Childhood Lead Poisoning in New Jersey

ANNUAL REPORT

Fiscal Year

2012

July 1, 2011

to

June 30, 2012

New Jersey Department of Health

CHILDHOOD LEAD POISONING IN NEW JERSEY

ANNUAL REPORT

STATE FISCAL YEAR 2012
(July 1, 2011– June 30, 2012)

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http://www.state.nj.us/health/fhs/newborn/lead.shtml

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GLOSSARY OF TERMS AND ACRONYMS

BLL: Blood Lead Level.

Children: Refers to individual children, in that one reported child is counted only once in reference to data (regardless of the number of tests that the child has had during the year). Unless otherwise specified, children means individuals who are <17 years of age.

Department: Refers to the New Jersey Department of Health.

EBLL: Elevated Blood Lead Level (10 µg/dL or greater).

Large Municipalities: Municipalities with a population >35,000 residents.

Local Boards of Health: Means the board of health of any municipality or the boards, bodies or officers in such municipality lawfully exercising any of the powers of a local board of health under the laws governing such municipality.

Population Data: Unless otherwise specified, Census 2010 population data.

SFY: State Fiscal Year for the period of July 1, 2011-June 30, 2012. Thus, for any State Fiscal Year identified, it begins July 1 of the preceding year and ends June 30 of the identified year.

µg/dL: micrograms per deciliter of whole blood.

TABLES, MAPS, AND FIGURES

WHY IS LEAD POISONING IN CHILDREN A PRIORITY FOR NEW JERSEY?

Scientific research has shown that even low levels of lead in the blood of children can adversely affect their health and ability to learn. Therefore, preventing children's exposures to known sources of lead is not only a priority for New Jersey, but also a national health objective.

When absorbed into the human body lead affects almost every organ and system. Lead's effects on the nervous system are particularly serious and can cause learning disabilities, hyperactivity, decreased hearing, mental retardation, and possible death. Lead is particularly hazardous to children between six months and six years of age. Children who have suffered from the adverse effects of lead exposure are frequently in need of special health and educational services.

Lead is a heavy metal that has been widely used in industrial processes and consumer products. The methods for lead to enter the body is through ingestion and inhalation. The amount of lead in gasoline began to be regulated in the United States in the 1970's and by January 1, 1996, the Clean Air Act banned the sale of leaded fuel for use in on-road vehicles. This action is credited with reducing the level of lead in the air. However, significant amounts of lead remain in the environment where it poses a threat to children. Some common lead containing substances that are ingested or inhaled by children include:

- lead-based paint;
- dust;
- soil;
- tap water;
- food stored in lead soldered cans or improperly glazed pottery;
- cultural products and remedies; and
- cosmetics.

All children in New Jersey are at risk because lead-based paint and other lead-containing substances are present throughout the environment. Some children, however, are at particularly high risk due to exposure of lead in their immediate environment. These potential sources include:

- lead-based paint that is peeling, chipping, or otherwise in a deteriorated condition;
- lead-contaminated dust created during removal or disturbance of leaded paint in the process of home renovation; and
- lead-contaminated dust brought into the home by adults who work in an occupation that involves lead or materials containing lead, or who engage in a hobby where lead is used.

Over the past few years, there has been increased attention focused by the media on the increasing number of imports into the United States being tainted with dangerous levels of lead. This has been alarming especially when these imports consist of toys and other products used primarily by children. However, the primary lead hazard to children comes from lead-based paint. In recognition of the danger that lead-based paint presents to children, lead-based paint was regulated for residential use in New Jersey in 1971, and nationwide in 1978. This action has effectively reduced the risk of lead exposure for children who live in houses built after 1978. Any house built before 1978 may still contain lead-based paint. The highest risk for children is found in houses built before 1950, when paint contained a very high volume of lead. New Jersey has nearly one million housing units built before 1950, which accounts for approximately 30% of the total housing stock. Every county in the State has more than 9,000 housing units built before 1950. Nearly 80% of the State's housing stock, more than 2.5 million housing units, was built prior to 1980. (Table 1 and Map 1)

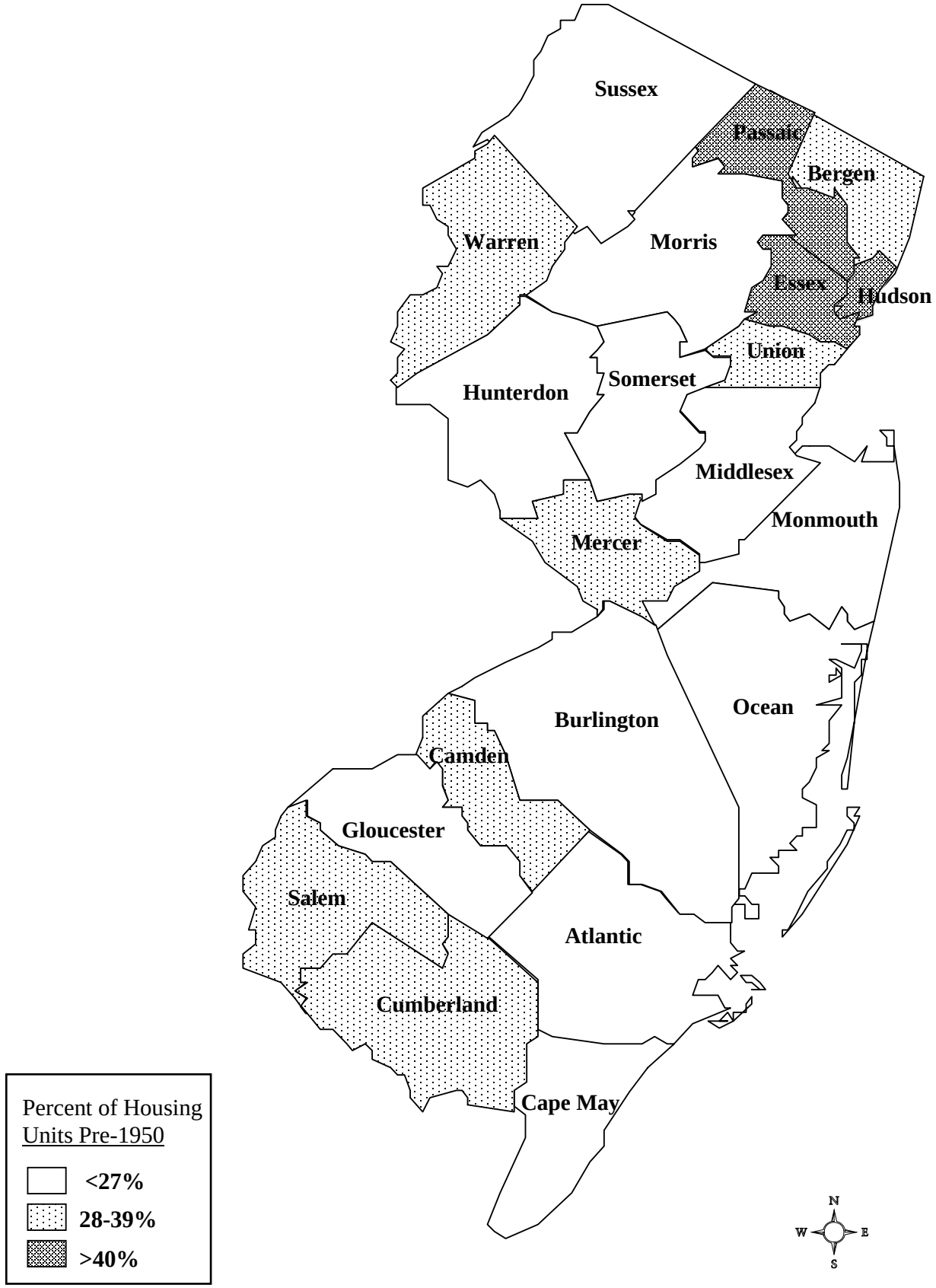
Table 1

Housing Built Pre-1950 and Pre-1980 in New Jersey
2000 U.S. Census

County	Total Housing Units	# of Housing Units Built Pre-1950	% of Housing Units Built Pre-1950	# of Housing Units Built Pre-1980	% of Housing Units Built Pre-1980
Atlantic	125,826	24,978	20%	76,682	61%
Bergen	351,122	120,802	34%	288,945	82%
Burlington	174,382	26,486	15%	107,916	62%
Camden	204,435	58,456	29%	155,289	76%
Cape May	98,394	20,736	21%	58,118	59%
Cumberland	55,406	15,576	28%	41,425	75%
Essex	311,738	135,729	44%	259,121	83%
Gloucester	108,337	18,827	17%	62,293	57%
Hudson	264,844	129,668	49%	209,373	79%
Hunterdon	49,159	11,185	23%	27,079	55%
Mercer	142,377	43,836	31%	101,745	71%
Middlesex	292,495	53,147	18%	191,473	65%
Monmouth	256,504	55,159	22%	164,937	64%
Morris	188,329	38,298	20%	127,666	68%
Ocean	275,793	24,951	9%	156,084	57%
Passaic	175,223	72,201	41%	149,917	86%
Salem	27,293	8,896	33%	20,664	76%
Somerset	122,244	19,600	16%	64,355	53%
Sussex	61,567	12,691	21%	41,071	67%
Union	198,668	74,531	38%	174,359	88%
Warren	44,897	14,129	31%	30,072	67%
Statewide Total	**3,529,033**	**979,882**	**28%**	**2,508,584**	**71%**

Map 1

Percentage of Housing Units
Built Pre-1950
New Jersey Counties



EXECUTIVE SUMMARY

N.J.A.C. 8:51A requires the protection of children under six years of age from the toxic effects of lead exposure by requiring lead testing pursuant to N.J.S.A. 26:2-137.1 through 137.7. This Annual Report on Childhood Lead Poisoning in New Jersey for State Fiscal Year (SFY) 2012 is submitted in compliance with N.J.S.A. 26:2-135, which requires the Commissioner of the Department of Health to issue an annual report to the Governor and the Legislature that includes a summary of the lead poisoning testing and abatement program activities in the State during the preceding SFY.

The number of children tested for lead in SFY 2012 was 220,787, which represents an increase of 2.9% over the 214,478 children tested during SFY 2011. The SFY 2012 number of children tested also includes 103,380 children, or 48%, who are between six and 29 months of age, the ages at which all children must be tested under State law.

While 213,020 (99.5%) children tested during SFY 2012 had blood lead levels below the Centers for Disease Control and Prevention (CDC) threshold of 10 μg/dL, there were 1,155 (0.52%) children with a test result above this threshold (Figure 6), including 236 children, who had at least one test result of 20 μg/dL or greater (Figure 7a).

The City of Newark continues to remain a central component in New Jersey's efforts to eliminate childhood lead poisoning. The City of Newark far exceeds any other large municipality in the number of children under 6 years of age with elevated blood lead levels (EBLL). In SFY 2012, the City of Newark comprised 15% of the total number of children (under 6 years of age) with EBLL in the State. Moreover, the City of Newark had the highest number of new cases (incidence) of lead poisoned children reported during SFY 2012 (Figure 12).

CHAPTER ONE

TESTING CHILDREN FOR LEAD POISONING

In New Jersey, all children are to be tested at both one and two years of age. At a minimum all children should have at least one blood lead test before their sixth birthday. Approximately 78% of children in New Jersey have had at least one blood lead test prior to reaching three years of age.

This chapter describes and depicts the testing statistics and trends based on the reports of blood lead tests received by the Department from clinical laboratories. Analysis to create the tables, graphs, or charts is based on individual children, counting only one test per child.

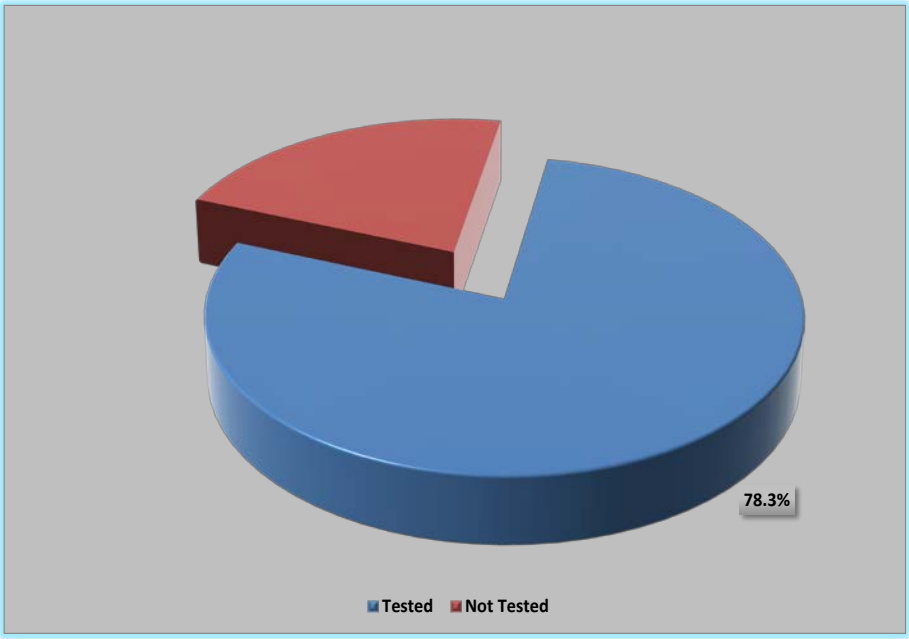
The tables and charts highlighting children between six and 29 months of age closely represent the testing rates. However, the data displayed throughout these tables and charts also include children that were tested during SFY 2012 as their second test at two years of age, while they were already tested at one year of age during SFY 2011.

