µg/dL from 10 µg/dL. These comments generally state that this change would result in more children receiving case management and the identification and removal of lead hazards. The comments generally commend the Department for proposing this change and support working with the Department on continuing to promote the prevention of elevated blood lead levels. (4, 7, 10, 12, 17, 18, 19, 21, 23, and 25 through 31)

RESPONSE: The Department thanks the commenters for their support of the rule.

48. COMMENT: One commenter states that N.J.A.C. 8:51-2.4(d)3xii, which recommends the primary care provider to communicate regarding medical treatment with the New Jersey Poison Information and Education System, is a good use of the valuable resource. (5)

RESPONSE: The Department thanks the commenter for his support of the rule.

49. COMMENT: Several commenters state that they agree with the Department's proposed renaming of N.J.A.C. 8:51 to Childhood Elevated Blood Lead Levels because the change incorporates the language most frequently used by experts in the field of child and adolescent health. (7, 25, 26, and 27)

RESPONSE: The Department thanks the commenters for their support of renaming N.J.A.C. 8:51.

50. COMMENT: Several commenters state that since the CDC does not distinguish between capillary or venous blood test methods for determining whether a child has an elevated blood lead level, the commenters recommend adoption of N.J.A.C. 8:51-2.5(a) which would require a home visit for both capillary and venous elevated blood lead level samples. (17, 23, and 31)

RESPONSE: The Department disagrees with the comment that it is appropriate to initiate a home visit at a capillary blood lead level of five to nine µg/dL. This is because a capillary test is generally not as reliable as a venous test and, therefore, should not be used to justify the initiation of case management. The Department set forth its rationale for not adopting a portion of proposed N.J.A.C. 8:51-2.5(a) in its Response to Comment 13.

Summary of Agency Initiated Changes:

The Department is correcting upon adoption N.J.A.C. 8:51-2.4(b)3, which the Department intended to read “In the case of a child with two confirmed blood lead levels of five to nine µg/dL or one confirmed blood lead level of 10-44 µg/dL.” This change is necessary to specify which interventions must be provided in the case of a child who has a blood lead level up to 44 µg/dL and to logically transition to adopted N.J.A.C. 8:51-2.4(c), which prescribes interventions in the case of a child who has a blood lead level of 45 µg/dL or greater.

Federal Standards Statement

The Department is not adopting the amendments, repeals, and new rules under the authority of, or in order to implement, comply with, or participate in any program established under Federal law. The Department's authority for this chapter is N.J.S.A.

24:14A-1 et seq., particularly 24:14A-11; 26:1A-7; 26:2-137 et seq., particularly 26:2-137.7; and 26:2Q-1 et seq., particularly 26:2Q-12, and Executive Order No. 100 (Corzine, April 29, 2008). The Department is not adopting the amendments under any other State statute that incorporates Federal law, standards, or requirements.

However, in order to establish standards consistent with existing Federal recommendations applicable to public health interventions to prevent elevated blood lead levels in children, the Department has elected to incorporate by reference, as amended and supplemented, the following policies and guidelines in the rules: "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" and "CDC Response to Advisory Committee on Childhood Lead Poisoning Prevention Recommendations in 'Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention'." The rules in this chapter do not impose requirements that exceed Federal policies and guidelines, therefore, a Federal standards analysis is not required.

Full text of the adopted amendments and new rules follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

8:51-1.3 Incorporated materials

(a) (No change from proposal.)

(b) The Department incorporates by reference the following forms and assessments in this chapter:

1.– 7. (No change from proposal.)

8. Childhood Lead Exposure Case Closure (N.J.A.C. 8:51 Appendix K) is the form required to be used by the public health nurse case manager to discharge children from case management *[; and]***.***

[9. Preliminary Environmental Evaluation (N.J.A.C. 8:51 Appendix L) is the form required to be used by the public health nurse case manager to identify lead sources in a child's environment.]

(c)-(e) (No change from proposal.)

8:51-1.4 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

…

["Preliminary environmental evaluation" means the collection of background information regarding physical characteristics by the local board of health using the form provided at N.J.A.C. 8:51 Appendix L, incorporated herein by reference.]

