Rebuilding the Public Health Infrastructure to Improve Childhood Lead Poisoning Prevention

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Written Testimony submitted by

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to the Joint Senate Committees on Health and Housing,
Construction and Community Development

Senator Rivera, Senator Kavanaugh and honorable members of the Senate Standing Committees on Health and Housing, Construction and Community Development, thank you on behalf of the 58 local health departments in New York State for the opportunity to share the local health department and county government perspectives regarding reducing the burden of lead poisoning in children.

Unlike emerging public health threats like COVID-19, there is a wealth of evidence about the impacts of lead poisoning and evidence-based models of the activities and policies that can prevent, or reduce, its occurrence. There is no safe level of exposure to lead. The New York State Legislature acted on this knowledge in 2019 to bring the actionable blood lead level to 5 µg/dL, in line with the existing CDC recommendations. In 2021, the CDC further lowered the recommendation to 3.5 µg/dL, raising the need for consider further policy changes in this area.

NYSACHO equally recognizes that the best approach to reducing the incidence of childhood lead poisoning is through primary prevention – that is, to remediate and mitigate lead hazards before exposure can occur. New York's lead poisoning problem is a housing problem, with a staggering 80% of New York's housing stock built prior to 1978, making it more likely to contain lead paint hazards. Again, New York State recognized the need to move our public health efforts downstream to address this key social determinant of health and primary source of lead poisoning in New York State by funding primary prevention initiatives in 15 counties with the highest incidence of lead poisoning. There are successful models resulting from that funding, most notably in Monroe County, where a partnership with codes enforcement has led to significant decline in the incidence of lead poisoning. Yet despite these efforts, only a handful of local health departments receive primary prevention funding, leaving public health resources focused on secondary interventions, after a child has been exposed to lead.

Unfortunately, NYSACHO must temper our public health ideals considering the resource realities facing New York State's local health departments. Flint, Michigan serves as a cautionary tale of the harm that can occur when fiscal austerity and public health needs collide. NYSACHO's support for all policy changes related to reducing the incidence of lead poisoning must be predicated on our state leaders' willingness to provide the sustainable and flexible fiscal resources needed to implement these policies.

Public Health policy requires public health resources. Because public health services are a shared state/local expense, state level public health policy changes that require a fiscal investment must also consider local governments' ability to support the policy change, and, given the state property tax cap, the proportionality of where the costs for the policy change mainly falls – on state revenues, or on local

taxpayers. A thorough assessment of the full fiscal implications of any new policy is crucial if the state wishes to deliver on their public health promises and to also be good stewards of taxpayer dollars.

As the on-the-ground public health responders for both day to day and emergent public health threats, before any new public health policies move forward, before we can talk about lead poisoning prevention, we must have a frank dialogue regarding our public health infrastructure.

Our eroding public health infrastructure

The public health system in New York State is in crisis. Numerous elements have conspired to weaken our public health response infrastructure to a point of unprecedented fragility: ten consecutive years of disinvestment by the state; a malignant and ongoing loss of public health workers; a demoralized public health system diminished by inadequately supported workload demands; the ongoing response to the covid pandemic; and the specter of an anticipated wave of public health staff retirements that will further diminish our public health response and prevention capabilities.

We are at what is perhaps the most meaningful public health inflection point in our lifetime, where only sound policy and resource decisions will steer us back to a path that will ensure our public health system is prepared for even greater challenges that we know will come.

In short, your leadership and support has never been needed more to protect the lives and health of the people of New York.

Within this confluence of factors, however, we see opportunity. The public better understands the real and deadly impact of public health threats, and the immeasurable value of a fully prepared public health system; our governor understands and honors the value of local partners, and the value of partnership and collaboration with the Legislature; and historic levels of state resources are available as we enter the coming budget season.

For the first time in decades, we fully comprehend the value and the needs of our public health system, and at the same time possess the financial means and public support to effectively address these needs.