The Department uses the range of six to 29 months of age to capture data on tests that are performed either earlier than 12 months of age or later than 24 months of age, as not all children are tested exactly at one and two years of age.

Figures 1a and 1b represent the percentages of children who had a lead test performed prior to turning three and six years of age during SFY 2012.

Figure 1a

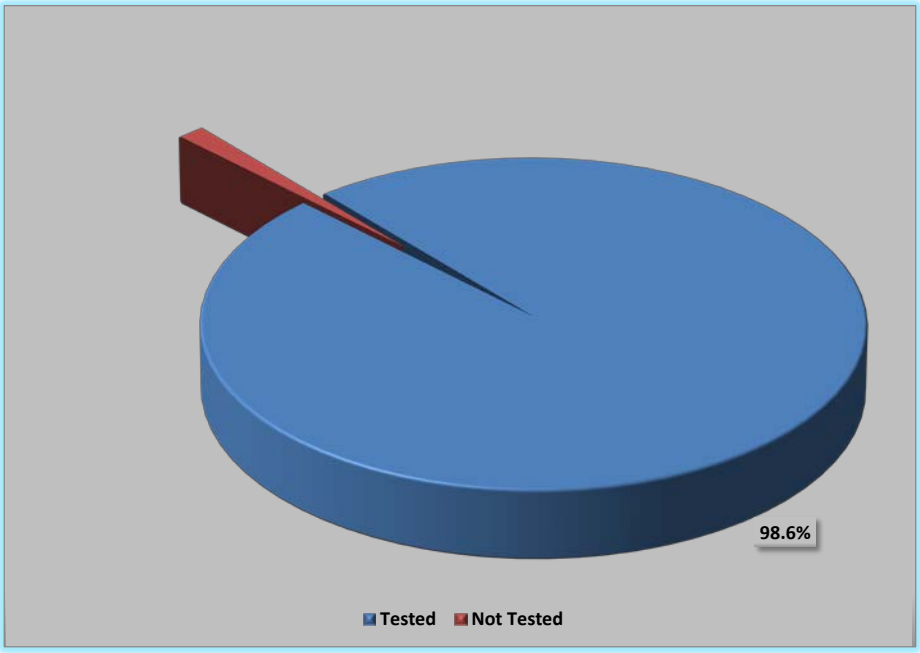
Percentage of Children* Who Turned Three Years of Age During SFY 2012 and Had at Least One Blood Lead Test in their Lifetime



*Number of children born in New Jersey between July 1, 2008 and June 30, 2009 (108,869); Source: Birth Registry data

Figure 1b

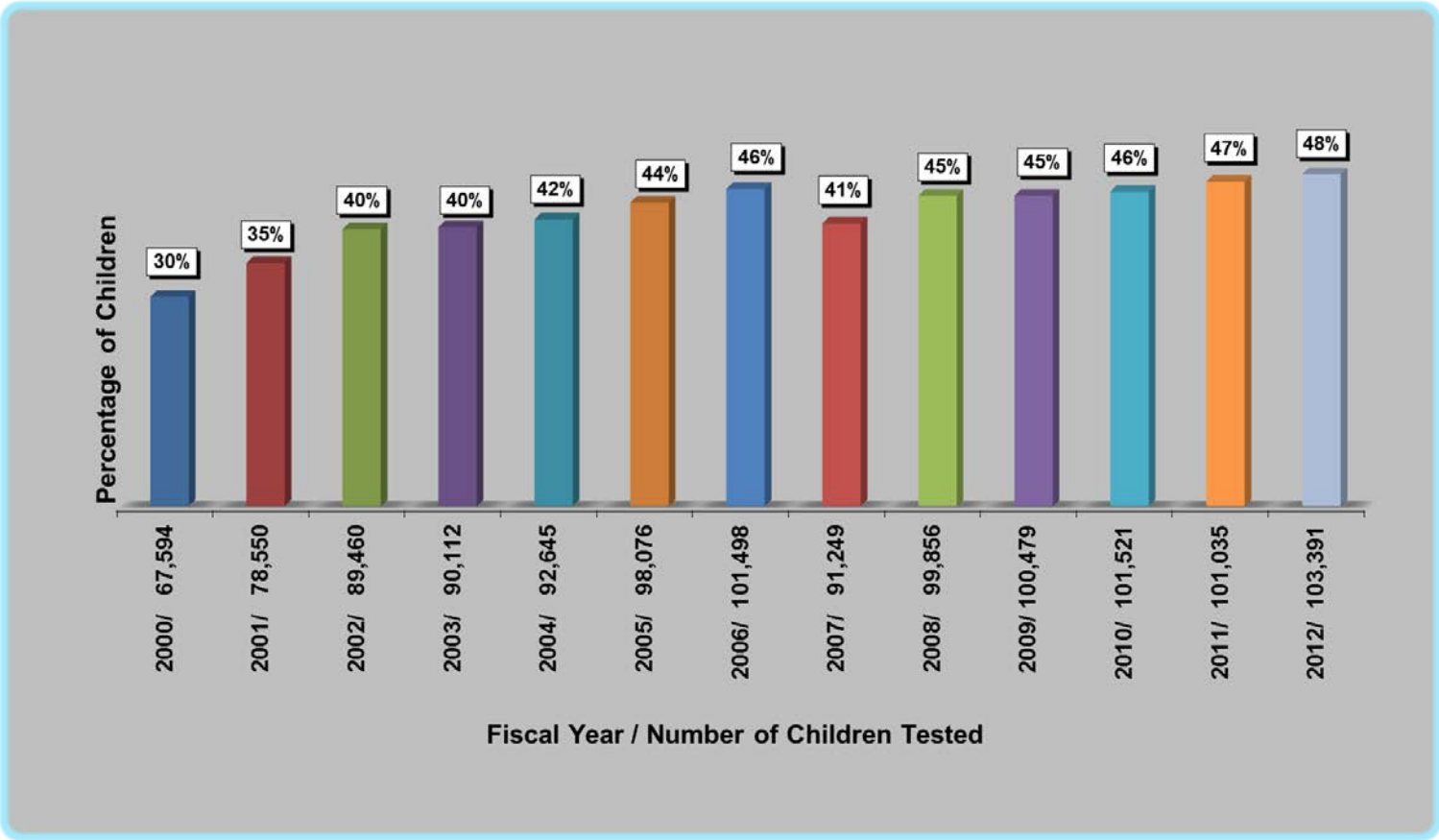
Percentage of Children* Who Turned Six Years of Age During SFY 2012 and Had at Least One Blood Lead Test in their Lifetime



* Number of children born in New Jersey between July 1, 2005 and June 30, 2006 (113,648); Source: Birth Registry data

Figure 2

Trend in Percentage of Children (ages six-29 months) Tested by SFY
(*n=222,837* and 214,727*)**



*The denominator for SFY 2000 through SFY 2010 utilizes the number of children who are one and two years of age, based on US Census 2000 data.

**The denominator for SFY 2011 and SFY 2012 utilizes the number of children who are one and two years of age, based on US Census 2010 data.

CHAPTER TWO

PROFILE OF BLOOD LEAD TESTS PERFORMED AND PREVALENCE OF CHILDHOOD LEAD POISONING

In this chapter, the tables and charts identify the statistics of testing performed for various ages and the prevalence of lead poisoning during SFY 2012 among all children.

Table 2 shows the testing statistics by county of residence for children between six and 29 months of age. Figures 3a and 3b show the prevalence of childhood lead poisoning among children between six and 29 months of age. The analyses behind the formulation of the tables are based on the number of children, reported during SFY 2012, which counts the highest BLL reported per child. The tables and charts in this chapter may also include children who were tested for a *second* time during SFY 2012 around two years of age, as required by law.

Tables 5 and 6 display the testing statistics and the prevalence of lead poisoning among the children that were tested at under 6 years of age during SFY 2012.

The Department maintains a database containing all blood lead tests reported on children. In order to exhibit the distribution of lead tests and the prevalence of lead poisoning among children, Table 6 and Figures 4a, 4b, 5, and 6 focus on the entire population of children who were tested and reported during SFY 2012.

Figures 7a and 7b depict the trend in number of children reported with EBLL by SFY.

The children in the age groups of under 6 years and under 17 years of age may have had one or more blood lead tests performed during their lifetime, either as routine lead testing or as a follow up to an elevated blood lead test. However, the analyses of data for the tables for these age groups were based on the number of individual children, reported during SFY 2012, counting the highest BLL reported per child.

Table 2

SFY 2012: Children (ages six to 29 months) by BLL and County of Residence

County	Total Children	% Tested	BLL (µg/dL)						
			<5	5 - 9	10 - 14	15-19	20-44	≥ 45	Total
ATLANTIC	6,521	44%	2,760	119	10	7	5		2,901
BERGEN	19,955	41%	7,883	186	8	13	7		8,097
BURLINGTON	10,166	23%	2,226	60	3				2,289
CAMDEN	13,215	32%	4,063	111	13	4	6		4,197
CAPE MAY	1,822	29%	496	22	3				521
CUMBERLAND	4,368	45%	1,792	131	14	4	6		1,947
ESSEX	21,569	54%	10,938	659	82	24	27		11,730
GLOUCESTER	6,862	19%	1,267	33	3	1			1,304
HUDSON	17,288	56%	9,327	287	34	7	17	1	9,673
HUNTERDON	2,316	35%	789	29	2		1		821
MERCER	8,591	45%	3,699	150	14	6	8		3,877
MIDDLESEX	19,965	37%	7,127	145	23	11	6		7,312
MONMOUTH	13,371	35%	4,609	95	15	4	5		4,728
MORRIS	10,700	28%	2,948	53	10	3	2		3,016
OCEAN	15,532	49%	7,440	131	6	3	2		7,582
PASSAIC	13,727	56%	7,361	320	41	12	7	1	7,742
SALEM	1,549	40%	576	38	5	1			620
SOMERSET	7,581	28%	2,072	25	8	3	1		2,109
SUSSEX	3,099	29%	899	11	1				911
UNION	14,148	50%	6,816	249	22	9	6		7,102
WARREN	2,382	37%	859	30	2	1			892
ZIP Unknown	N/A	N/A	13,714	295					14,009
Total	**214,727**	**48%**	**99,661**	**3,179**	**319**	**113**	**106**	**2**	**103,380**

Table 3

SFY 2012: Children (ages six to 29 months) by BLL and Municipality* of Residence

Municipality	Total Children	% Tested	BLL (µg/dL)						Total
			<5	5 - 9	10 - 14	15-19	20-44	≥ 45	
ATLANTIC CITY	1,249	77%	877	68	9	4	3		961
BAYONNE	1,528	48%	699	25	2	3	3		732
BELLEVILLE	869	61%	508	18	2	1	1		530
BERKELEY	509	7%	36						36
BLOOMFIELD	1,224	49%	575	20	3		2		600
BRICK	1,531	30%	451	4			1		456
BRIDGEWATER	978	43%	417	3					420
CAMDEN	2,838	57%	1,533	63	8	3	3		1,610
CHERRY HILL	1,449	26%	368	3	1				372
CLIFTON	2,123	46%	955	28	2		1		986
EAST BRUNSWICK	860	31%	268						268
EAST ORANGE	1,916	49%	850	80	5	2	2		939
EDISON	2,560	44%	1,083	25	5	2	1		1,116
EGG HARBOR	1,038	45%	463	7		1	1		472
ELIZABETH	3,943	58%	2,164	100	5	3	1		2,273
EVESHAM	1,016	4%	43	1					44
EWING	600	35%	203	4	2				209
FORT LEE	725	33%	233	3					236
FRANKLIN	1,759	8%	147	1	1				149
FREEHOLD	652	64%	408	8	2				418
GALLOWAY	724	35%	251	5					256
GLOUCESTER	1,520	10%	150	7	1				158
HACKENSACK	1,118	61%	666	18	1		2		687
HAMILTON	1,814	31%	549	3	3	1			556
HILLSBOROUGH	866	45%	386			1			387
HOBOKEN	1,467	59%	852	13					865
HOWELL	1,125	27%	304				2		306
IRVINGTON	1,692	72%	1,077	110	18	4	5		1,214
JACKSON	1,100	29%	311	5					316
JERSEY CITY	7,192	60%	4,096	181	25	4	9		4,315
KEARNY TOWN	895	47%	408	8	1		1		418
LAKEWOOD	6,556	79%	5,080	99	6	2	1		5,188
LINDEN	911	52%	464	9	1	1			475
MANALAPAN	778	32%	248						248
MANCHESTER	448	12%	53	1					54