…

8:51-2.3 Confirmation of blood lead test results

(a) A capillary blood screening sample that produces a blood lead level of five µg/dL or greater shall be confirmed by a venous blood lead sample before an environmental intervention *[or preliminary environmental evaluation]* is performed.

1. (No change from proposal.)

(b) (No change from proposal.)

8:51-2.4 Case management

(a) Whenever a child has a ***confirmed*** blood lead level of five µg/dL or greater, the local board of health shall provide for case management of the child and his or her family.

*[(b) Whenever a child has a capillary blood lead level 5 µg/dL to 9 µg/dL a public health staff member shall perform case management consisting of:

1. Education, both written and verbal, and counseling of the parents(s)/legal guardian about the effects and prevention of elevated blood lead levels;

2. Recommending venous blood lead retesting of the child and, when indicated, blood lead screening of siblings and other children living in the same household, and of pregnant women living in the same household in cooperation with the health care provider in accordance with N.J.A.C. 8:51A.

3. Determining whether or not the child has a health care provider, and, if not, referral to a health care provider;

4. Education and counseling about nutrition and its role in reducing lead absorption;

5. Education and counseling about personal hygiene, housekeeping, and other risk reduction measures that the parent(s)/legal guardian can take to reduce the child’s exposure to sources of lead; and,

6. Referrals to appropriate community resources including, but not limited to: health insurance coverage; Women, Infants and Children; transportation services; and other community services.]*

[(c)] ***(b)*** Whenever a child has a confirmed blood lead level of five µg/dL or greater, a public health nurse shall perform case management consisting of:

1. – 2. (No change.)

3. In the case of a child with two confirmed blood lead levels of five to nine µg/dL or one confirmed blood lead level of 10 ***to 44*** µg/dL, a review of the lead Hazard Assessment Questionnaire, available at N.J.A.C. 8:51 Appendix A, with the lead inspector/risk assessor certified by the Department to ensure that the child's environment has been evaluated for non-paint lead hazards and that the environmental evaluation has been performed in accordance with N.J.A.C. 8:51-4.2; *[or, in the case of a child with a single confirmed blood lead level of five to nine µg/dL, a review of the Preliminary Environmental Evaluation, available at N.J.A.C. 8:51 Appendix L, to ensure that the child's environment has been evaluated for potential paint and non-paint lead hazards in accordance with N.J.A.C. 8:51-4.1(g);]*

4. - 16. (No change from proposal.)

[(d)] ***(c)*** Whenever a child has a confirmed blood lead level of 45 µg/dL or greater case management shall:

1. (No change from proposal.)

2. Comply with *[(c)]* ***(b)*** above; and

3. (No change from proposal.)

[(e)] ***(d)*** (No change in text.)

[(f)] ***(e)*** (No change in text from proposal.)

8:51-2.5 Home visits

(a) Each public health nurse completing case management shall conduct an initial home visit according to the following schedule upon notification by the Department of an elevated blood lead level:

Blood Lead Levels (µg/dL)	Time Frame For Initial Home Visit
*[5 to 9 capillary	Within four weeks]*
5 to 14 venous sample	Within three weeks
15 to 19 venous sample	Within two weeks
20 to 44 venous sample	Within one week
45 to 69 venous sample	Within 48 hours
>/= 70 venous sample	Within 24 hours

(b) (No change from proposal.)

8:51-3.2 Reporting by local boards of health

(a) When a local board of health receives a report of a child with a blood lead level of five µg/dL or greater, it shall report to the Department through the Childhood

Lead Information Database as set forth at N.J.A.C. 8:51-10, on the actions it has taken on behalf of the child.

1.- 2. (No change.)

*[3. The local board of health shall report the following preliminary environmental evaluation information:

i. General information, including the date the case was referred, dwelling type, occupancy, year built;

ii. The local board of health staff member's name, address, phone (work office and work mobile);

iii. Date the preliminary environmental evaluation was started; date the preliminary environmental evaluation was completed; reported or evidence of conditions that may contribute to elevated blood lead levels.]*

(b) – (c) (No change from proposal.)

