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HEALTH

PUBLIC HEALTH SERVICES BRANCH

DIVISION OF LOCAL PUBLIC HEALTH

MATERNAL AND CHILD HEALTH SERVICES CHILD AND ADOLESCENT HEALTH PROGRAM

Childhood Blood Lead at or Above the Blood Lead Reference Value

Readoption with Amendments: N.J.A.C. 8:51

Adopted Repeals and New Rules: N.J.A.C. 8:51 Appendices E, K, and M

Proposed: May 6, 2024, at 56 N.J.R. 708(a).

Adopted: September 11, 2024, by Kaitlan Baston, MD, MSc, DFASAM, Commissioner, Department of Health (in consultation with the Public Health Council).

Filed: September 12, 2024, as R.2024 d.098, **with a non-substantial change** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 24:14A-1 et seq., particularly 24:14A-11; 26:1A-7; 26:2-137 et seq., particularly 26:2-132 and 26:2-137.7; and 26:2Q-1 et seq., particularly 26:2Q-12; and Executive Order No. 100 (2008).

Effective Dates: September 12, 2024, Readoption;
October 7, 2024, Amendments, Repeals, and New Rules.

Expiration Date: September 12, 2031.

Summary of Public Comments and Agency Responses:

The official comment period ended July 5, 2024. The following is a summary of the comments received from members of the public and the Department of Health's

(Department) responses. The Department received comments from the following individuals, organizations, and individuals on behalf of their respective organizations:

1. Marc Leckington, Affordable Housing Professionals of NJ
2. Debbie Mans, Lead-Free NJ
3. Yvette Jordan, Lead-Free NJ
4. Shereyl Snider, Lead-Free NJ
5. Sheila Caldwell, Lead-Free NJ
6. Bert Cooper, Lead-Free NJ
7. Ruth Ann Norton, Green and Healthy Homes Initiative
8. Mary Coogan, Advocates for Children of New Jersey
9. Cort Adelman, Virtua Health

1. COMMENT: The Department received a comment that the blood lead reference value should be zero, and that New Jersey's laws that require lead abatement need to be updated to the Lead Hazard Control model. (1)

RESPONSE: The Department follows the Center for Disease Control's (CDC) recommendations for the Blood Lead Reference Value, which are based on science and adopted by the majority of states. The part of the comment that calls for a statutory change in connection with lead abatement and the Lead Hazard Control model would require an act of the Legislature and is outside of the authority of the Department, which is in the executive branch of New Jersey government. The Department notes, however, that the requirement that local health officials provide educational materials to the families of children with blood lead at the Blood Lead Reference Value is consistent with the Federal Lead Hazard Control model of the U.S. Department of Housing and Urban

Development. Accordingly, the Department adopts the definition of “Blood Lead Reference Value” as proposed.

2. COMMENT: Several commenters expressed support for readopting existing public health measures, such as case management services, education, clinical services, and environmental hazard assessments for children with varying blood lead in excess of the Blood Lead Reference Level. The commenters further stated that the Department should require lead hazard assessments and home visits at lower elevated blood lead levels than proposed. The commenters also requested that the State consider requiring home visits, completion of hazard assessment questionnaires, and limited hazard assessments when a child has a confirmed blood lead level of 3.5 µg/dL. With respect to case management practices, the commenters made the following recommendations: (1) For blood lead levels between the Blood Lead Reference Value and 9.9 µg/dl, “Surveillance” should include one confirmed venous blood lead sample, “Clinical Recommendation” should include nutrition education and iron deficiency evaluation, and “Environmental Action” should include notice provided to an applicable municipal rental inspection program, providing referral contact information and applications, as available, for lead hazard assessment and remediation programs in the municipality, and providing interim control measures if elevated lead levels are found in dust, soil, or water; (2) For blood lead levels between 10 µg/dl and 19.9 µg/dl, “Clinical Recommendation” should include nutrition education, iron deficiency evaluation, and developmental screening, and “Environmental Action” should include notice provided to an applicable municipal rental inspection program, and providing referral contact