Municipality	Total Children	% Tested	BLL (µg/dL)						Total
			<5	5 - 9	10 - 14	15-19	20-44	≥ 45	
MARLBORO	767	18%	140		1				141
MIDDLETOWN	1,444	16%	237		1				238
MONROE (Gloucester County)	898	7%	60	1					61
MONROE (Middlesex County)	655	12%	78						78
MONTCLAIR	869	36%	305	9		1			315
MOUNT LAUREL	886	19%	164	1					165
NEW BRUNSWICK	1,573	69%	1,030	33	8	4	3		1,078
NEWARK	8,382	65%	5,049	318	46	10	12		5,435
NORTH BERGEN	1,498	50%	743	8	1		1		753
NORTH BRUNSWICK	1,220	35%	429	2					431
OLD BRIDGE	1,478	25%	369	5					374
PARSIPPANY-TROY HILLS	1,207	9%	99		4		1		104
PASSAIC	2,767	73%	1,897	93	9	6	2		2,007
PATERSON	4,632	68%	2,954	171	27	6	4	1	3,163
PENNSAUKEN	845	40%	330	9					339
PERTH AMBOY	1,584	56%	857	24	2				883
PISCATAWAY	1,361	43%	573	13		2	1		589
PLAINFIELD	1,628	78%	1,172	83	9	4	2		1,270
SAYREVILLE	1,137	26%	289	3					292
SOUTH BRUNSWICK	935	9%	80	3	1				84
TEANECK	1,075	36%	369	13		1			383
TOMS RIVER	1,816	43%	779	9		1			789
TRENTON	2,786	65%	1,665	133	9	5	7		1,819
UNION CITY	1,880	45%	813	25	3		1	1	843
UNION TWP	1,250	56%	690	8			1		699
VINELAND	1,729	43%	726	13	2		1		742
WASHINGTON (Gloucester County)	900	6%	49	1					50
WAYNE	995	41%	400	6	1				407
WEST NEW YORK	1,523	64%	970	10	1				981
WEST ORANGE	1,263	39%	468	19	2		2		491
WINSLOW	1,122	5%	56	1					57
WOODBRIDGE	2,495	18%	452	5	3	1			461
Total	**112,173**	**48%**	**51,468**	**1,939**	**233**	**73**	**77**	**2**	**53,792**

*****Large Municipalities only

Figure 3a

Trend in Percentage of Children (ages six-29 months) with BLL ≥ 20 µg/dL by SFY

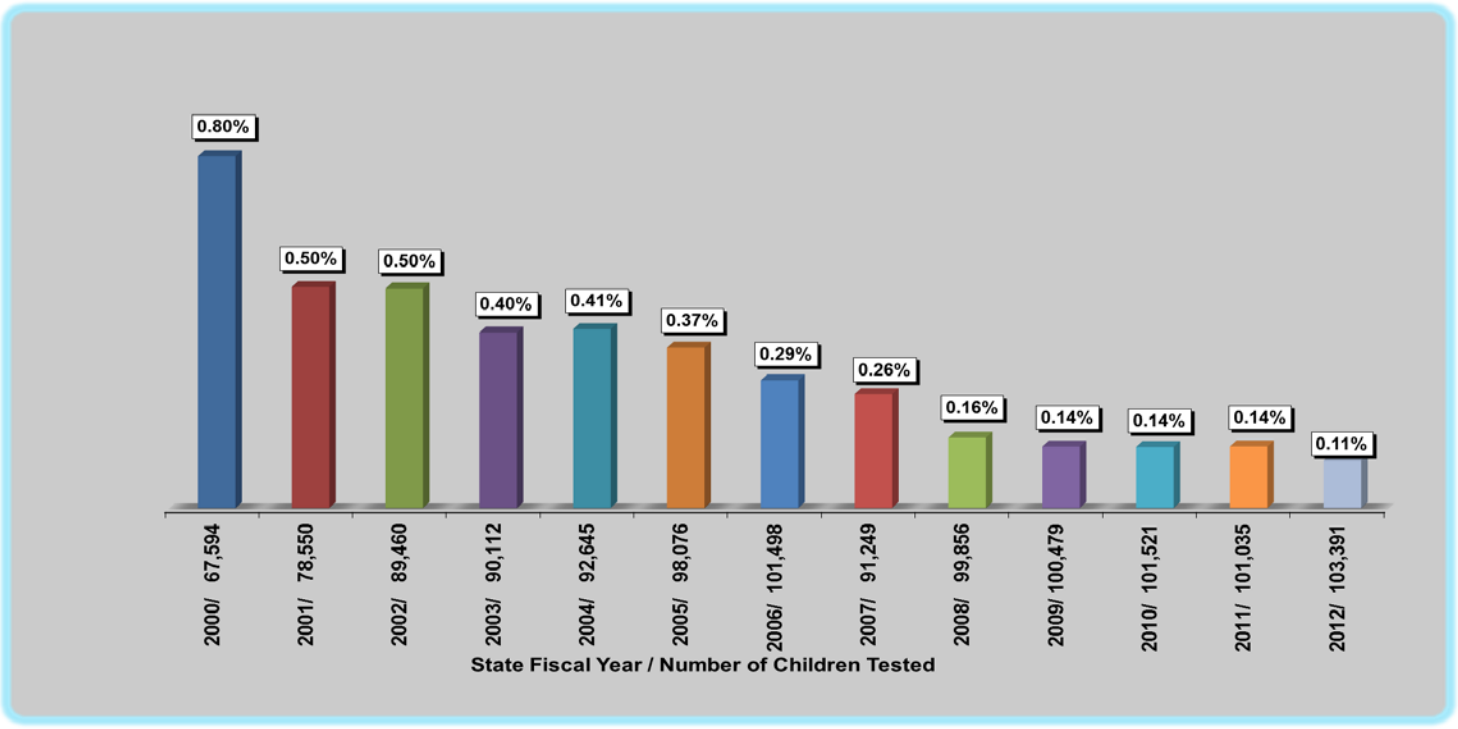


Figure 3b

Trend in Percentage of Children (ages six-29 months) with BLL ≥ 10 µg/dL by SFY

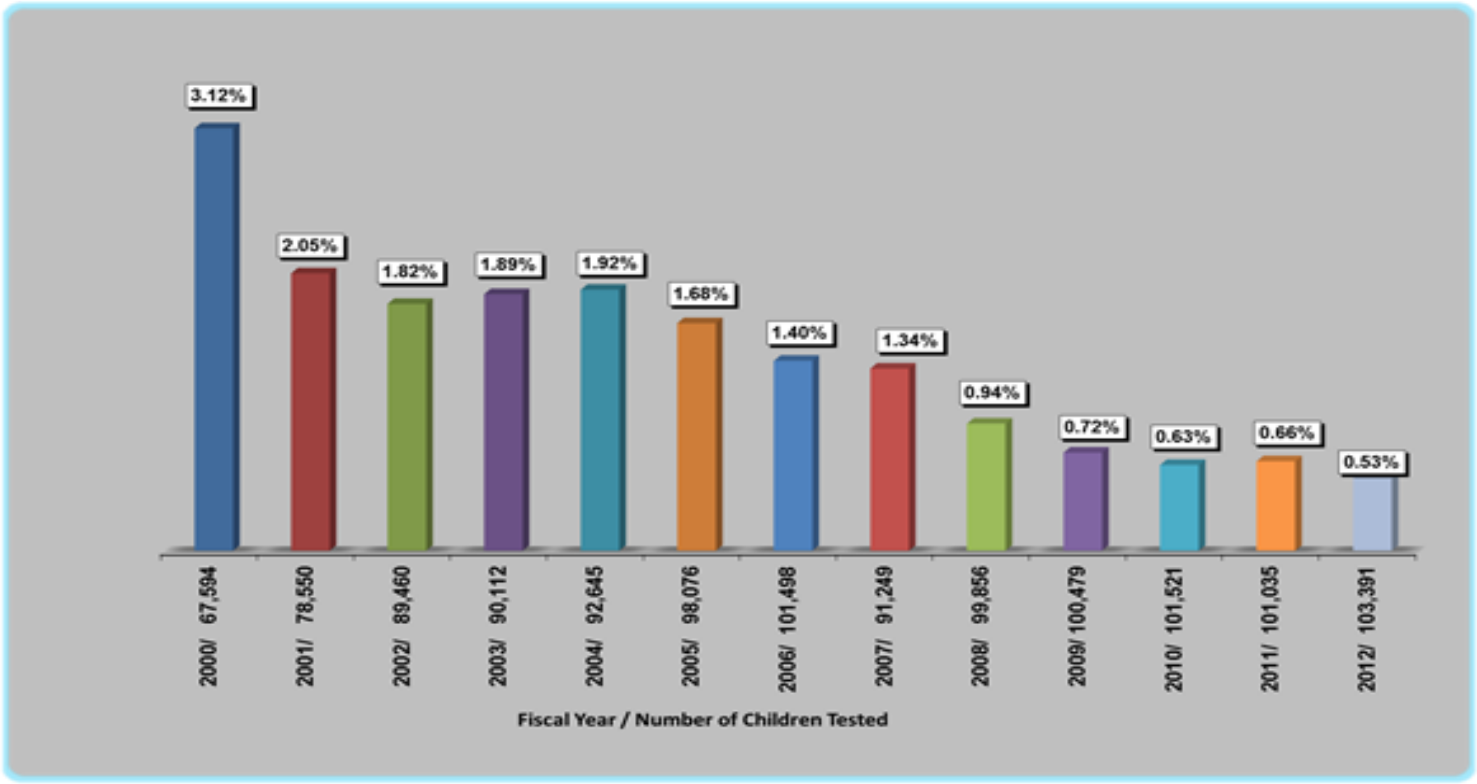


Table 4

SFY 2012: Children (<6 Years of Age) by BLL and County of Residence

County	Total Children	% Tested	BLL (µg/dL)						
			<5	5 - 9	10 - 14	15 - 19	20 - 44	≥ 45	Total
ATLANTIC	19,909	28%	5,229	236	20	14	8		5,507
BERGEN	61,192	21%	12,748	267	17	14	11		13,057
BURLINGTON	31,546	11%	3,354	113	6		1		3,474
CAMDEN	40,195	15%	5,920	182	24	8	9	1	6,144
CAPE MAY	5,423	16%	809	41	3			1	854
CUMBERLAND	12,963	27%	3,238	210	21	7	8	1	3,485
ESSEX	64,591	41%	25,026	1,459	185	57	61	2	26,790
GLOUCESTER	21,059	9%	1,788	49	4	1			1,842
HUDSON	49,759	38%	18,454	536	59	15	26	3	19,093
HUNTERDON	7,484	12%	897	31	4		2		934
MERCER	26,052	26%	6,342	268	27	14	11		6,662
MIDDLESEX	60,249	22%	12,746	272	43	13	10	1	13,085
MONMOUTH	42,404	17%	7,171	166	21	5	6		7,369
MORRIS	33,493	14%	4,459	68	13	5	3		4,548
OCEAN	46,657	27%	12,133	225	10	6	5		12,379
PASSAIC	41,179	38%	14,951	654	86	18	19	4	15,732
SALEM	4,625	19%	794	59	8	1	1		863
SOMERSET	23,622	13%	3,014	45	11	3	2		3,075
SUSSEX	9,701	13%	1,269	16	2				1,287
UNION	43,085	33%	13,824	484	45	17	17		14,387
WARREN	7,434	15%	1,070	38	4	2			1,114
ZIP Unknown	N/A	N/A	21,410	526					21,936
Total	**652,622**	**28%**	**176,646**	**5,945**	**613**	**200**	**200**	**13**	**183,617**

Table 5

SFY 2012: Children (<6 Years of Age) by BLL and Municipality* of Residence

Municipality	Total Children	% Tested	BLL (µg/dL)						
			<5	5-9	10-14	15-19	20-44	≥ 45	Total
ATLANTIC CITY	3,677	55%	1,844	139	17	7	5		2,012
BAYONNE	4,576	35%	1,540	41	3	4	5		1,593
BELLEVILLE	2,601	40%	1,013	27	2	1	1		1,044
BERKELEY	1,565	4%	56						56
BLOOMFIELD	3,575	32%	1,110	31	4	1	2		1,148
BRICK	4,558	16%	739	9			1		749
BRIDGEWATER	3,052	18%	540	5					545
CAMDEN	8,525	29%	2,327	115	15	4	4		2,465
CHERRY HILL	4,588	12%	530	5	2				537
CLIFTON	6,187	31%	1,840	54	6		3		1,903
EAST BRUNSWICK	2,725	17%	470	1	2				473
EAST ORANGE	5,534	42%	2,111	187	13	7	7		2,325
EDISON	7,774	25%	1,849	47	7	2	2		1,907
EGG HARBOR	3,341	23%	750	15		2	1		768
ELIZABETH	11,792	44%	4,971	208	16	6	3		5,204
EVESHAM	3,117	2%	55	2					57
EWING	1,797	19%	333	6	2		1		342
FORT LEE	2,171	21%	442	4					446
FRANKLIN	5,182	5%	271	5	2				278
FREEHOLD	2,156	31%	650	11	3				664
GALLOWAY	2,240	19%	408	7					415
GLOUCESTER	4,647	4%	192	9	1				202
HACKENSACK	3,223	42%	1,322	28	4		3		1,357
HAMILTON	5,480	17%	922	8	4	1			935
HILLSBOROUGH	2,736	18%	486			1			487
HOBOKEN	3,779	31%	1,159	17					1,176
HOWELL	3,591	13%	479	2			2		483
IRVINGTON	4,993	59%	2,640	262	44	8	15		2,969
JACKSON	3,649	14%	504	9					513
JERSEY CITY	20,393	42%	8,138	347	44	10	16	1	8,556
KEARNY TOWN	2,681	36%	939	18	1		1	1	960
LAKEWOOD	18,872	44%	8,186	164	10	4	4		8,368
LINDEN	2,726	35%	922	20	2	2			946
MANALAPAN	2,541	14%	348						348