8:51-3.3 Confidentiality of records

(a) All medical information or information concerning reportable events pursuant to this chapter, including all written and electronic records maintained by the Department, and by local boards of heatlh, regarding blood lead screening, case management activities, ***and*** environmental interventions*[, and preliminary environmental evaluations]* that identify individual children, including address information and laboratory results, shall not be disclosed, except under the following circumstances:

1.-3. (No change from proposal.)

(b) – (c) (No change from proposal.)

SUBCHAPTER 4. ENVIRONMENTAL INTERVENTION *[AND PRELIMINARY ENVIRONMENTAL EVALUATION]*

8:51-4.1 Environmental intervention for all children with confirmed blood lead levels of five µg/dL or greater

(a) – (d) (No change from proposal).

(e) The local board of health shall conduct the initial environmental intervention *[or preliminary environmental evaluation]* according to the following schedule upon notification by the Department of an elevated blood lead level:

Blood Lead Levels (µg/dL)	Time Frame For Initial Environmental Intervention
Following two consecutive test results	
5 to 9 venous sample	Within three weeks
5 to 14 venous sample	Within three weeks
15 to 19 venous sample	Within two weeks
20 to 44 venous sample	Within one week
45 to 69 venous sample	Within 48 hours
>/= 70 venous sample	Within 24 hours

(f) (No change from proposal.)

*[(g) Whenever a child has a confirmed elevated blood lead level of five to nine µg/dL, the local board of health in whose jurisdiction the child resided at the time of testing shall conduct a preliminary environmental evaluation to identify possible lead hazards, using the form provided at N.J.A.C. 8:51 Appendix L, incorporated herein by reference.

(h) The local board of health shall conduct the preliminary environmental evaluation at the primary residence of the child.

1. The local board of health shall presume the address given on the report of a blood lead test result to be the primary residence of the child.

2. If it is determined that the child no longer resides, never resided, or that the reported address is a previous primary or secondary address, the local board of health shall attempt to determine the child's current address.

3. If it is determined that the child resided at the reported address at the time of the blood lead test, and subsequently moved to another primary address, then the local board of health shall conduct a preliminary environmental evaluation at the current primary address.

4. If it is determined that the child has moved, subsequent to being tested, to a primary residence outside of its jurisdiction, then the local board of health shall notify the local board of health in whose jurisdiction the child now resides, which shall conduct a preliminary environmental evaluation at the child's new primary residence.

5. If it is determined that the child did not reside at the reported address at the time of the blood lead test, the local board of health shall attempt to determine the child's address at the time of the blood lead test and conduct a preliminary environmental evaluation at that address.

6. If the primary residence of the child is part of a multi-unit dwelling, the local board of health shall conduct a preliminary environmental evaluation on the dwelling unit in which the child resides.

i. The local board of health shall provide written lead educational materials to tenants of all units of a multi-unit dwelling when a child with an elevated blood lead level is identified in one of the units, in compliance with the Health Insurance Portability and Accountability Act of 1996 Privacy Rule, found at 45 CFR 160 and 45 CFR 164 Subparts A and E, incorporated herein by reference, as amended and supplemented, respectively.

(i) Prior to performing a preliminary environmental evaluation, each local board of health staff member shall attend training as follows:

1. The Department shall post notice of the time and date of each training on the New Jersey Learning Management System, which can be found on the Internet at https://njlmn.rutgers.edu/.

2. Interested persons can register for training on the Internet at https://njlmn.rutgers.edu/.]*

8:51-4.2 Environmental intervention for children up to 72 months of age

(a) (No change from proposal.)

(b) The local board of health shall conduct a limited hazard assessment *[and dust sampling]* on the following addresses that are determined, through the Hazard Assessment Questionnaire, available at N.J.A.C. 8:51 Appendix A, to have been built before 1978 or to not have a lead-free certificate:

1.- 2. (No change.)

(c) (No change from proposal.)