information and applications, as available; (3) For blood lead levels between 20 µg/dl and 44.9 µg/dl, “Clinical Recommendation” should include nutrition education, iron deficiency evaluation, developmental screening, and consultation with a lead specialist, and “Environmental Action” should include notice provided to an applicable municipal rental inspection program, and providing referral contact information and applications, as available; (4) For blood lead levels between 45 µg/dl and 69.9 µg/dl, “Clinical Recommendation” should include nutrition education, iron deficiency evaluation, developmental screening, consultation with lead specialist, and complete chelation therapy, ensuring proper administration of the medication and timely medical follow-up during and after chelation; and (5) For blood lead levels from 70 µg/dl or higher, “Clinical Recommendation” should include nutrition education, iron deficiency evaluation, developmental screening, hospitalization, consultation with a lead specialist, and complete chelation therapy, and “Environmental Action” should include notice provided to an applicable municipal rental inspection program, and providing referral contact information and applications, as available. The commenters requested that the State consider updates to case management practices that would clarify clinical recommendations for case management, enable lead hazard assessments and home visits at lower Elevated Blood Lead Levels, and improve family access to lead risk assessment and lead hazard remediation services offered in their local areas. The commenters also requested that the State consider requiring home visits, completion of hazard assessment questionnaires, and limited hazard assessments when a child has a confirmed blood lead level of 3.5 µg/dL. The commenters also recommended revising the definition of Blood Lead Reference Value to specify that it be consistent with the

level as adopted by the U.S. Centers for Disease Control and Prevention based on the 97.5th percentile of the blood lead distribution in the U.S. among children ages one to five years. The commenters also recommended that the Department coordinate with local boards of health to distribute information to the public about lead poisoning prevention case management practices and key points of contact for childhood lead poisoning prevention and hazard reduction. (3, 4, 5, 6, and 7)

RESPONSE: The Department agrees with the commenters in part. The Department is already implementing guidance and education for case management at all confirmed blood lead levels from 3.5 µg/dL and above. These rules do not require iron deficiency evaluations as they are outside the scope of practice for nurses, who perform virtually all case management functions in the State. The Department does not believe that these rules should require home visits and inspections for blood lead levels 3.5 µg/dL through 4.9 µg/dL because such a requirement would place an undue burden on the State's local health departments. The existing rules require inspections starting at two consecutive venous blood samples of five to nine µg/dL that are one to four months apart, or one venous blood sample at 10 µg/dL or greater. The commenters also suggested providing lead remediation and risk assessment services. The Department points out that the existing rules can require lead abatement in the case of primary addresses and can justify lead remediation in secondary and previous primary addresses. The Department agrees with adopting the Blood Lead Reference Value that the CDC recommends, which is the 3.5 ug/dl level that the Department hereby adopts. The Department agrees with the commenters about distributing educational materials during case visits including laminates, brochures, and literature, and is already

coordinating with local health departments to do so. Local health departments can also allocate their grant funds for health education materials. Nurse case managers also refer families to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) if the family is nutritionally at risk and would benefit from nutritional assistance. If a child is reported to have a blood lead test result on a capillary sample, the local board of health in whose jurisdiction the child resides shall contact the child's parent or guardian to ensure that a timely venous confirmatory blood lead test is performed, in accordance with CDC recommendations and in cooperation with the child's primary care provider. Whenever a child has a confirmed blood lead level of 3.5 µg/dL to 4.9 µg/dL, the local board of health shall provide written guidance about common sources of lead exposure and written guidance on how to prevent such exposure to the parent(s) or guardian(s) of the child within seven days of notification to the local board of health of such confirmed blood lead level. The Department has already posted health education material at https://www.nj.gov/health/childhood-lead/documents/childhood-lead-brochure-EN.pdf that includes information about nutrition for local boards of health to distribute to the parents/guardians of affected children. For confirmed blood lead results greater than or equal to five µg/dL, the local board of health utilizes N.J.A.C. 8:51 Appendix G, Childhood Lead Exposure Prevention Home Visit form to evaluate the child's iron deficiency and nutritional status. Developmental status is also captured using the form "Ages & Stages Questionnaires." For the full list of case management activities, please refer to N.J.A.C. 8:51-2.4. Regarding the recommended environmental actions by the commenters, the Department has taken a step-by-step approach in reducing the threshold for

environmental investigations. Previously, environmental investigations were only conducted for two consecutive confirmed blood lead levels of 10 to 14 ug/dl or a single confirmed blood lead level of 15 ug/dL or higher until September 2017. See 49 N.J.R. 3168(a). The most recent rule adoption, effective September 18, 2017, lowered the actionable blood lead level to two consecutive confirmed blood lead levels of five to nine µg/dL or a single confirmed blood lead level of 10 ug/dL or higher. The nurse case management and environmental intervention process map is publicly available at: https://cdrss.nj.gov/cdrss/common/cdrssHelpDocuments. The Department agrees with the commenters that the public will benefit from a health education campaign. To this end, the Department launched a health education campaign in July 2024 to increase awareness in childhood lead poisoning. The campaign is called “Stay Lead-Free, Test Twice Before Three.” It emphasizes ways to prevent lead exposure to children, sources of lead, and the importance of blood lead testing for children ages one and two. The campaign features information posted on the Childhood Lead program's website, available at https://www.nj.gov/health/childhood-lead/, and television and radio advertisements, billboard and social media posts, and other ads. Accordingly, the Department declines to modify the rule based on the comment.