Municipality	Total Children	% Tested	BLL (µg/dL)						
			<5	5 - 9	10 - 14	15 - 19	20 - 44	≥ 45	Total
MANCHESTER	1,372	9%	118	3					121
MARLBORO	2,606	9%	232	1	1				234
MIDDLETOWN	4,615	8%	349	2	1				352
MONROE (Gloucester County)	2,794	4%	98	1					99
MONROE (Middlesex County)	2,082	6%	116	1					117
MONTCLAIR	2,701	21%	533	18		2	2		555
MOUNT LAUREL	2,705	8%	204	1					205
NEW BRUNSWICK	4,753	40%	1,797	64	14	4	5		1,884
NEWARK	24,831	56%	12,995	731	103	27	22	1	13,879
NORTH BERGEN	4,473	33%	1,461	18	1		1		1,481
NORTH BRUNSWICK	3,502	21%	727	8					735
OLD BRIDGE	4,548	13%	590	9					599
PARSIPPANY-TROY HILLS	3,671	5%	167		4		1		172
PASSAIC	8,226	58%	4,535	174	20	9	8		4,746
PATERSON	13,987	48%	6,293	378	56	9	8	4	6,748
PENNSAUKEN	2,696	19%	494	13	1	1			509
PERTH AMBOY	4,756	44%	2,025	45	3	1		1	2,075
PISCATAWAY	3,903	25%	962	20	1	3	1		987
PLAINFIELD	4,961	59%	2,775	141	15	7	6		2,944
SAYREVILLE	3,338	16%	517	5					522
SOUTH BRUNSWICK	3,130	5%	156	6	2				164
TEANECK	3,142	19%	565	17	1	1			584
TOMS RIVER	5,617	24%	1,342	19		1			1,362
TRENTON	7,998	46%	3,412	242	20	11	9		3,694
UNION CITY	5,742	29%	1,626	49	6	1	1	1	1,684
UNION TWP	3,701	36%	1,303	20	1	1	3		1,328
VINELAND	5,058	26%	1,295	26	2		1		1,324
WASHINGTON (Gloucester County)	2,968	2%	66	2					68
WAYNE TWP	3,105	18%	542	9	2				553
WEST NEW YORK	4,258	51%	2,128	23	3				2,154
WEST ORANGE	3,635	26%	884	34	5		4		927
WINSLOW	3,336	3%	108	1	1				110
WOODBRIDGE	7,326	12%	839	14	6	1			860
Total	**335,580**	**32%**	**101,340**	**3,898**	**473**	**139**	**148**	**9**	**106,007**

*****Large municipalities only

Figure 4a

SFY 2012: Breakdown of Children by Years of Age with BLL ≥10 µg/dL

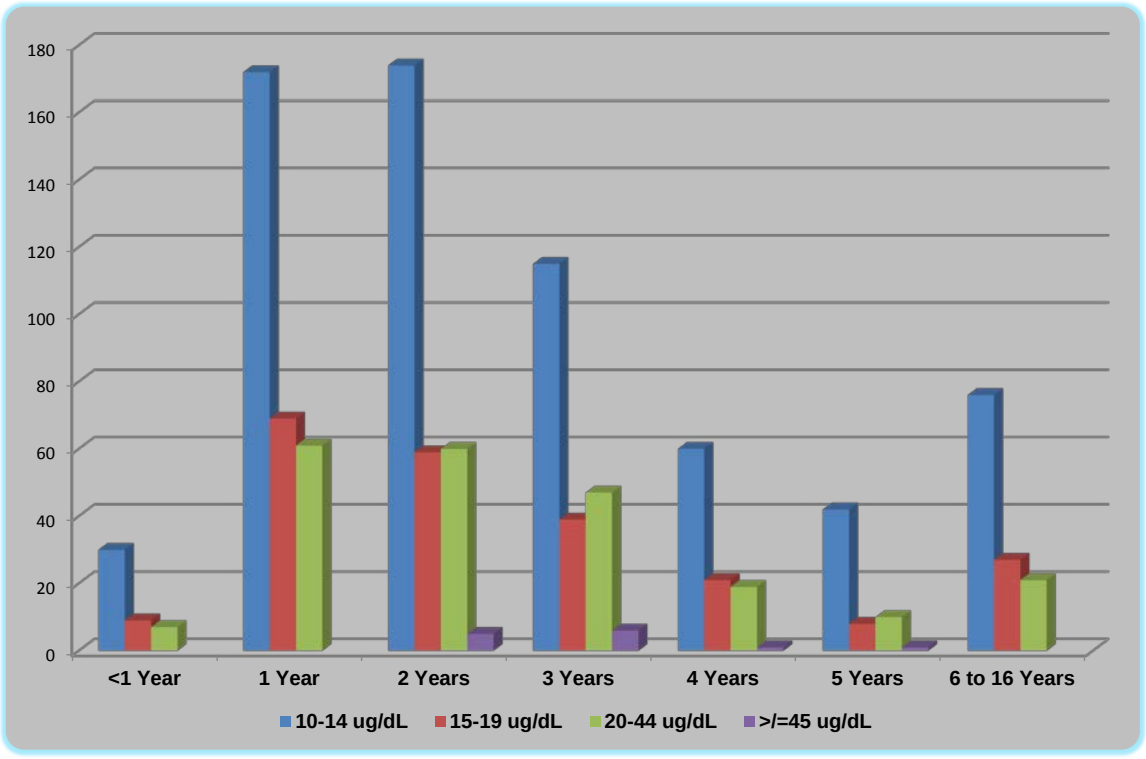


Figure 4b

SFY 2012: Breakdown of Children by Years of Age with BLL <10 µg/dL

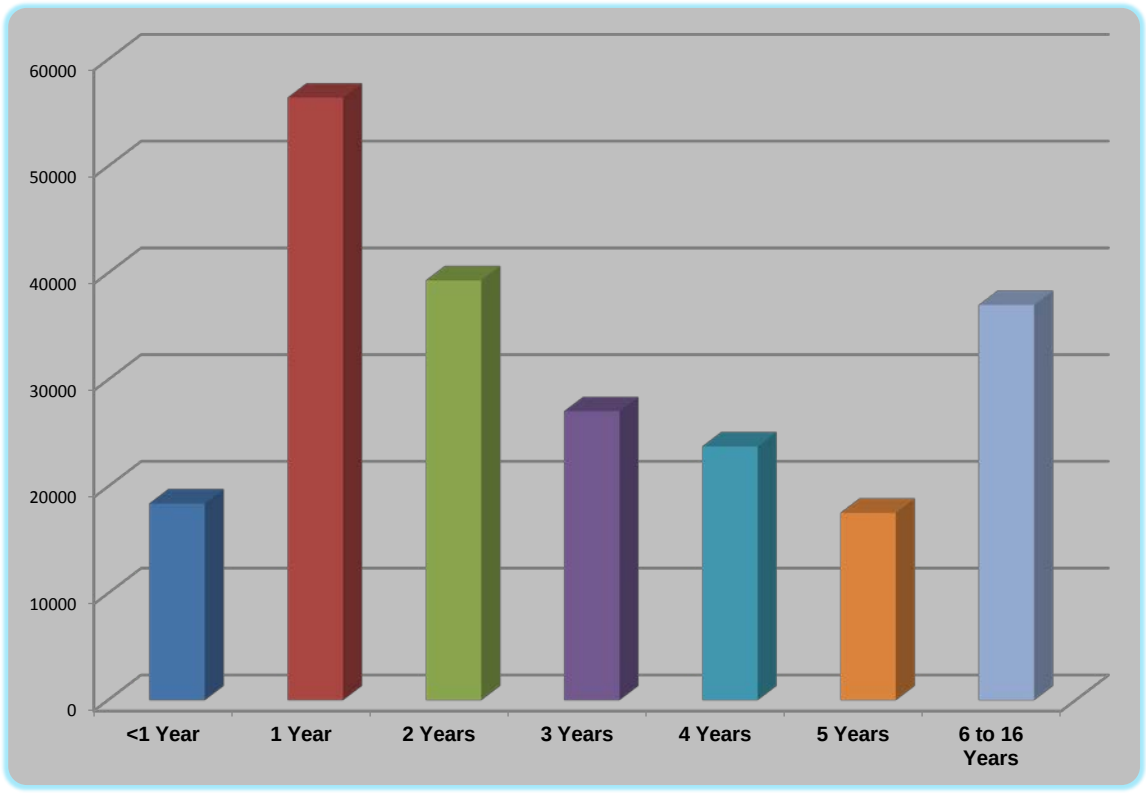


Table 6

SFY 2012: Children by BLL and County of Residence

County	BLL (µg/dL)						
	<5	**5-9**	**10-14**	**15-19**	**20-44**	**≥45**	**Total**
ATLANTIC	6,197	258	24	14	8		6,501
BERGEN	15,014	303	19	16	11		15,363
BURLINGTON	3,746	119	8		1		3,874
CAMDEN	6,737	200	25	9	11	1	6,983
CAPE MAY	902	46	3			1	952
CUMBERLAND	3,657	236	27	10	8	1	3,939
ESSEX	31,220	1,634	205	67	65	2	33,193
GLOUCESTER	1,896	51	5	1			1,953
HUDSON	23,569	595	65	16	29	3	24,277
HUNTERDON	957	32	4		3		996
MERCER	7,890	295	29	14	13		8,241
MIDDLESEX	16,112	306	53	14	12	1	16,498
MONMOUTH	8,352	188	25	7	6		8,578
MORRIS	4,966	72	14	5	4		5,061
OCEAN	13,666	252	10	6	6		13,940
PASSAIC	18,375	716	94	23	22	4	19,234
SALEM	858	63	8	1	1		931
SOMERSET	3,533	50	12	3	3		3,601
SUSSEX	1,463	19	2				1,484
UNION	17,572	547	54	19	20		18,212
WARREN	1,185	41	4	2			1,232
ZIP Unknown	25,153	591					25,744
Total	**213,020**	**6,614**	**691**	**228**	**224**	**12**	**220,787**

Figure 5

SFY 2012: Percent of Children Tested by Age
(n=220,787)

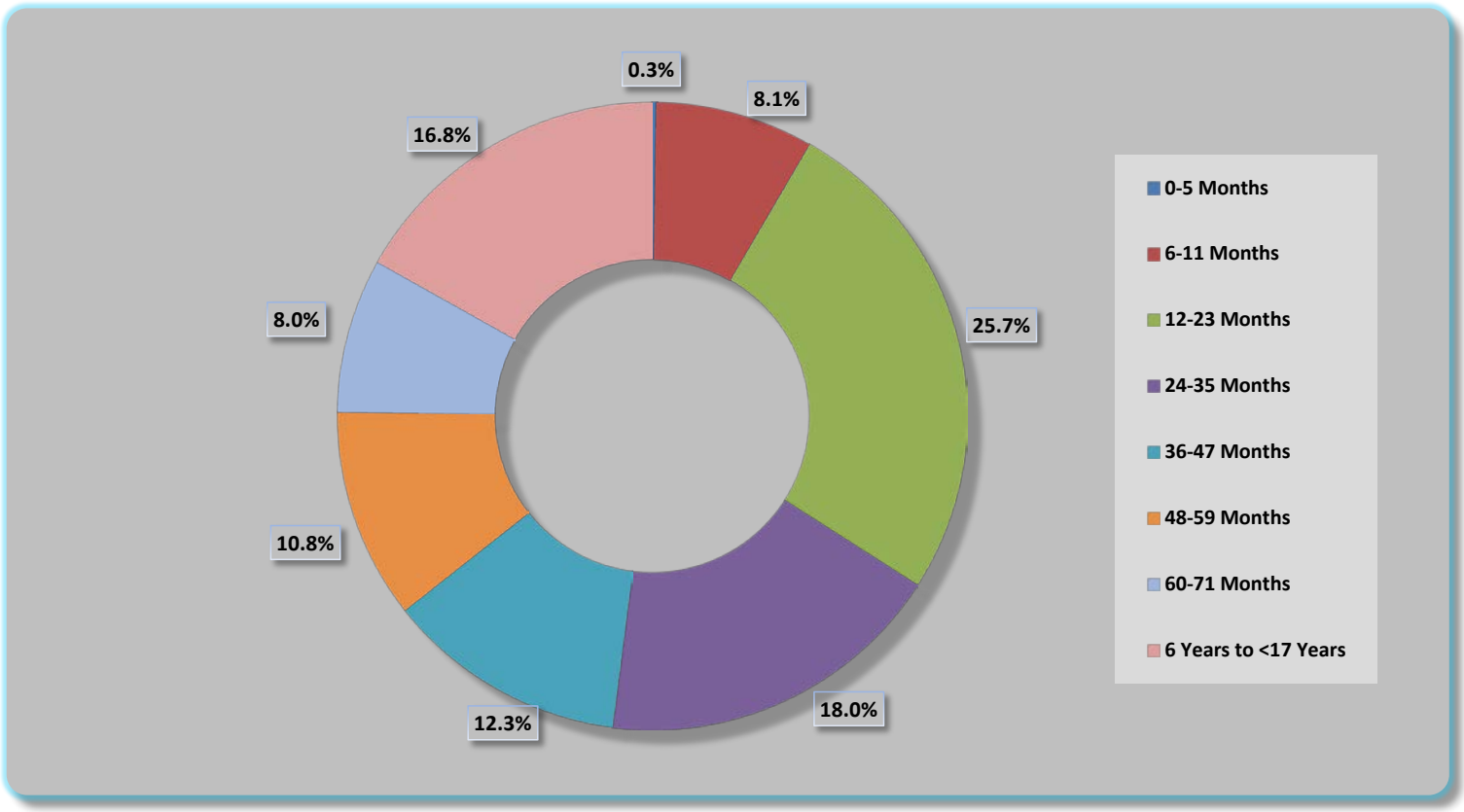


Figure 6

SFY 2012: Percentage of Children by BLL
(n=220,787)