8:51-4.4 Reporting results of environmental interventions

(a) – (e) (No change from proposal.)

[(f) The local board of health shall provide a Preliminary Environmental Evaluation Report, available at N.J.A.C. 8:51 Appendix L, incorporated herein by reference, to the child's parent(s)/legal guardian, describing the findings of the preliminary environmental evaluation.]

8:51-10.1 Childhood Lead Information Database

(a) (No change from proposal.)

(b) The Department's purpose of the database is to:

1. (No change.)

2. Maintain a central location for local board of health case managers, environmental inspectors, and local board of health staff members to document and track their case management activities*[,]* ***and*** environmental interventions activities *[and preliminary environmental evaluation activities]*;

3. Collect, maintain, and track Statewide childhood elevated blood lead level data, case management activities*[,]* ***and*** environmental intervention activities*[, and preliminary environmental evaluation activities]*;

4. – 7. (No change from proposal.)

(c) - (h) (No change from proposal.)

(i) Each user shall utilize the database to:

1. - 2. (No change from proposal.)

3. Document case management*[,]* ***and*** environmental intervention*[, and preliminary environmental evaluation]* activities as set forth at N.J.A.C. 8:51-3.2(a) in corresponding sections of the database, including assigning or reassigning cases to case managers;

4. – 6. (No change from proposal.)

(j) – (n) (No change from proposal.)

(**Agency Note:** The text of N.J.A.C. 8:51 Appendices G, K, L, and M follows without change symbolization, the appendices appear in their final form, including the changes discussed in the responses to comments above.)

APPENDIX G

CHILDHOOD LEAD EXPOSURE PREVENTION HOME VISIT

***Note:** This form is intended for use during nurse case manager home visits to document issues not captured through the Lead Hazard Assessment Questionnaire **(Appendix A)**. The nurse case manager and environmental inspector should collaborate in administration of the form.*

Contact Information (To facilitate data entry, verify spellings against written documents.)			
Date of Visit	Child's Date of Birth		
Last (Family) Name of EBLL Child			
First Name	Middle Name		
Street Address	Apt. #	Floor #	
Town/City	Zip Code		
Primary Phone ( )	Alternate Phone or Cell ( )		
Most likely times to reach someone at the primary phone			
Directions to Home			
Caregiver Information			
Person Interviewed			
Primary Language of the Household	Will translator be needed for future visits? ☐ Yes ☐ No		

Name/Relationship/Country of Origin	**Phone Numbers**	**Occupation and Work Schedule**
Mother	Home	Occupation
	Business	Work Schedule
Country of Origin	Cell	
Father	Home	Occupation
	Business	Work Schedule
Country of Origin	Cell	
Foster Parent/Legal Guardian	Home	Occupation
	Business	Work Schedule
Country of Origin	Cell	
Other	Home	Occupation
	Business	Work Schedule
Country of Origin	Cell	

CHILDHOOD LEAD EXPOSURE PREVENTION HOME VISIT
(Continued)

Emergency Contact (who will always know how to reach you in case you move)		
Name	Relationship	Home Phone
Address		Cell Phone
Name	Relationship	Home Phone
Address		Cell Phone

Household Members						
First Name	**Last (Family) Name**	**Relationship**	**Sex**	**DOB**	**Health Status (i.e., pregnant, physical disability)**	**Date Screened for Lead (Child or pregnant woman only)**

Medical Insurance/Social Services Currently Received By Child with Elevated Blood Lead Level	
Family Care/Medicaid:	ID #: Medicaid #:
HMO:	Name:
HMO Case Manager:	
Uninsured:	Describe why:
Private Insurance:	Name:

Who is the child's current primary care provider?

Primary Care Provider/Clinic Name: _____ Phone #: _____

Address: _____

Is this child experiencing any barriers to obtaining medical care?

☐ Yes ☐ No

If Yes, specify:

☐ Transportation ☐ Language Barrier ☐ Not Convenient for Work Schedule

☐ Cannot Find Child Care for Other Children ☐ Literacy

☐ Other: _____

Does the family use any alternative sources for medical advice?