These factors align to beg a simple question: If not now, then when? The answer is clear. It must be now.

Background and Trends in New York's Public Health Workforce

New York State's local public health workforce is responsible for promoting and protecting the health of New York's communities. Working for one of New York State's 58 local health departments, the local public health workforce - made up of public health nurses, disease control investigators, sanitarians, community health workers and other professionals – is responsible for preventing disease, protecting the health of New Yorkers, and keeping our communities safe.

Most of the staff in the state's local health departments (LHDs) work to deliver one or more of six core public health services: community health assessment, communicable disease control, chronic disease prevention, maternal and child health services, emergency preparedness services and in 31 of the 58 local health departments, environmental health services. These six core responsibilities are set forth in statute and are known as Article 6 services as they are reimbursed by the state through the statutory mechanisms authorized in Article 6 of the public health law. The six core, or basic, services provide the minimum foundational public health responsibilities delivered by local health departments; however, additional statutory and programmatic mandates fall under these six broad service areas. Lead poisoning prevention involves core public health services in maternal child health, environmental health and community health assessment, and when unchecked, can address other programs, such as Early Intervention services and PreK services of children with special health care needs.

Unfortunately, over the past several years in New York State, the number of LHD staff delivering Article 6 core services has declined. According to data from the New York State Department of Health, the number of FTEs working on Article 6 services declined by 7% between 2015 and 2020. During this same period, the population of the state increased by 3%. This reduction in staff has made it harder for the state's local health departments to address the public health challenges facing their communities, including responding to the COVID-19 pandemic. While the largest reduction in staff was experienced by the New York City Department of Health and Mental Hygiene, other LHDs also experienced a decline.

In fact, most of New York's LHDs do not have sufficient staff needed to provide a basic package of public health services. According to the Public Health Center for Innovations and the de Beaumont Foundation, local health departments nationally need approximately 54,000 new staff to be able to provide adequate infrastructure and a minimum package of public health services.[1] When applying this formula for how many local public health workers each community needs to New York's LHDs, an estimate

showed that 90% of LHDs do not have enough staff to adequately provide basic foundational public health services to their communities. In total, over 1,000 additional Full-Time staff are needed to be able to provide an adequate infrastructure and a minimum package of public health services.

Public Health Burnout and the Experiences of Public Health Workers

According to a survey led by SUNY Oneonta, Bassett Healthcare Network Research Institute and the New York State Association of County Health Officials, *Pain and Perseverance*, public health workers have been subject to targets of protests and have experienced overwhelming burnout while responding to the pandemic. Of the two-hundred and nine public health workers who completed the survey, data indicates:

- 90.4% of respondents have felt overwhelmed by workload.
- 75.6% felt disconnected from family and friends because of workload
- 65% felt unappreciated at work and 75% felt inadequately compensated.
- Over half of respondents reported experiencing stigma or discrimination during the crisis.
- 35% received job-related threats because of work by members of the public.
- 55% felt bullied or harassed because of work by the members of the public.
- 30% have received any sort of hate mail/email/messages from the public.

To protect and retain the dedicated workers employed by local health departments, investments need to be made to article 6 state aid funding to ensure that these public health entities are appropriately staffed and thus able to allow employees to manage work-life balance and avoid burnout. Making such investments will protect and ensure longevity in the state's public health workforce.

New York's Looming Retirement Crisis

Based on a survey conducted by NYSACHO, the state is approaching the loss of decades upon decades of public health expertise through local retirements. It is only a matter of time before a large segment of the public health workforce begins to retire and we need to be realistically prepared to rebuild the public health system when we are confronted with another public health crisis. Retirement survey findings indicate:

- 42 LHD respondents reported a total of 1257 LHD employees statewide were eligible to retire in 2020.

    - Of these, 743 were in NYC and 514 in rest of state. This represents a total of *22% of the LHD workforce statewide who were eligible for retirement in 2020*, with 25% of the NYC LHD workforce eligible to retire, and 19% of the total LHD workforce outside of NYC eligible to retire.