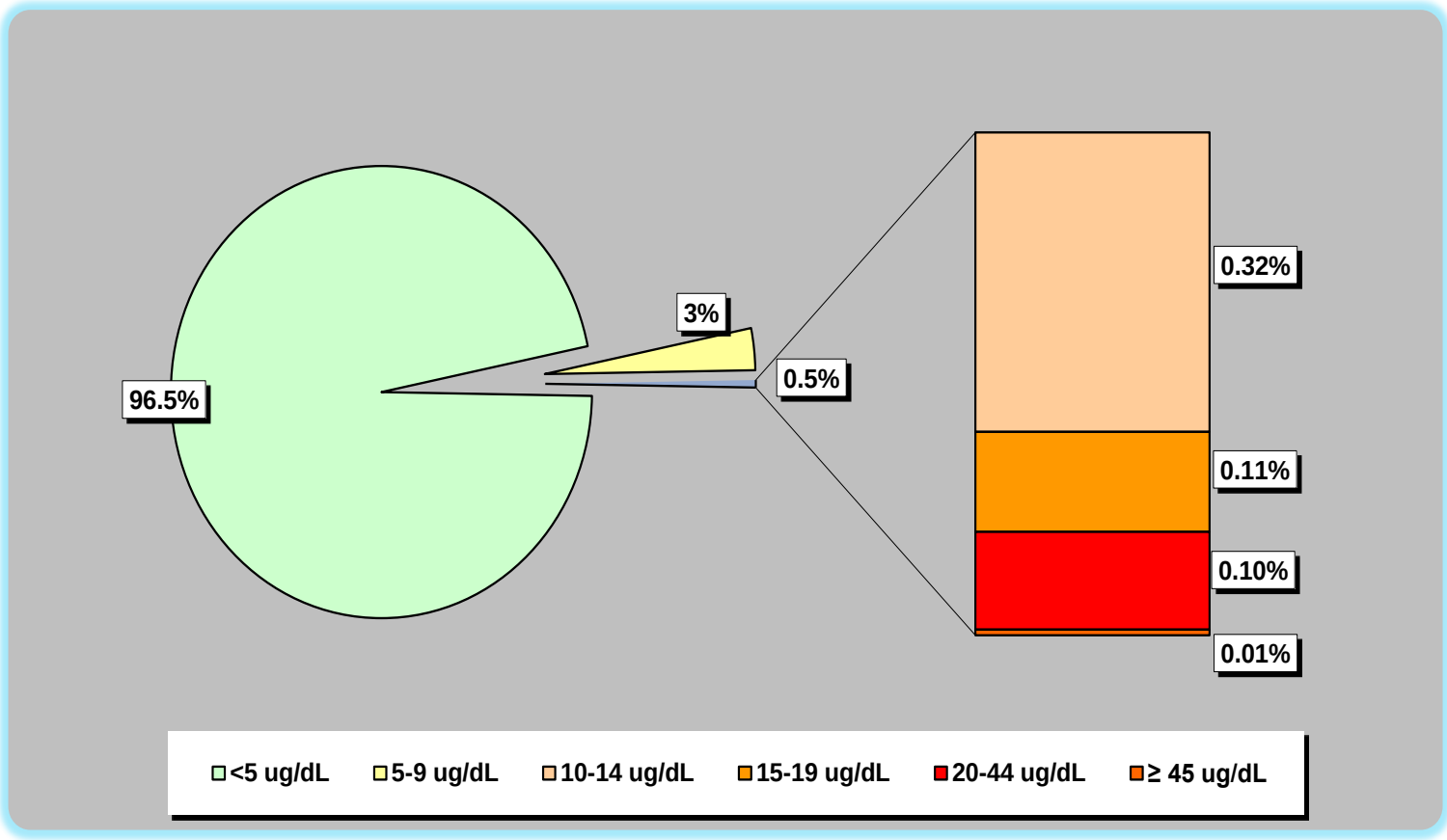


Figure 7a

Children with BLL ≥20 µg/dL by SFY

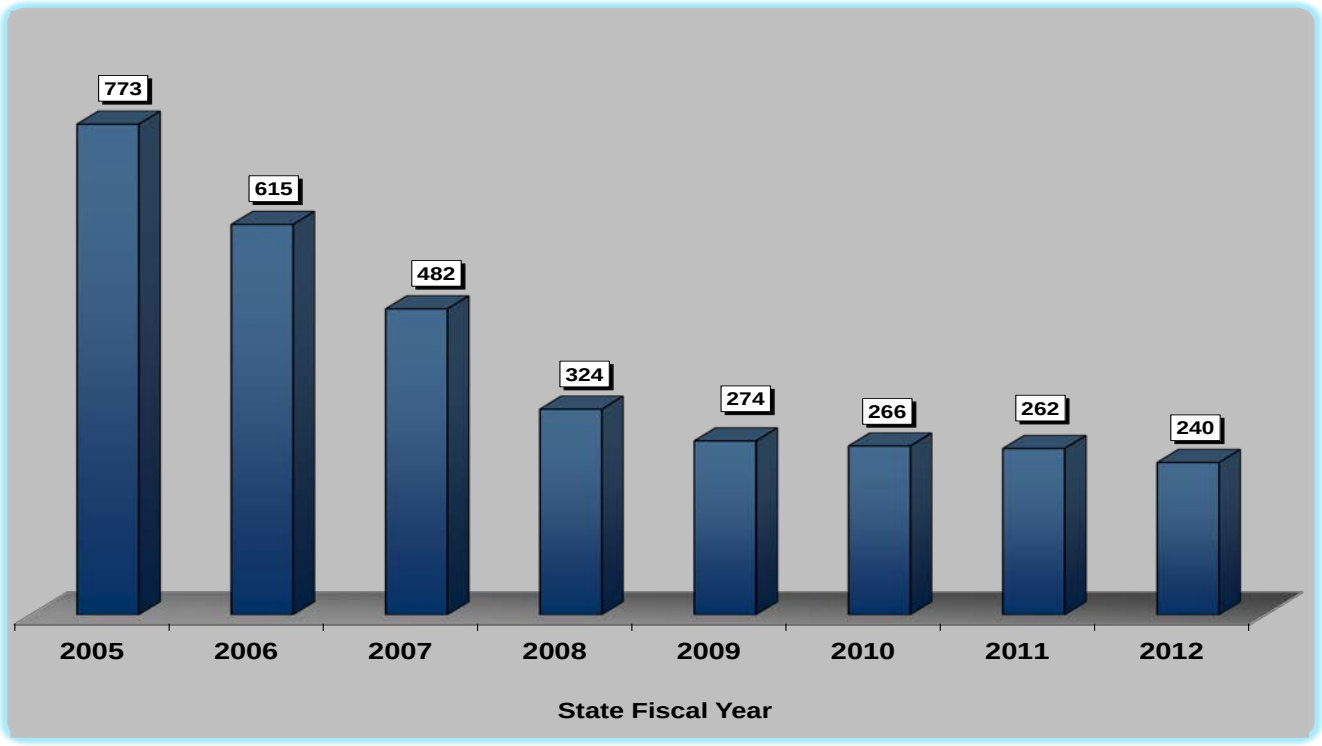


Figure 7b

Children with BLL ≥10 µg/dL by SFY

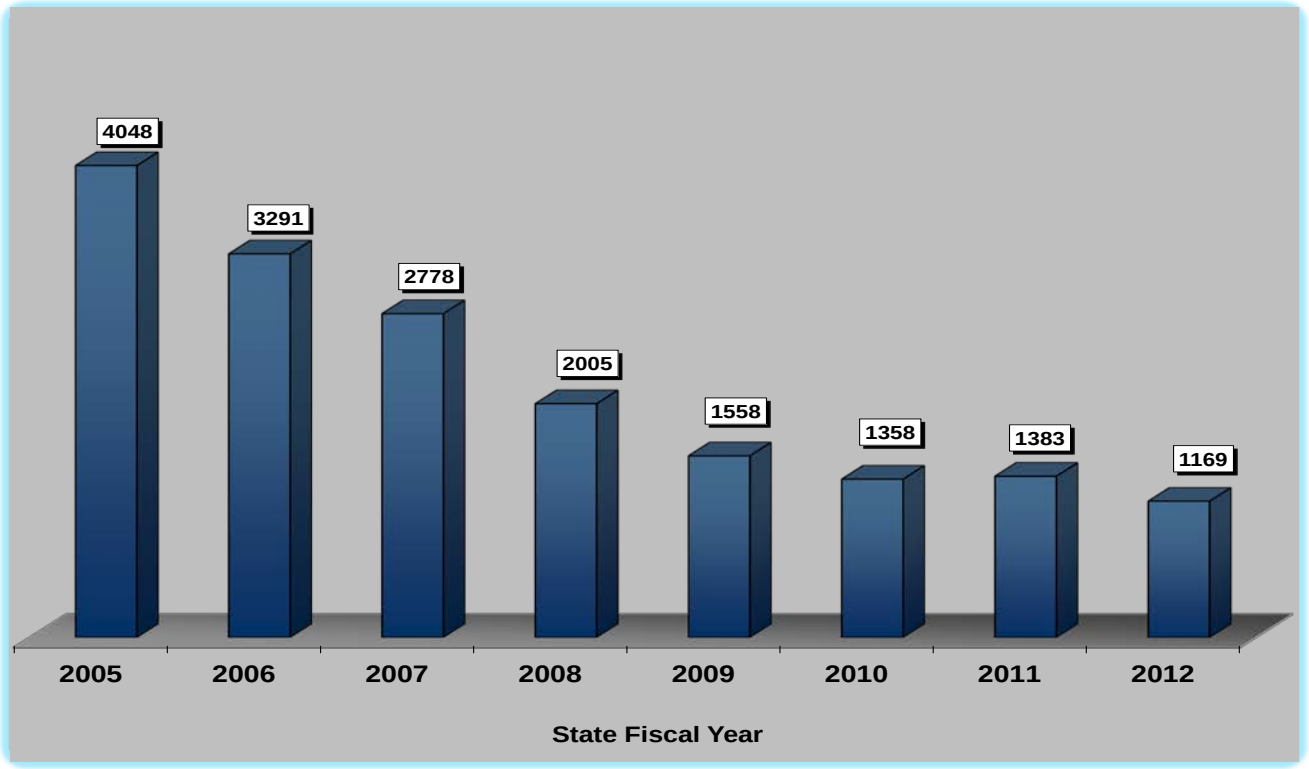
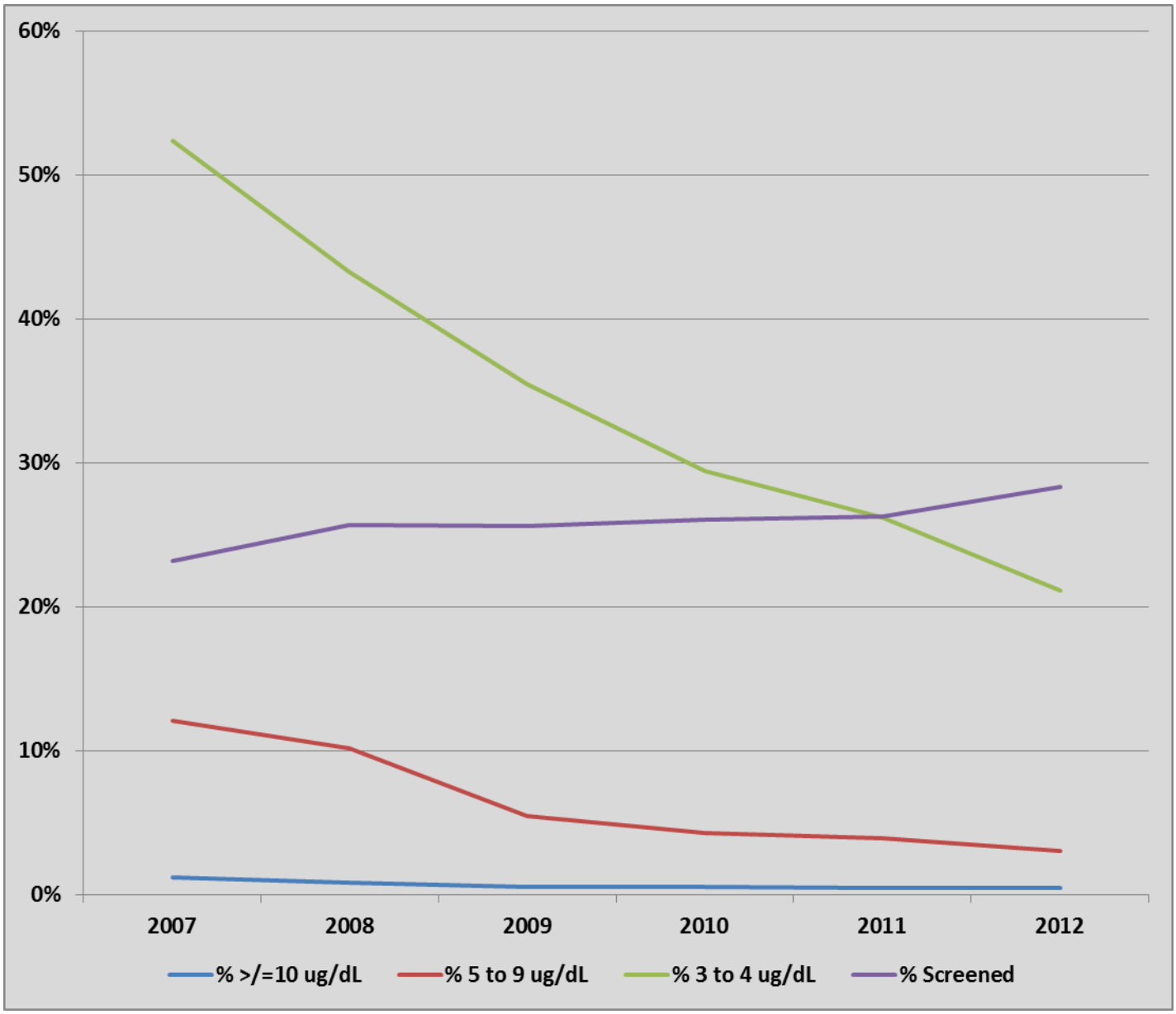