☐ Yes ☐ No

If Yes, specify:

Alternative Medical Provider: _____ Phone #: _____

Address: _____

STOP: Administer the Lead Hazard Assessment Questionnaire before proceeding with remaining questions

Special Child Services

Is the child being served by any of the following agencies?

WIC	☐ Yes	☐ No
Food Banks	☐ Yes	☐ No
Special Child Health Services	☐ Yes	☐ No
Early Intervention Services (EIS)	☐ Yes	☐ No
Head Start	☐ Yes	☐ No
Energy Assistance for Low Income Families	☐ Yes	☐ No
Department of Children and Families	☐ Yes	☐ No
Other Health Department Maternal and Child Health Programs *(describe)*:		
_____	☐ Yes	☐ No
_____	☐ Yes	☐ No

Child's Health History

Do you have any concerns about your child's health?

☐ Yes ☐ No

If Yes, explain: _____

_____

When was the last time your child was seen by a primary care provider? _____

Child's Lead Test History

Is the primary care provider aware of your child's blood lead test history?	☐ Yes	☐ No
Has your child ever been hospitalized for elevated blood lead levels?	☐ Yes	☐ No
If Yes, dates: _____		
Has your child ever received chelation therapy?	☐ Yes	☐ No
If Yes, dates: _____		
Has any other child in this household been diagnosed with elevated blood lead levels?	☐ Yes	☐ No
If Yes, name/dates: _____		
_____		

Other Health Conditions

Does your child have a history of.....? *(Check all that apply)*

Condition			**Date Diagnosed**
Iron Deficiency Anemia	☐ Yes	☐ No	_____
Hearing or Vision Problems, Headaches	☐ Yes	☐ No	_____
Attention Deficit or Learning Disabilities	☐ Yes	☐ No	_____
Weight Loss, Loss of Appetite	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____

CHILDHOOD LEAD EXPOSURE PREVENTION HOME VISIT
(Continued)

Other Health Conditions, Continued

Does your child have a history of.....? *(Check all that apply)*

Condition			Date Diagnosed
Heart Disease	☐ Yes	☐ No	
Hepatitis	☐ Yes	☐ No	
Mental Illness	☐ Yes	☐ No	
Sickle Cell	☐ Yes	☐ No	
Fine motor coordination, gait or balance problems	☐ Yes	☐ No	
Chronic constipation, vomiting or stomach pain	☐ Yes	☐ No	
Lethargy, tiredness, sleep loss	☐ Yes	☐ No	
Seizure Disorder	☐ Yes	☐ No	
Tuberculosis	☐ Yes	☐ No	
Drug or alcohol dependency	☐ Yes	☐ No	
HIV	☐ Yes	☐ No	
Scoliosis	☐ Yes	☐ No	
Other: _____	☐ Yes	☐ No	
Other: _____	☐ Yes	☐ No	

Allergies

Allergies *(Check all that apply)*:

☐ Medications ☐ Food ☐ Environmental ☐ Other ☐None

If checked, describe: _____

Current Medications - Include all prescription medications, over-the-counter, and vitamin/mineral/herbal supplements (including supplements prescribed by a primary care provider).

Medication Prescribed by Primary Care Provider	Dose	Route	Frequency	Start Date	Reason
Over the Counter	**Dose**	**Route**	**Frequency**	**Start Date**	**Reason**
Vitamin/Mineral/Herbal Supplements/Home Remedies	**Dose**	**Route**	**Frequency**	**Start Date**	**Reason**

CHILDHOOD LEAD EXPOSURE PREVENTION HOME VISIT
(Continued)