3. COMMENT: One commenter recommended that the Department coordinate with local boards of health to distribute information to the public about lead poisoning prevention case management practices and key points of contact for childhood lead poisoning prevention and hazard reduction. The commenter expressed the view that the timing for such outreach is important due to the required compliance of local

governments and property owners with the Lead-Based Paint Inspections in Rental Dwelling Units law enacted in 2022. The commenter also recommended that Blood Lead Reference Value be defined to specify that the State's Blood Lead Reference Value shall be consistent with the level as adopted by the U.S. Centers for Disease Control and Prevention based on the 97.5th percentile of the blood lead distribution in U.S. children ages one to five years. The commenter also suggested that the Department consider updating the New Jersey Administrative Code case management plan to clarify surveillance, education, clinical, and environmental actions. The commenter also suggested that the New Jersey Administrative Code should specify that if a child under age six has a confirmed elevated blood lead level, the local board of health should provide case management services, including coordination and/or delivery of specific surveillance, education, clinical services, and environmental hazard assessment and remediation services. In particular, the commenter suggested that regulations should specify that case management staff will support direct referrals of households who qualify for Department of Community Affairs (DCA) Lead Remediation and Abatement Program services to local agencies implementing the program. The commenter also recommended that the Department consider lowering the threshold to require home visits, completion of hazard assessment questionnaires, and limited hazard assessments when a child has a confirmed blood lead level of 3.5 µg/dL. (7)

RESPONSE: The Department agrees in part with the commenter. The Department agrees that the State should adopt the Blood Lead Reference Value recommended by the CDC. Accordingly, the proposed rule introduced a change in the reference value from five to 3.5 µg/dL, and it also updated the terminology from "Elevated Blood Lead

Level" to "Blood Lead Reference Value," consistent with CDC guidelines. Additionally, the rulemaking outlines a new workflow for blood lead levels ranging from 3.5 to 4.9 µg/dL at N.J.A.C. 8:51-2.4 and 8:51 Appendix M. See also the "Blood Lead Test to Abatement Process Map" and "Blood Lead Test to Child Case Process Map," both publicly available at: https://cdrss.nj.gov/cdrss/common/cdrssHelpDocuments. Recognizing the complexity of nurse case management and environmental interventions, the Department agrees that the public will benefit from a health education campaign. The Department launched a health education campaign in July 2024 to increase awareness of childhood lead poisoning. The campaign is called "Stay Lead-Free, Test Twice Before Three." It emphasizes ways to prevent lead exposure to children, sources of lead, and the importance of blood lead testing for children ages one and two. The campaign features fliers posted on the Childhood Lead program's website, available at https://www.nj.gov/health/childhood-lead/resources/, as well as television and radio advertisements, and billboard and social media posts and ads. The Department does not agree with the suggestion that the New Jersey Administrative Code should specify that if a child under age six has a confirmed elevated blood lead level, the local board of health should provide case management services including coordination and/or delivery of specific surveillance, education, clinical services, and environmental hazard assessment and remediation services as a blanket proposal because the commenter does not specify at which blood lead reference value each of the named interventions should be provided. The Department and local health departments do refer households that may qualify for the DCA Lead Remediation and Abatement Program to local implementing agencies, and since such referrals are

already taking place, the Department does not believe it is necessary that these rules should mandate such referrals. The Department also declines to adopt the suggestion that it lower the threshold to require home visits, completion of hazard assessment questionnaires, and limited hazard assessments when a child has a confirmed blood lead level of 3.5 µg/dL because such measures would unduly strain resources at the local level. Accordingly, the Department declines to modify the rule based on the comment.

4. COMMENT: One commenter encouraged the Department to continue its public education efforts to ensure that parents and caretakers appreciate the importance of screening their children for lead as early as possible, as well as encouraging pediatricians and other medical providers to educate parents on the dangers of lead exposure and the importance of screening young children. (8)
RESPONSE: The Department thanks the commenter for her comment in support of the notice of proposal.