Figure 7c

Trends for Children <6 Years of Age:
Testing Rates and Percentages of Newly Reported BLL by SFY



While the testing rate is increasing, the percentage of EBLL is consistently declining. The percentage of newly reported children with BLL between 5 µg/dL and 9 µg/dL is also declining.

CHAPTER THREE

SPOTLIGHT ON THE CITY OF NEWARK

The City of Newark has the greatest burden of lead poisoned children compared to any other local board of health in the State. Newark comprised 15% of the State's children under six years of age with an EBLL during SFY 2012. Additionally, in SFY 2012, Newark comprised 20% of the total number of children under six years of age with an EBLL in all large municipalities.

Newark has worked to address the issue of childhood lead poisoning through several means. Newark has been aggressive in obtaining grants from governmental and non-governmental sources to help eliminate childhood lead poisoning. In addition, Newark established and locally administers the State's only Lead Safe Houses, which are lead-free, municipal-owned properties. The Lead Safe Houses are used to relocate residents who have a lead poisoned child when the family has no other housing alternatives. This is a great achievement that other municipalities have expressed an interest in exploring. Further, Newark provides a primary prevention, community-based presence through the Newark Partnership for Lead Safe Children. This partnership provides lead poisoning prevention education and outreach opportunities to residents.

Whether or not New Jersey achieves its goal of eliminating childhood lead poisoning depends profoundly on Newark's ability to successfully address their lead contamination issues.

Figure 8

SFY 2012: Percentage of EBLL Cases in Newark Compared to the Rest of New Jersey
(n=1,026)

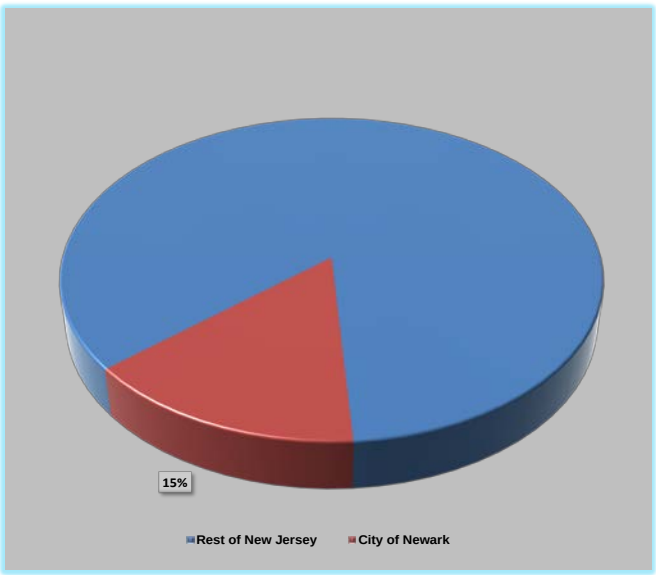
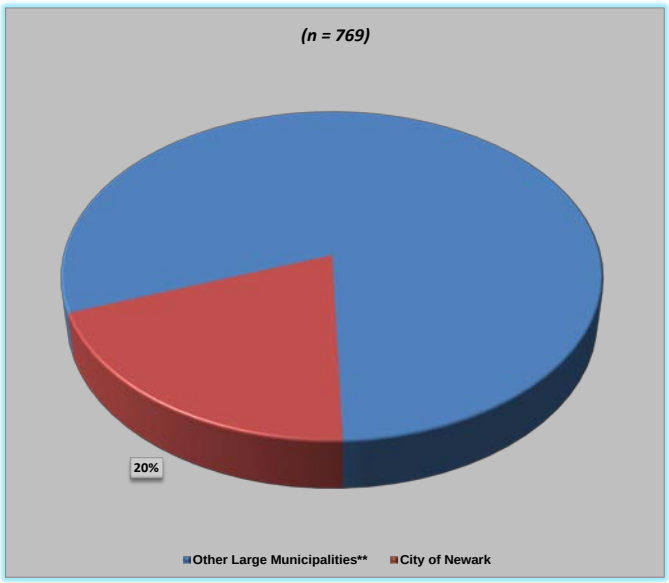


Figure 9

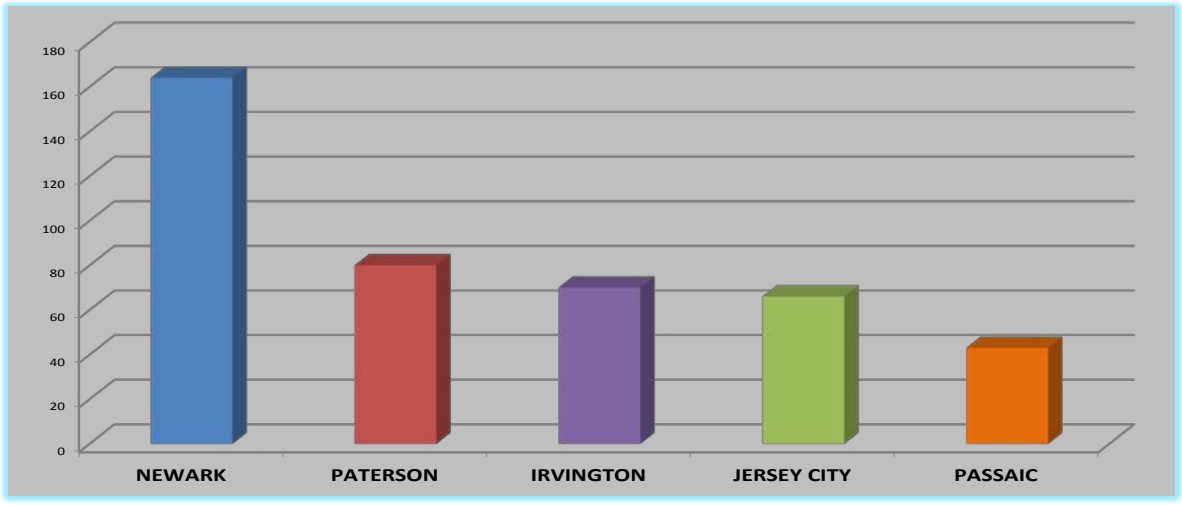
SFY 2012: Percentage of EBLL Cases in Newark Compared to Other Large Municipalities in New Jersey
(n=769)



There is a disproportionate distribution of lead poisoned children in Newark compared to the rest of the State and other large municipalities. The data is based on the total number of individual children under six years of age who have a confirmed EBLL. Of the 153 children identified in Newark during SFY 2012 only the highest blood lead test per child is counted.

Figure 10

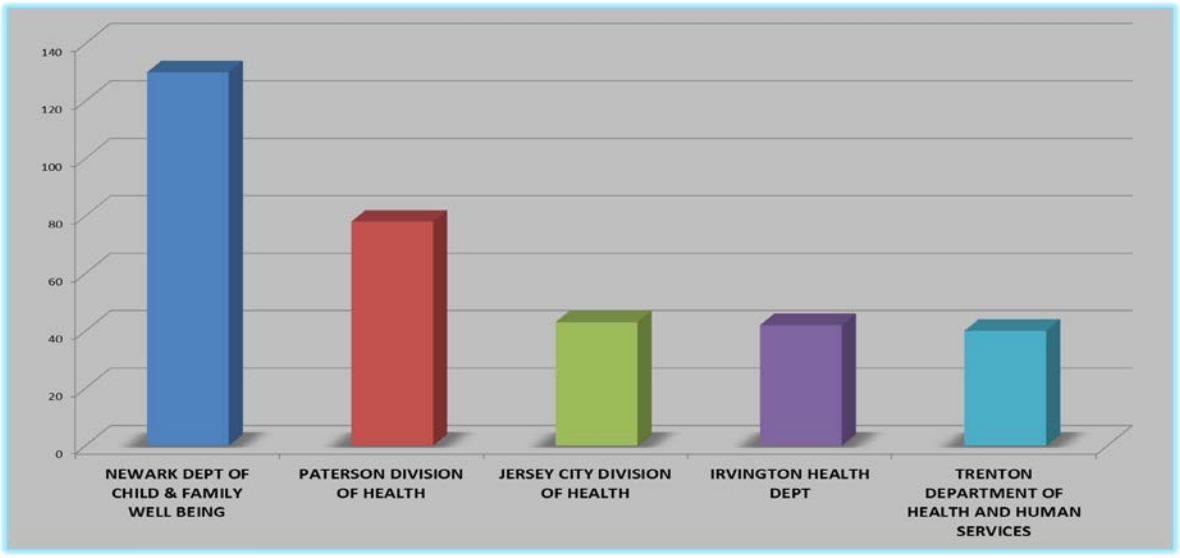
SFY 2012: Newark Exceeds Other Large Municipalities in the Number of Children Reported with EBLL



There is a disproportionate distribution of lead poisoned children in Newark compared to other municipalities in New Jersey. The data is based on the total number of children who have a confirmed EBLL test. Of the children reported with EBLL during SFY 2012, only the highest blood lead test per child is counted.