Nutritional Assessment

Do you have food available for the family all days of the month? ☐ Yes ☐ No

Does your child have a good appetite? ☐ Yes ☐ No

How many meals does your child eat each day? _____

How many snacks? _____

Does your child eat at school/daycare? ☐ Yes ☐ No

How many meals? _____

Does your child eat at fast food restaurants? ☐ Yes ☐ No

How often? _____

Record the frequency with which the child eats the following foods:	Daily	Weekly	Never
Milk Products:			
Cheese, Yogurt			
Whole Milk			
Skim or Low-fat Milk			
Breast Milk			
Formula			
Meat and Beans:			
Chicken, Beef, Pork, Poultry			
Fish and Shellfish			
Eggs			
Dried Beans, Peas, Peanut Butter			
Grains:			
Bread, Crackers, Cereal, Macaroni, Spaghetti, Tortillas, Pasta			
Fruits:			
Fruit, Fruit Juice			
Vegetables:			
Vegetables			
Potatoes			
Other:			
Soft Drinks			
Pastries, Ice Cream, Desserts			
Candy			
Chips, Snacks or Other High-fat Foods			

CHILDHOOD LEAD EXPOSURE PREVENTION HOME VISIT
(Continued)

Home Safety Checklist					
Working smoke alarms	☐ Yes	☐ No	Living area free of dust and debris	☐ Yes	☐ No
Medications stored out of reach	☐ Yes	☐ No	Insects/rodents absent	☐ Yes	☐ No
Structurally sound	☐ Yes	☐ No	Absence of foul odor	☐ Yes	☐ No
Adequate heat	☐ Yes	☐ No	Adequate water supply	☐ Yes	☐ No
Stairs in good repair	☐ Yes	☐ No	Adequate sewage disposal	☐ Yes	☐ No
Child safety gates present	☐ Yes	☐ No	Uses child seat in car	☐ Yes	☐ No
Unobstructed exits/entries	☐ Yes	☐ No	Emergency numbers present	☐ Yes	☐ No
Uncluttered living space	☐ Yes	☐ No	Adequate lighting in hall/stairs/exit	☐ Yes	☐ No
Mats/throw rugs secured	☐ Yes	☐ No	Locked storage of toxic chemicals	☐ Yes	☐ No
Proper functioning stove	☐ Yes	☐ No	Night lights in bathrooms	☐ Yes	☐ No
Functioning refrigerator	☐ Yes	☐ No	Covers on electrical outlet	☐ Yes	☐ No
Sink with running water	☐ Yes	☐ No	Family escape plan for fire	☐ Yes	☐ No
Properly vented gas appliances	☐ Yes	☐ No	Fire extinguishers present and working	☐ Yes	☐ No
No exposed/frayed wiring	☐ Yes	☐ No	Working carbon monoxide detector	☐ Yes	☐ No
Water temp. set <120F	☐ Yes	☐ No	Yard free of clutter	☐ Yes	☐ No
Window guards present (if unit is above ground floor)	☐ Yes	☐ No	Curtain/blind cords secured	☐ Yes	☐ No
			Trash in covered receptacle	☐ Yes	☐ No
No mold/moisture	☐ Yes	☐ No	Absence of tobacco smoke in unit	☐ Yes	☐ No
Allergen-proof mattress/pillow covers on beds of asthmatics	☐ Yes	☐ No	Heavy furniture and electronics secured	☐ Yes	☐ No

Name of Case Manager who completed this form:	
Name (Print)	Date

Name of Case Manager who updated this form since initial home visit:	
Name (Print)	Date

APPENDIX K

CHILDHOOD LEAD EXPOSURE
CASE CLOSURE

Child's Full Legal Name	
Address	
Date Case Closed	Last Blood Lead Level (BLL) _____ µg/dL ___capillary ___venous
Name of Primary Care Provider (notified of case closure)	Date Case Closure Form sent to Primary Care Provider

CRITERIA FOR CASE CLOSURE		
Cases should be closed when the following criteria are met: 1. Single, venous, BLL 5 to 9 µg/dL, in accordance with 2.4(b). 2. Two, venous (1-4 months apart), BLL 5 to 9 µg/dL, in accordance with 2.4(b) and 4.1(a)-(d), and as applicable 4.1(f), 4.2, 4.3(a)-(b), 4.3(c). 3. Single, venous, BLL 10 to 44 µg/dL, in accordance with 2.4(b) and 4.1(a)-(d), and as applicable 4.1(f), 4.2, 4.3(a)-(b), 4.3(c). 4. Single, venous, BLL 45 µg/dL or greater, in accordance with 2.4(c) and 4.1(a)-(d), and as applicable 4.1(f), 4.2, 4.3(a)-(b), 4.3(c).	**OR**	**Cases should be closed administratively if:** • At least 3 documented attempts to locate or gain access to the child and parent/legal guardian have failed. • One documented attempt as certified letter from the board of health to the parent/legal guardian has failed.