5. COMMENT: A commenter recommended that the Department bolster the interventions provided to children with blood lead reference values between 3.5 and 4.9 µg/dL, and noted that the Department's rulemaking would establish a new requirement for children with blood levels between 3.5 and 4.9 µg/dL for local boards of health to provide "written guidance about common sources of lead exposure and … how to prevent such exposure …" The commenter recommended that the Department supplement this requirement to provide a "more substantial" intervention to mitigate

potential sources of lead, including an assessment of the home or other environmental factors, referral for venous blood draws, or an appropriate level of case management. The commenter suggested that written guidance alone, as sets forth in the proposed modifications at N.J.A.C. 8:51-2.4, may be insufficient to mitigate the presence of lead, especially in underserved or marginalized communities. The commenter also suggested that the Department modify N.J.A.C. 8:51-4.1, 4.2, and 4.3 to lower the eligibility for environmental intervention from five to 3.5 µg/dL. (9)

RESPONSE: The Department has taken a step-by-step approach in reducing the threshold for environmental investigations. Previously, environmental investigations were only conducted for two consecutive confirmed blood lead levels of 10 to 14 ug/dl or a single confirmed blood lead level of 15 ug/dL or higher until September 2017. That rulemaking lowered the actionable blood lead level to two consecutive confirmed blood lead levels of five to nine µg/dL or a single confirmed blood lead level of 10 ug/dL or higher. See 49 N.J.R. 3168(a). Identifying a source of lead at a level of 3.5 µg/dL is almost impossible and would place an undue financial burden on homeowners. Laboratory specificity and precision are plus or minus four µg/dL. Accordingly, laboratory testing cannot indicate with certainty that the blood lead level is accurate at low levels. It would be an undue burden on local governments to require environmental interventions based upon inaccurate test results. Accordingly, the Department declines to modify the rule based on the comment.

Summary of Agency-Initiated Change:

The Department is making a non-substantial change upon adoption at N.J.A.C. 8:51 Appendix E, number 4, to delete the letter “s” in the word “projects” because the word “project” is grammatically correct.

Federal Standards Statement

The Department is not readopting these rules with amendments, repeals, and new rules pursuant to the authority of, or in order to implement, comply with, or participate in any program established pursuant to 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 (2008). The Department is not adopting amendments pursuant to 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 blood lead at or above the blood lead reference value 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 readopted with amendments, repeals, and new rules in this chapter do not impose requirements that exceed Federal policies and guidelines and, therefore, a Federal standards analysis is not required.

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 8:51.

Full text of the adopted amendments and new rules follows (deletion indicated in brackets with asterisks *[thus]*):

Appendix E

Communicable Disease Reporting and Surveillance System (CDRSS) User Agreement
(Effective May 2018)

All users of the CDRSS must read and sign a copy of this user agreement and return it to the Division of Epidemiology, Environmental and Occupational Health (EEOH). Access to the CDRSS is for the purpose of fulfilling the mission of the EEOH. The data in the CDRSS are to be treated as confidential and each user agrees to the following:

1. All users must respect the confidential nature of the CDRSS data. Users must not act in any way that will intentionally (or unintentionally) compromise the confidentiality of these data.
2. Only authorized users are allowed access to the system. User access is limited by use of individual, unique system user ID and password combinations. New users must complete all necessary system training before being granted password access. Users must not share passwords with others or assist in unauthorized access to the system. Users should not save their unique CDRSS login information on the internet browser.
3. The system is to be accessed only by authorized users while those users are actively performing project tasks requiring use of the system. As soon as users are finished actively performing tasks requiring use of the system, they must exit from password-protected system areas.
4. Access rights to the system are given only to project employees with a clear need to know. Rights are given based on the principle of least privilege. Thus, users will only be given the minimum rights necessary to perform project*[s]* tasks for which they have authorization.
5. Any individual detecting a breach of system security or potential security vulnerability must report this finding in writing to the CDRSS Helpdesk (cdrs.admin@doh.nj.gov).
6. Users are encouraged to notify the supervisor and CDRSS Helpdesk if access rights are no longer needed for areas of the CDRSS.
7. Any CDRSS data linkages must be properly documented and authorized by the CDRSS project manager.

I have read the above information. I understand the importance of and agree to uphold the user agreement rules of the CDRSS.

Date: _____ □ ILI User Only (please check)

User's Signature: _____

Please print the items below (black or blue ink only):

User's Full First and Last Name: _____

User's E-mail address: _____

User's Telephone Number: _____

Organization: _____