Figure 11

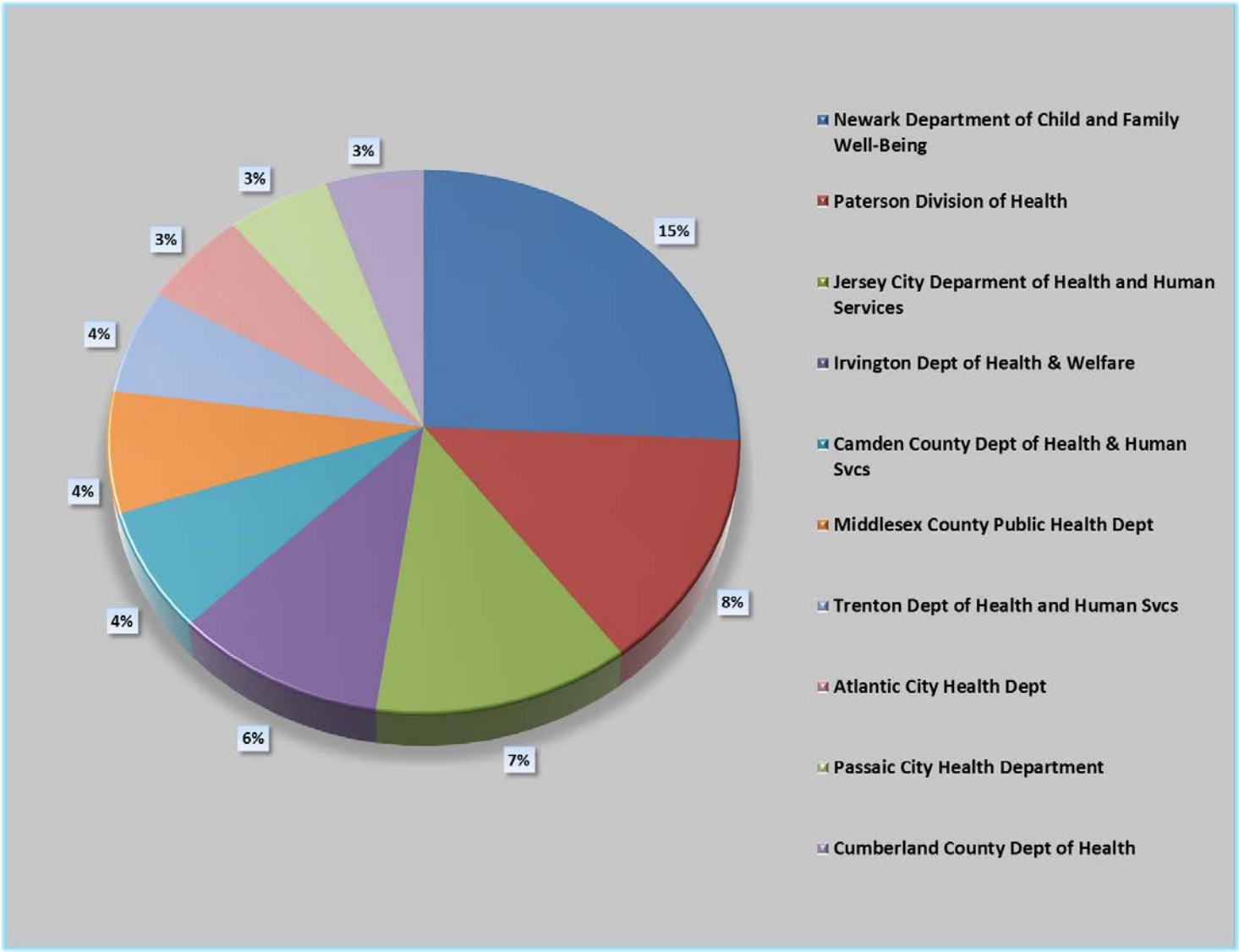
SFY 2012: Top Five Local Boards of Health with ≥20 New Environmental Cases



There is a disproportionate distribution of lead poisoned children in the Newark Department of Child and Family Well-Being catchment area compared to other Local Boards of Health in New Jersey. The data is based on the total number of new environmental cases opened during SFY 2012.

Figure 12

SFY 2012: Top Ten Local Boards of Health Comprising the Highest Percentages* of New EBLL Cases



There is a disproportionate distribution of lead poisoned children within the jurisdiction of Newark Department of Child and Family Well-Being compared to other Local Boards of Health in New Jersey. The data in Figure 12 are based on the percentage of new environmental cases opened during FY 2012.

**Percent share of all new cases of lead poisoning during FY 2012 in the entire State.*

CHAPTER FOUR

ENVIRONMENTAL INVESTIGATIONS BY LOCAL BOARDS OF HEALTH

New Jersey law (N.J.S.A. § 24:14A-6) requires local boards of health to investigate all reported cases of childhood lead poisoning within their jurisdiction and to order the abatement of all lead hazards identified in the course of the investigation. The procedures for conducting environmental investigations in response to a lead poisoned child are specified in N.J.A.C. § 8:51. The local board of health must conduct an inspection of the child's primary residence and any secondary address, such as a child care center, the home of a relative or babysitter, or wherever the child spends at least 10 hours per week. If the child moves, the property where the child resided when the blood lead test was performed must be inspected. The environmental inspection includes a determination of the presence of lead-based paint and leaded dust; the identification of locations where that paint is in a hazardous condition such as peeling, chipping, or flaking; and, as appropriate, the presence of lead on the dwelling's exterior or soil. The inspector, with the public health nurse, speaks to the child's parent/guardian and completes a questionnaire to help determine any other potential sources of exposure to lead.

In addition, the local board of health arranges for a home visit by a public health nurse to educate the parents/guardians about lead poisoning and the steps that they can take to protect their child from further exposure. The public health nurse also provides on-going case management services to assist the family, including but not limited to, receiving follow-up testing, medical treatment, and social services that may be necessary to address the effects of their child's exposure to lead.

The data listed in Tables 7, 8, and 9 in this chapter reflect the results of environmental investigations as reported to the Department by local boards of health. The data are accurate to the extent that the local boards of health make complete and timely reports to the Department through the electronic childhood lead poisoning information database. It is possible that additional inspections and/or abatements may have been completed, but not reported by local boards of health.

Table 7

SFY 2012: Environmental Activity Status by County

County Name	Cases Referred	Investigation Required	Investigation Completed	Abatement Required	Abatement Completed
ATLANTIC	28	17	17	11	8
BERGEN	40	13	11	2	2
BURLINGTON	5	3	3	0	0
CAMDEN	34	11	11	1	0
CAPE MAY	3	1	1	1	0
CUMBERLAND	42	26	25	15	8
ESSEX	252	101	78	48	12
GLOUCESTER	3	2	2	1	0
HUDSON	78	45	45	21	9
HUNTERDON	2	0	0	0	0
MERCER	47	21	20	17	6
MIDDLESEX	42	9	8	3	1
MONMOUTH	30	16	16	8	7
MORRIS	20	8	7	6	2
OCEAN	29	6	6	2	2
PASSAIC	125	60	60	49	20
SALEM	9	1	1	0	0
SOMERSET	15	3	2	1	2
SUSSEX	3	3	3	0	0
UNION	65	18	16	15	2
WARREN	2	2	2	2	0
Total	**874**	**363**	**334**	**203**	**81**

Table 7 above displays the profile of environmental activity for each county, based on the number of EBLL reports (referrals) for new environmental cases sent to the appropriate local board of health. A new environmental case is generated and referred to the appropriate local board of health when a child with an EBLL is reported who resides at an address that does not have an existing environmental case open.

Table 8

SFY 2012: Local Boards of Health with ≥20 New Environmental Cases

Local Board of Health	Cases Referred	Investigation Required	Investigation Completed	Abatement Required	Abatement Completed
NEWARK DEPT OF CHILD & FAMILY WELL-BEING	127	45	25	12	2
PATERSON DIVISION OF HEALTH	76	34	34	25	4
JERSEY CITY DIVISION OF HEALTH	43	23	22	10	3
IRVINGTON DEPT OF HEALTH	42	14	15	9	1
EAST ORANGE HEALTH DEPT	38	21	21	13	7
PASSAIC CITY HEALTH DEPT	37	22	22	21	14
CUMBERLAND COUNTY HEALTH DEPT	37	23	22	14	8
TRENTON DEPT OF HEALTH & HUMAN SVCS	37	19	19	17	6
CAMDEN COUNTY DEPT OF HEALTH	34	10	11	1	0
PLAINFIELD HEALTH DEPT	33	11	10	9	1
OCEAN COUNTY HEALTH DEPT	29	5	6	2	2
WEST ORANGE HEALTH DEPT	27	18	15	12	4
MIDDLESEX COUNTY PUBLIC HEALTH DEPT	27	4	4	3	1

See Appendix 1 for complete data on the status of all EBLL reports issued to local boards of health.
A new environmental case is generated and referred to the appropriate local board of health when a child with an EBLL is reported who resides at an address that does not have an existing environmental case open.

TABLE 9

Current Environmental Investigation Status by SFY 1997-2012

SFY	Environmental Cases Opened	Investigation Required	Investigation Completed	Investigation Completed	Investigation Pending	Abatements Completed	Abatements Pending	Abatements Completed
1997	2168	1499	1468	98%	31	767	12	98%
1998	2014	1455	1405	97%	50	725	13	98%
1999	1517	1044	952	91%	92	558	29	95%
2000	1144	815	705	87%	110	484	29	94%
2001	932	648	562	87%	86	374	12	97%
2002	867	601	546	91%	55	363	7	98%
2003	796	527	495	94%	32	288	21	93%
2004	748	526	471	90%	55	289	20	94%
2005	718	542	481	89%	61	277	24	92%
2006	688	494	408	83%	86	229	40	85%
2007	1008	728	615	84%	113	344	68	83%
2008	750	581	487	84%	94	245	120	67%
2009	583	500	427	85%	73	308	44	88%
2010	450	411	343	83%	68	230	77	75%
2011	573	530	458	86%	72	236	63	79%
2012*	874	363	334	92%	29	81	122	40%

**Based on the information entered into the Childhood Lead Poisoning Information Database as of September 30, 2012 by local boards of health.*

Table 9 illustrates how it can take several years to complete the abatement process for a property where lead hazards are identified. The length of time between the initial report of an EBLL and the completion of the abatement process can be affected by a number of factors. These factors include:

- *difficulty identifying and communicating with absentee property owners;*
- *lengthy enforcement actions and court proceedings against recalcitrant property owners;*
- *delays in contracting with and scheduling work to be performed by State-certified lead abatement contractors; and*
- *new barriers faced by property owners to obtain financial assistance to pay for the cost of the required abatement. The Lead Hazard Control Assistance (LHCA) Fund, administered by the Department of Community Affairs (DCA), has received significant reductions in funding in recent SFY, which has caused an increase in property owner applications being rejected or held as pending. Effective March 31, 2012, DCA no longer accepted applications due to the elimination of funding for SFY 2013.*

CHAPTER FIVE

ADDRESSING CHILDHOOD LEAD POISONING IN NEW JERSEY

In October 2011, the U.S. Department of Health and Human Services released ***Healthy People 2020*** that established health objectives for the Nation for the next 10 years.

Objective: Eliminate elevated BLLs in children.
Baseline: 0.9 percent of children had elevated BLLs in 2005-2008
Target: 0
Data Source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS

Objective: Reduce the mean BLLs in children.
Baseline: 1.5 µg/dL Children 1 to 5 years of age had an average BLL of 1.5 µg/dL in 2005–08
Target: 1.4 µg/dL Average BLL in children 1 to 5 years of age (10 percent improvement)
Data Source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS

The New Jersey Department of Health's goal is to reduce, and ultimately eliminate, childhood lead poisoning as a public health priority in New Jersey, which supports these national objectives.

FY 2012 Accomplishments

A. Increasing Testing Rates

Lead Screening Pilot Project: The Department embarked on a public-private partnership to screen children for lead poisoning through a reinvesting of resources by exchanging approximately $100,000 in obsolete lead screening equipment for new, state of the art equipment for a two (2) year pilot project. In March 2012, the Department conducted a training session for nine (9) local boards of health who were selected to participate in a lead screening pilot project. The pilot project will utilize the LeadCare II analyzer, a point of care device that delivers a BLL result, by capillary blood draw, in three (3) minutes. This point of care device will allow users to educate families about specific BLL and immediately care for and track children that present with an EBLL. The pilot project participants received their clinical laboratory licenses in mid-May 2012, and began screening in their community. The pilot study will run through December 2013 and it is anticipated that over 2,000 children will be screened for lead poisoning. The participating local boards of health are the counties of Camden, Cumberland, Monmouth, Middlesex, Salem, and the cities of Hackensack, Jersey City, Morristown, and Passaic.

Data Sharing and Matching: On an ongoing basis, the Department matched its Childhood Lead Poisoning Information Database records with children's records supplied by the Department of Human Services, Division of Medical Assistance and Health Services (Medicaid). This quarterly match activity helped Medicaid staff identify testing rates of Medicaid enrolled children, obtain their BLL, and identify untested Medicaid enrolled children. Medicaid utilized the match results to increase testing rates of Medicaid enrolled children.

New Jersey Immunization Information System (NJIIS): The Department continued to upload blood lead test results, on a weekly basis, into NJIIS, which is the State's electronic immunization

registry. The registry provided physicians in New Jersey with the ability to track the blood lead test results of their patients.

Master Client Index (MCI): This project is spearheaded by the Department of Human Services (DHS), Division of Medical Assistance and Health Services (Medicaid), under a federal transformation grant. The MCI links data from the Childhood Lead Poisoning Information Database, NJIIS, and Medicaid using hardware set-up by the Department's Office of Information Technology (OIT). Department staff participated in the various rounds of technical discussions with all the agencies involved in this project. The project is anticipated to be completed in SFY 2013.

Refugee Health Program (RHP): The RHP was created in response to the passage of the United States Federal Refugee Act of 1980. The goal of the RHP is to ensure refugees received a preventative health assessment within 90 days of entry into the State. Refugee children, age 16 years and under, historically numbered fewer than 100 per year and has not significantly changed from SFY to SFY. The majority arrived from Cuba and Jordan with the remainder from Kenya, Pakistan, Burma, Egypt, Ghana, Malaysia and Nepal. The Department collaborated with Voluntary Refugee Resettlement Sponsoring Agencies in referring and assisting new arrivals to access medical providers in obtaining a health examination, including an initial blood lead test. The Department provided assistance to the local boards of health to comply with CDC recommendations that refugee children obtain a second blood lead test within three to six months after the refugees' resettlement.

B. Surveillance

Electronic Laboratory Reporting: The Department witnessed an increase of traditional laboratories and point-of-care test users who electronically reported blood lead test results. Currently, 98.4% of BLL are reported electronically while the remainder are reported via facsimile or regular mail. This is an increase from 92% in SFY 2004.