CHECK ALL THAT APPLY:		
Check	**Closure Reasons**	**Additional Notes:**
	Single venous BLL below 5µg/dL after 3 months.	
	Environmental lead hazards have been abated and/or managed using interim controls.	
	Plans have been completed with the primary care provider and the parent/legal guardian for long-term developmental follow-up.	
	Administrative Closure: Lost to follow-up/Unable to locate	Date of first home visit attempt: _____ Date of second home visit attempt: _____ Date certified letter sent: _____
	Services refused	
	Moved out of Jurisdiction/State to: _____ _____	Date of referral: _____ Name of Agency referred to: _____
	Other (Specify): _____ _____	

Signature of Case Manager	Date of Signature

LP-11
APR 16

APPENDIX L (RESERVED)

Appendix M
Summary of Public Health Actions
for Elevated Blood Lead Levels

Category 1			
Blood Lead Level	**Specimen Type and Frequency**	**Case Management**	**Environmental Intervention**
5 to 9 ug/dL	Single venous	**2.4(b) Activities** **2.5 Home Visit Schedule** • Home visit • Provide education, both written and verbal, and counseling about the effects of elevated blood lead levels and its prevention (nutrition, personal hygiene, housekeeping) and other risk reduction measures. • Determine whether or not the child has a primary care provider. Refer to appropriate community resources. • Complete case management assessments (Appendices G, H, I) • Assist the family in arranging for venous follow-up and monitor blood lead retesting and results. • Educate about lead hazards that may be present on the premises. • Monitor follow-up activities.	

Category 2			
Blood Lead Level	**Specimen Type and Frequency**	**Case Management**	**Environmental Intervention**
5 to 9 ug/dL OR 10 to 44 ug/dL	Two venous (1-4 months apart) Single venous	**2.4(b) Activities** **2.5 Home Visit Schedule** • Home visit • Provide education, both written and verbal, and counseling about the effects of elevated blood lead levels and its prevention (nutrition, personal hygiene, housekeeping) and other risk reduction measures. • Determine whether or not the child has a primary care provider. • Refer to appropriate community resources. • Complete case management assessments (Appendices G, H, I) • Assist the family in arranging for venous follow-up and monitor blood lead retesting and results. • Educate about lead hazards that may be present on the premises. • Monitor follow-up activities. • Assess the need for emergency relocation. • Ensure a hazard assessment is completed at all proposed relocation addresses.	**4.1(a)-(d) Activities** **4.1(e) Home Visit Schedule** Conduct Environmental Intervention **4.1(f) (premise constructed in 1978 or later)** • Hazard Assessment Questionnaire (Appendix A) at primary residence. **4.2 (children up to 72 months)** • Hazard Assessment at primary residence. • Limited Hazard Assessment at previous primary and secondary addresses. **4.3(a) & (b) (children 72 months or greater)** • Limited Hazard Assessment at primary and secondary addresses. **4.3(c) (children 72 months or greater who have been medically diagnosed as having a development disability or developmental delay in which the effective developmental age is up to 72 months)** • Hazard Assessment at primary residence. • Limited Hazard Assessment at previous primary and secondary addresses.