- Out of 45 LHDs responding, 23 indicated that they had employees who intended to retire in 2021, for a total of 69 employees statewide.
- Out of 43 LHDs respondents, 33 indicated that they had employees who had, or intended to retire by the end of 2020, for a total of 236 employees statewide.
- Since the start of the COVID-19 pandemic, New York has seen 9 out of 58 local health officials (leadership positions within health department) retire and 5 county health officials leave for other/unidentified reasons.

Solutions: Investing in New York's Public Health Infrastructure

Public health work, particularly response to emergencies like the COVID-19 pandemic, requires trained, highly educated workforce. New York State sets minimum qualifications for 13 public health titles; all but one of these requires a minimum of a bachelor's degree and several require advanced degrees. Given other employment opportunities and the typically lower salary rates of public vs. private sector jobs, fringe benefits are critical for recruitment and retention of a qualified, experienced workforce. Provision of the core public health services required by New York State under Article Six requires that LHDs maintain this educated and highly trained workforce.

Emergency funding for public health threats does not sustain workforce investment. LHDs cannot retain and utilize experienced staff hired for emergency response when funding is time limited. Skills needed and core services provided during COVID-19 and other public health emergencies are those that are used every day for core public health services.

The current fringe ineligibility set forth under Article 6 does not work efficiently in a post clinical care public health model. When Article Six was initially enacted, clinical care revenues reduced, or often fully covered fringe expenses; at that time, localities were the safety net providers of primary and clinical home care services in a fee-for-service payment model, to provide basic care for un- and

under-insured populations. New payment models and expansion of the availability of health care meant that LHDs were largely no longer needed as safety net providers. Rather than reinvesting public health dollars from clinical care to population health services, public health funding was simply reduced. Concurrently, while the state disinvested in existing population health services and expertise provided by local health departments, it directed funding towards pushing clinical care providers towards population health services; rather than coordinating the two, too often, clinical care simply duplicated public health services. COVID-19 showed why clinical care and public health have unique and complementary roles to play, with clinical care focused on individual health and public health focused on population health.

NYSACHO s 2022-2023 Article 6 State Budget Request

1. Increase Article 6 base grant to $750,000 or $1.30 per capita in full-service counties.
2. Increase Article 6 base grant to $577,500 in partial service counties.
3. Restore NYC to 36% reimbursement beyond the base grant under Article 6 state aid.
4. Permit *fringe benefits* as an eligible expense under article 6 state aid and reimburse fringe at 36% in all counties.

Infrastructure Gaps for Existing Lead Poisoning Prevention Mandates

We raise our public health infrastructure funding request at a hearing on lead poisoning prevention because in addition to this being on ongoing need, the 2019 lowering of the actionable blood lead level represents a prime example of New York State's failure to fund a public policy sufficient to address the staffing and resources needed to achieve the protections it promises.

$30.3 million is the minimum cost of the 2019 lowering of the EBLL, which remains unfunded by New York State. This figure represents the floor of potential costs, calculated using the state average costs for lead-related nursing visits and case coordination, and environmental assessment, inspection and follow-up costs multiplied by the number of children with BLLs between 5-9 in 2017. It does not include additional equipment, such as XRF machines, nor other staffing costs related to data entry and other support services. It also does not include unreimbursed local costs related to fringe benefits, nor does it reflect the potential for longer monitoring times needed to assure that a child's EBLL gets to below the current actionable level. And finally, it does not address the potential increase in compliance with

testing requirements as the new mandate is rolled out, which may increase the anticipated numbers of children with elevated levels.

LHD Roles and Responsibilities in Lead Poisoning Prevention[2]

Children are screened by their health care provider for elevated blood lead levels (bll) at ages one and two. Under current statute, a public health response is initiated when a child has an elevated BLL of 5 or higher, which includes both nursing and environmental interventions.

