February 3, 2017

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

RE: PRN 2016-199

Dear Ms. Lindo,

The Housing and Community Development Network of NJ (the Network) is pleased to have the opportunity to present comments on proposed amendments to N.J.A.C. 8:51 as well as new proposed rules N.J.A.C. 8:51 Appendices L and M.

The Network is the statewide association of more than 250 housing and community development corporations, individuals and other organizations that support the creation of housing and economic opportunities in communities like the eleven where children have a higher percentage of elevated lead levels than Flint did in 2015 – Atlantic City, East Orange, Elizabeth, Irvington, Jersey City, New Brunswick, Newark, Passaic, Paterson, Plainfield and Trenton.

Since 1989, the Housing and Community Development Network of New Jersey has convened key stakeholders to identify challenges, shape solutions and promote opportunities for collaboration among our 250 community development corporations, private sector partners and leaders across the state. Our policy agenda includes raising awareness for and obtaining resources to address the health needs of communities and constituencies around the state. As community advocates and developers of homes for lower income residents, our members have fought to end New Jersey's childhood lead poisoning epidemic.

Lead exposure in children causes lifelong health, educational and developmental impacts, in particular for children exposed at a very young age. There is *no* safe level of Lead in the blood.

On May 2, 2016 Gov. Christie embraced a 2012 recommendation by the CDC that said family notification, follow-up screening and other case management services are warranted if a child's blood test reveals at least 5 micrograms per deciliter of lead in the blood.

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

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

The Network echoes the Advocates for Children of New Jersey (ACNJ) recommendation revising the regulations in the definitions section (N.J.A.C. 8:51-1.4) and elsewhere in the regulations where reference is made to a five micrograms per deciliter level with clear language that the "elevated blood lead level" for young children will be "five micrograms per deciliter or other such amount as may be identified in the most recent recommendations from the federal Centers for Disease Control and Prevention, and that necessitates the undertaking of responsive action." The Network also agrees with the ACNJ recommendation to add: an additional subchapter stating that NJDOH will revisit the regulations to comply with CDC guidelines on an annual basis.

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

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

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

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

The Network agrees with ACNJ's recommendations clarifying the circumstances under which the number and percentage of children who have received mandated blood lead tests, the number of children with elevated blood lead levels, the number of abatements or inspections within a school district or school catchment area, or other relevant data can be shared with state and local education agencies. Additionally ACNJ recommends that in cases when a child is under three

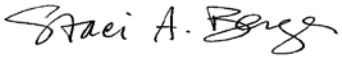
years of age, case management as defined by N.J.A.C. 8:51-2.4 should include information and referral when appropriate to New Jersey Early Intervention Services.

Conclusion

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

Thank you for the opportunity to add comments. If I can provide any further information, please contact me via email at sberger@hcdnnj.org, or our Senior Policy Coordinator, Arnold Cohen, at acohen@hcdnnj.org.

Sincerely,



Staci Berger
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