Category 3			
Blood Lead Level	**Specimen Type and Frequency**	**Case Management**	**Environmental Intervention**
45 or greater ug/dL	Single venous	**2.4(c) Activities** **2.5 Home Visit Schedule** • Home visit • Provide education, both written and verbal, and counseling about the effects of elevated blood lead levels and its prevention (nutrition, personal hygiene, housekeeping) and other risk reduction measures. • Determine whether or not the child has a primary care provider. • Refer to appropriate community resources. • Complete case management assessments (Appendices G, H, I) • Assist the family in arranging for venous follow-up and monitor blood lead retesting and results. • Educate about lead hazards that may be present on the premises. • Monitor follow-up activities. • Assess the need for emergency relocation. • Ensure a hazard assessment is completed at all proposed relocation addresses. • Recommend to the primary care provider immediate hospitalization. • Recommend to the primary care provider to communicate with New Jersey Poison Information and Education System (NJPIES). • Ensure that the child is relocated to lead-safe housing. • Ensure that the environmental intervention is completed at the relocation address prior to hospital discharge. • Assist the family in obtaining required prescriptions before discharge from the hospital.	**4.1(a)-(d) Activities** **4.1(e) Home Visit Schedule** Conduct Environmental Intervention **4.1(f) (premise constructed in 1978 or later)** • Hazard Assessment Questionnaire (Appendix A) at primary residence. **4.2 (children up to 72 months)** • Hazard Assessment at primary residence. • Limited Hazard Assessment at previous primary and secondary addresses. **4.3(a) & (b) (children 72 months or greater)** • Limited Hazard Assessment at primary and secondary addresses. **4.3(c) (children 72 months or greater who have been medically diagnosed as having a development disability or developmental delay in which the effective developmental age is up to 72 months)** • Hazard Assessment at primary residence. • Limited Hazard Assessment at previous primary and secondary addresses.

		• Ensure proper administration of the medication and timely medical follow-up during and after chelation. • Maintain communication regarding child's response to chelation, neurodevelopmental assessments, the referral process and the abatement status of the primary residence.	

N.J.A.C. 8:51 Defined Terms

Case Management - a public health nurse's coordination, oversight and/or provision of the services required to identify lead sources, eliminate a child's lead exposure and reduce the child's blood lead level below 5 µg/dL.

Case Management Assessments - assessments that identify the wellness of the child and family consisting of Appendices G, H, and I.

Environmental Intervention – identification of lead hazards in the child's environment, order of abatement or interim controls, education of the family.

Hazard Assessment –

- Administer the Hazard Assessment Questionnaire (Appendix A) and complete Appendices B and F.
- Collect information regarding physical characteristics and residential use patterns including age of structure and any additions; copies of any previous lead hazard inspections; diagram of the dwelling showing each room and its use; number of children up to 72 months of age and pregnant women; potential lead exposure sources in the neighborhood.
- Conduct a visual inspection of all interior and exterior painted surfaces and for evidence of chewing on painted surfaces.
- Test defective paint on interior surfaces, other buildings on the premises, furniture, toys and play structures using an XRF instrument.
- Test paint on intact friction surfaces and on chewable or evidence of chewing surfaces using an XRF instrument.
- Test paint on impact surfaces if damage of damage using an XRF instrument.
- Dust sampling of window sills and floors and areas where the child is likely to come in contact with dust.
- Evaluate exterior of the residence if no lead-based paint hazard is found in the interior.
- Testing of the soil, if no lead-based paint hazard is found in either the interior or exterior of the residence.

Limited Hazard Assessment –

- Administer the Hazard Assessment Questionnaire (Appendix A) and complete Appendices B and F.
- Collect information regarding physical characteristics and residential use patterns including age of structure and any additions; copies of any previous lead hazard inspections; diagram of the dwelling showing each room and its use; number of children up to 72 months of age and pregnant women; potential lead exposure sources in the neighborhood.
- Conduct a visual inspection of all interior and exterior painted surfaces and for evidence of chewing on painted surfaces.
- Test defective paint on interior surfaces, other buildings on the premises, furniture, toys and play structures using an XRF instrument.
- Dust sampling of window sills and floors and areas where the child is likely to come in contact with dust.

Lead Hazard - any condition that allows access or exposure to lead, in any form, to the extent that adverse human health effects are possible.

Note:

- Abatement is required on interior surfaces where a lead hazard has been identified.
- Abatement or interim controls may be ordered at the local health department's discretion on exterior surfaces where a lead hazard has been identified.