For bll of 5 or higher, LHD Lead Program staff work with the child's health care provider to follow-up as appropriate. This may include:

Confirmatory and follow-up blood lead testing;

- Risk reduction education;
- Nutritional counseling;
- Diagnostic evaluation which includes a detailed lead exposure assessment, a
- nutritional assessment including iron status, and developmental screening;
- Medical treatment, if necessary;
- Environmental management ; and
- Case management.

In most cases, it will be the health care provider who does the medical follow-up on risk reduction, nutrition, etc., though in some cases, for example, for a child who is un- or under-insured, the LHD might provide these services. The LHD must ensure that the follow-up is provided.

A bll of 5 or greater also triggers the environmental investigation/management work. This LHD or state District Office Environmental Health staff (partial service counties) investigates/identifies possible sources of exposure. This includes looking at interior and exterior paint, water sources, dust, soil, hobbies, home medicines, cosmetics, pottery, occupation. Examples might be

- Exposure due to peeling paint or lead-based paint dust during a home renovation
- Exposure to lead in soil in a yard where a child plays
- Lead in drinking water due to corrosion from household service pipes

- Exposure due to the hobby of someone in the household – i.e. a family member does target shooting, comes up with lead dust on clothing and child is exposed to lead through the clothing.
- A household member works in an occupation that exposes them to lead and a contaminated article (clothing typically) is brought into the home where the child is then exposed.
- Cosmetics, pottery or home medicines imported from other countries which may contain lead.

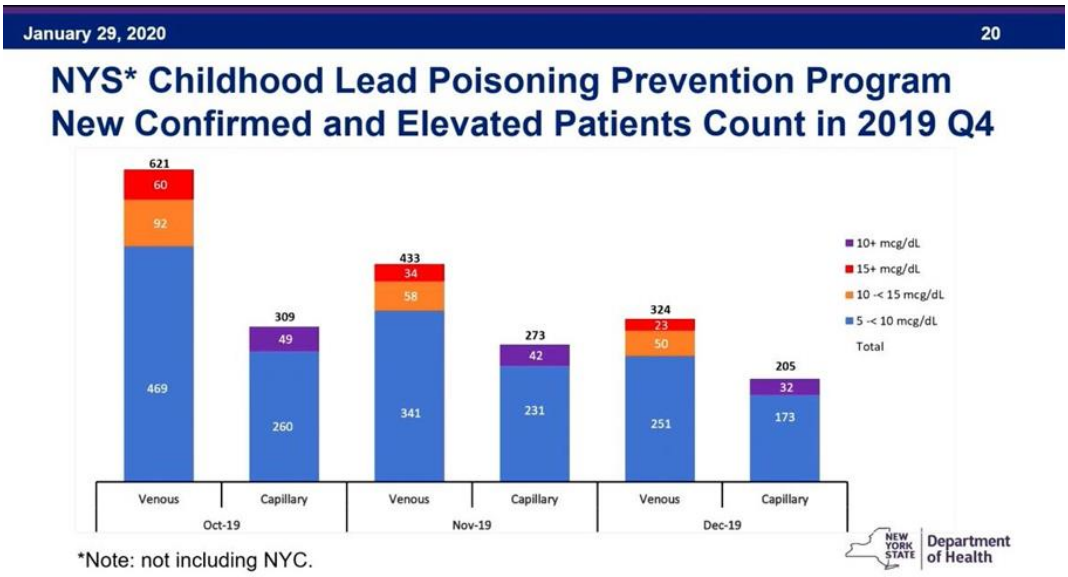
Once the source is identified, the LHD will order specific abatement activities. This might be as simple as mopping to remove lead-based paint dust, or as involved as removal of all lead-based paint.

If the dwelling owner fails to comply with an abatement order, there are civil penalties, and, if needed, the county may take the necessary legal action to ensure compliance.