Childhood Lead Poisoning Information Database: The database was enhanced with additional tools in addition to improved layout and functionality for environmental intervention data entry. Since being deployed in July 2006, the database has been in a Continuous Quality Improvement mode, being further customized for betterment of features, utility, and ease of use by Department staff and local boards of health users.

Environmental Public Health Tracking Network (Network): The Network is a collaboration between the Department's Division of Family Health Services and Division of Consumer and Environmental Health Services. Its web portal was launched in December 2008 (http://nj.gov/health/epht/index.shtml). The Network collected data on health, human exposures, and environmental hazards as a means to understand patterns and trends in diseases. The Department's statistical data on childhood lead poisoning is contributed to this portal.

Data-sharing Agreements: The Department continues to share environmental activity data through a Memorandum of Agreement (MOA) with the Department of Community Affairs (DCA). The DCA matches the address data to help populate the Lead Safe Housing Registry. The registry is available online (http://www.njleadsafe.info) and is publically accessible.

C. Follow-up of Children with EBLL

Cultural Competency: In May 2012, the Department through the JFK Medical Center – Muhlenberg Campus, hosted a training session to assist Local Boards of Health with providing culturally competent care and treatment to lead poisoned children and their families.

D. Public and Professional Education

Newark Partnership for Lead-Safe Children: The City of Newark, due to its receipt of HUD funding for healthy homes and lead hazard reduction, in addition to support by the Kresge Foundation, enabled the Newark Partnership for Lead Safe Children to strengthen interagency collaboration. The collaborations included members and their agencies identifying properties for the city to remediate for lead-based paint hazards and other housing-based health issues.

Regional Childhood Lead Poisoning Prevention Coalitions: Three coalitions (Northern, Central, and Southern) have been in existence since SFY 2003 and continued to provide statewide direct outreach and education. Funding from the Department provided support to increase community capacity building efforts so that communities can address lead issues on a local level.

Healthy Homes: The Department was awarded $594,000 through a Cooperative Agreement with CDC's Healthy Homes and Lead Poisoning Prevention Branch. Due to Congressional budget cuts, the Department was notified in March 2012 that the Cooperative Agreement was not being renewed after Year 1 (September 1, 2011-August 31, 2012). Several initiatives that were established in SFY 2012 are anticipated to continue in SFY 2013 with support from other Federal funding sources. In October 2011, the New Jersey Healthy Homes Training Center was established in partnership with Isles, Inc. During its first year of operation, over 200 health and social services home visitors and housing inspectors attended the Essentials for Healthy Homes Practitioners course. The 2-day course covered the seven principles of a Healthy Home and taught participants how to look for cues of housing-related hazards that may contribute to injury and disease in the housings' occupants. The Department's primary partners in SFY were local boards of health staff who performed nurse case management and environmental inspections for children who are lead poisoned and the New Jersey Department of Children and Families (DCF). With financial support through the Affordable Care Act's Maternal, Infant, and Early Childhood Home Visitation (MIECHV) grants, inter-Departmental collaboration was underway to integrate initiatives that provided Healthy Homes training, data collection, and referral resources for home visitors who worked with children, and their families, who are at risk for child abuse and were likely living in areas that placed them at risk for lead poisoning as well as other health hazards related to housing conditions. All Department collaborations continued to focus on cost-effective, staff efficient, and sustainable initiatives.

APPENDIX 1

Environmental Activity Status* by Local Board of Health Jurisdiction SFY 2012

*** those local boards of health that had at least one environmental case opened during SFY 2012**

Local Board of Health	Cases Referred	Investigation Required	Investigation Completed	Abatement Required	Abatement Completed
ATLANTIC CITY HEALTH DEPT	15	11	11	8	6
ATLANTIC CO HEALTH DEPT	13	6	6	3	2
BAYONNE DEPT OF HEALTH	15	13	13	7	4
BERGEN CO DEPT OF HEALTH SVCS	13	5	3	0	1
BLOOMFIELD DEPT OF HEALTH	7	0	0	0	0
BURLINGTON CO HEALTH DEPT	5	3	3	0	0
CAMDEN CO DEPT OF HEALTH	34	11	11	1	0
CAPE MAY CO HEALTH DEPT	3	1	1	1	0
CLARK HEALTH DEPT	1	1	0	0	0
CLIFTON HEALTH DEPT	9	4	4	3	2
CLOSTER HEALTH DEPT	1	1	1	0	0
CUMBERLAND CO HEALTH DEPT	37	23	22	14	8
DOVER HEALTH DEPT	1	1	1	1	0
EAST ORANGE HEALTH DEPT	38	21	21	13	7
EDISON DEPT OF HEALTH and HUMAN RESOURCES	9	4	3	0	0
ELIZABETH DEPT OF HEALTH and HUMAN SVCS	12	4	4	4	1
ELMWOOD PARK DEPT OF HEALTH	1	0	0	0	1
ENGLEWOOD HEALTH DEPT	1	0	0	0	0
EWING TWP HEALTH DEPT	3	0	0	0	0
FRANKLIN TWP HEALTH DEPT	2	0	0	0	0
FREEHOLD AREA HEALTH DEPT	6	3	3	1	1
GLOUCESTER CO DEPT OF HEALTH	3	2	2	1	0
HACKENSACK HEALTH DEPT	6	2	2	0	0
HAMILTON TWP DIV OF HEALTH	4	1	1	0	0
HARRISON BOARD OF HEALTH	3	0	0	0	0
HAZLET-ABERDEEN HEALTH DEPT	1	1	1	0	0
HILLSBOROUGH TWP HEALTH DEPT	1	0	0	0	0
HOPEWELL TWP HEALTH DEPT	1	0	0	0	0
HUNTERDON CO DEPT OF HEALTH	2	0	0	0	0
IRVINGTON DEPT OF HEALTH and WELFARE	42	15	15	9	1
JERSEY CITY DIV OF HEALTH	43	23	22	10	3
KEARNY DEPT OF HEALTH	4	3	3	2	1
LINDEN BOARD OF HEALTH	7	0	0	0	0
LONG BRANCH DEPT OF HEALTH	3	2	2	1	0
MADISON BORO BOARD OF HEALTH	1	0	0	0	0

Local Board of Health	Cases Referred	Investigation Required	Investigation Completed	Abatement Required	Abatement Completed
MID-BERGEN REGIONAL HEALTH COMMISSION		4	4	1	0
MIDDLE-BROOK REGIONAL HEALTH COMMISSION	1	0	0	0	0
MIDDLESEX CO PUBLIC HEALTH DEPT	27	4	4	3	1
MONMOUTH CO HEALTH DEPT	10	6	6	3	3
MONMOUTH CO REGIONAL HEALTH COMMISSION	10	4	4	3	3
MONTCLAIR HEALTH DEPT	10	2	1	1	0
MONTVILLE TWP HEALTH DEPT	1	1	1	1	0
MORRISTOWN DIV OF HEALTH	7	5	4	4	2
MT. OLIVE TWP HEALTH DEPT	1	0	0	0	0
N.W. BERGEN REGIONAL HEALTH COMMISSION	3	0	0	0	0
NEWARK DEPT OF CHILD AND FAMILY WELL-BEING	127	45	25	12	0
NORTH BERGEN HEALTH DEPT	11	5	5	2	1
OCEAN COUNTY HEALTH DEPT	29	5	6	2	2
PARSIPPANY HEALTH DEPT	3	1	1	0	0
PASSAIC CITY HEALTH DEPT	37	22	22	21	14
PATERSON DIV OF HEALTH	76	34	34	25	4
PEQUANNOCK TWP BOARD OF HEALTH	1	0	0	0	0
PISCATAWAY TWP HEALTH DEPT	4	1	1	0	0
PLAINFIELD HEALTH DEPT	33	11	10	9	0
PRINCETON REGIONAL HEALTH COMMISSION	2	1	0	0	0
RAHWAY HEALTH DEPT	4	1	1	1	0
ROCKAWAY TWP HEALTH DEPT	2	0	0	0	0
ROSELLE HEALTH DEPT	4	0	0	0	0
ROXBURY TWP BOARD OF HEALTH	2	0	0	0	0
SALEM CO DEPT OF HEALTH	9	1	1	0	0
SOMERSET CO HEALTH DEPT	10	2	2	1	1
SOMERVILLE HEALTH DEPT	1	1	0	0	0
SOUTH BRUNSWICK HEALTH DEPT	1	0	0	0	0
SOUTH ORANGE HEALTH DEPT	1	1	1	1	0
SUSSEX CO DEPT HEALTH, PUBLIC SAFETY AND SENIOR SVCS	3	2	3	0	0
TEANECK DEPT OF HEALTH AND HUMAN SVCS	2	0	0	0	0
TWP OF UNION DEPT OF HEALTH	1	0	0	0	0
TWP OF WASHINGTON LOCAL HEALTH AGENCY	2	1	1	1	0
TRENTON DEPT OF HEALTH and HUMAN SVCS	37	19	19	17	6
VINELAND DEPT OF HEALTH	5	3	3	1	0
WEST NEW YORK HEALTH DEPT	2	2	2	0	0
WEST ORANGE HEALTH DEPT	27	18	15	12	4
WESTFIELD REGIONAL HEALTH DEPT	3	1	1	1	1
WESTWOOD HEALTH DEPT	2	0	0	0	0
WOODBRIDGE TWP DEPT OF HEALTH & HUMAN SVCS	1	0	0	0	0

APPENDIX 2

Centers for Disease Control and Prevention's (CDC) Response to Recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP)

Source: www.cdc.gov/nceh/lead/ACCLPP/CDC_Response_Lead_Exposure_Recs.pdf

On January 4, 2012, the Advisory Committee on Childhood Lead Poisoning Prevention met and a majority vote approved the recommendations made in the report "Low Level Lead Exposure Harms Children: A Renewed Call of Primary Prevention". On June 7, 2012, CDC concurred, or concurred in principle, with all of the recommendations in the report. The Centers for Disease Control and Prevention (CDC) in the past year experienced a 93% reduction in funding ($29 million down to $2 million). This reduced amount is expected to be included in a continuing resolution through March 2013. As a result, states, including New Jersey, that were awarded funding saw their funding terminated as of August 31, 2012. This reduces the CDC's, as well as their grantees', ability to implement many of the recommendations. New Jersey has historically received funding for its variety of programs and services from a variety of State and federal sources.

- Eliminate the use of the term "level of concern" based on the compelling evidence that low blood lead levels (BLL) are associated with IQ deficits, attention-related behaviors, and poor academic achievement.

- Emphasize the prevention, control, and elimination of lead exposures rather than responding after the exposure has taken place. This is commonly referred to as "primary prevention".

- Develop and help implement a nationwide primary prevention policy to ensure that no children in the U.S. live or spend significant time in homes, buildings or other environments with lead exposure hazards.

- Examine the possibilities of working with the U.S. Department of Housing and Urban Development (HUD), the Health Resources and Services Administration (HRSA), Environmental Protection Agency (EPA), state and local governments, and philanthropic organizations to identify opportunities for collaboration on primary prevention in the future.

- According to CDC, HUD's Lead-Based Paint Hazard Control Program provides approximately $100 million annually and is the most easily identifiable and largest source of federal funding for lead hazard remediation.

- Collaborate with local, state, and federal agencies to shift priorities to primary prevention and provide guidance to respond to BLL <10 ug/dL.

- Incorporate the use of the term "reference value" which is based on the 97.5th percentile of the BLL distribution among children 1-5 years old in the U.S. using data generated by the National Health and Nutrition Examination Survey (NHANES). Approximately 450,000 children in the U.S. have BLLs higher than this reference value (currently 5 ug/dL). The reference value will be updated every 4 years.

- Conduct additional research to develop and evaluate interventions that effectively maintain BLLs below the reference value in children. Other research priorities to be included: efforts to better use data from testing programs; development of next-generation, point-of-care lead analyzers; and improvement of the understanding of epigenetic mechanisms of lead action.

- Ensure that clinicians are reliable sources of information on lead hazards and take the primary role in educating families about preventing lead exposures. Clinical care would include prescribing environmental assessments

for high-risk children before the child is lead poisoned. Monitoring of health status would continue until environmental investigations and remediation strategies are complete.

- Encourage local, state, and other federal agencies to: facilitate data-sharing between health and housing agencies; develop and enforce preventive lead-safe housing standards for rental and owner-occupied housing; identify financing for remediation; and provide families with information to protect their children from hazards in the home.

- Assist elected officials and the leaders of health, housing, and code enforcement agencies in adopting a suite of preventive policies and evidence-based strategies. This includes prevention strategies to reduce environmental lead exposures in soil, dust, paint, and water.

The Child and Adolescent Health Program concurs with the recommendations of the ACCLPP and will continue its focus on preventing children's exposures to sources of lead. The most important step that can be taken is to prevent lead poisoning before it occurs (primary prevention) since lead poisoning's effects are permanent. Current guidelines, available at the Department's website (http://www.state.nj.us/health/fhs/newborn/lead.shtml), remain the same regarding the prevention of childhood lead poisoning, testing of children's blood for lead, and local boards of health's responsibilities for case management and environmental investigation of children's blood lead levels $\geq$ 10 µg/dL.