Pre-Pandemic Implementation of the Lowered EBLL

In 2019, as part of the SFY 2019-20 state budget, the actionable elevated blood lead level was lowered from 10 to 5 µg/dL. Throughout the budget negotiations, and then through the regulatory process leading up to implementation, NYSACHO communicated resource gaps on behalf of local health departments. These included the $30.3 million for additional nursing and environmental inspection visits, as well as additional, uncalculated costs for equipment and other support staff needed to implement the mandate. While some localities were able to add some additional staffing, many instead reduced services and redeployed existing staff away from other public health priorities to meet the expanded workload.

The current actionable level of 5 µg/dL for lead poisoning interventions went into effect in October 2019. At the January 29, 2020, Lead Poisoning Prevention Advisory Council meeting, the New York State Department of Health presented data on the first quarter of implementation, showing that an additional 1725 children between the ranges of 5-9 µg/dL. While this highlights the importance of this policy action, it also represents the equivalent to 2.5 years of work occurring in a single quarter when compared to prior years.



This data was presented just six days after the New York State Department of Health held its first briefing for healthcare providers and local health departments on a novel Coronavirus that had emerged from Wuhan, China. By late March 2020, COVID-19 cases and deaths were increasing and spreading throughout the state, NY on PAUSE was in place, and local health department staff were engaged in the pandemic response of a scale not seen since the previous century.

NYSACHO recognizes the impact of the COVID-19 pandemic on children will have many public health implications, including increased risks relative to lead poisoning. These include pandemic period reductions in lead testing of one- and two-year-old's, children remaining indoors in home settings with potentially prolonged exposures to lead hazards and the inability to conduct in-home public health visits during the New York on Pause orders. Additionally, financial hardships property owners due to tenants' inability to pay rent during the pandemic are likely to contributed to may delays in abatement activities and ongoing maintenance, further causing deterioration of lead-based paint and increasing the risk of exposure.

Yet despite recognition of the inadequate funding to implement the EBLL mandate, and despite the known additional risks posed by the pandemic, the 2020-21 and 2021-22 state budgets provided no additional funding to implement this sound and important public health policy.

County Civil Liability - Potential Fiscal Risk

Current and any new and expanded duties placed on local health departments may result in increased civil liability for our county governments. Due to the severity and lifelong damage lead poisoning causes, awards in lead paint poisoning/ abatement lawsuits are considerable, reaching in the billions nationwide. Those sued are typically paint manufactures or building owners/landlords. However, with the expanded role that New York counties must take on in this field, as well as the State's underfunding of the program, this issue has become an increased risk for county civil liability.

As a rule, in New York State, for a municipality to be held liable against a claimant, a "special relationship" must be established (De Long v. County of Erie, 60 N.Y.2d 296, 304, 469 N.Y.S.2d 611, 457 N.E.2d 717). The elements of this "special relationship" are: (1) an assumption by the municipality, through promises or actions, of an affirmative duty to act on behalf of the party who was injured; (2) knowledge on the part of the municipality's agents that inaction could lead to harm; (3) some form of direct contact between the municipality's agents and the injured party; and (4) that party's justifiable reliance on the municipality's affirmative undertaking. These elements may be more commonly found with the county health department's expanded role in this field, thereby increasing liability.

Primary Prevention Investment

New York State has funded up to 15 local health departments to conduct childhood lead poisoning primary prevention activities, designed to proactively address lead hazards in housing and identify children at risk of lead poisoning earlier for intervention. Lead poisoning is in large part a housing problem, with most elevated blood lead levels linked to exposure to lead paint hazards in residential dwellings. The most notable success in upstate New York has been the Monroe County/City of Rochester model, which uses code enforcement certificates of occupancy and the use of the Spiegel Act to withhold rental assistance payments when landlords fail to address lead hazards in housing where the family's housing costs are supported by public assistance. Unfortunately, despite widespread knowledge of the success of the Monroe County model, most local health departments receive no primary prevention funding, and many rural municipalities have limited code enforcement resources. Again, if New York state is to successfully reduce the incidence of childhood lead poisoning, leaders must be willing to increase their investment in primary prevention activities.

Additional Infrastructure Needs

Good data is foundational to public health interventions. The New York State Department of Health recently made enhancement to its data system, LeadWeb, designed to streamline and update the

collection of childhood lead poisoning environmental exposure investigation data, to complement ongoing improvements. Additionally, the New York State Immunization Information System allows providers to enter and access information related to blood lead level testing, as well as offering parent/guardian educational resources and the ability to run a variety of aggregate reports to assess the practice's adherence to lead testing requirements and providing opportunities for systemic improvements to assure that children are appropriately tested. While these system improvements and resources are steps forward, there continues to be a lack of publicly available and current data on the incidence of childhood lead poisoning. Investments at NYSDOH to improve staffing for data analysis would help assure that interventions are targeted to areas of current need, rather than based on historic data, often several years old, and will also provide evidence necessary to identify successful intervention strategies. Similarly, investments in data related to housing and abatement could allow more targeted primary prevention interventions. For example, the successful primary prevention model in Monroe County could be replicated in other areas with state investment in supporting and increasing municipalities'' code enforcement resources. In rural communities in particular, many code enforcement officers are part-time, or serve multiple municipalities. Any primary prevention work related to environmental assessment of lead hazards as part of codes enforcement are unlikely to be accomplished under existing funding and will require additional state investment to be successful, given the revenue limitations posed by the state's property tax cap.

Local Health Department comments on current legislative proposals

NYSACHO's Environmental Health committee reviewed several current legislative proposals in advance of this hearing. While NYSACHO as a membership has not yet acted on any committee recommendations, we share the committee feedback in this testimony to help inform efforts to move the various bills forward in the upcoming legislative session.

S.2142-A/A6608 Requiring lead paint test results disclosures in real estate transactions

NYSACHO's committee overall supports the intent of this legislation, and recommends that the bill sponsors consider the following:

- Are there an adequate number of EPA certified inspectors to provide this service?

- The bill language appears to apply to all real estate transaction, including new buildings and buildings built after the usual 1978 year used for other lead-based paint policies, where the testing would add additional costs to transactions with no public health benefit.
- The legislation references that those purchasers may want to consider lead service lines, but does not explicitly require disclosure of lead service lines. Having these identified with the disclosure may provide additional public health benefit if the buyer is aware of the potential need to replace these lines.

S.3079/A.7748 Prohibiting the exclusion of coverage for losses or damages caused by exposure to lead-based paint

NYSACHO's committee raised the following questions:

- Does this bill shift liability for owner negligence onto the insurer?
- Given the age of New York's housing stock, particularly in rural areas, will this make it more difficult for homeowners/purchasers of pre-1978 homes in obtaining necessary coverage, thus impacting sales and property values?

S.6554/A7177 establishing the New York State Lead-safe renovation, repair and painting act

NYSACHO's committee indicates that this bill would require a significant fiscal investment on the part of the state and localities to increase in staffing resources for both state and local health departments.

S.5024-B/A.7325-A Additional prevention and screening for elevated blood lead levels in children

NYSACHO's committee agreed that increased education and lead screening by pediatricians could help parents identify and address lead hazards and reduce the incidence of lead poisoning. Currently education too often occurs once a child has been identified as having elevated blood lead levels. There was some concern regarding time constraints for providers during well-child visits that might impact provider compliance.

S.6969 Enacting the Lead-Free Homes Act

NYSACHO's committee agreed that while primary prevention is ideal and the direction that New York State should be moving towards, this bill cannot be implemented without a significant influx of resources to support the work.

Proposed funding options to fund current and new lead poisoning prevention mandates

A. Funding Mechanism

Lead Poisoning Prevention Activities delivered by local health departments are supported through a variety of funding mechanisms, including the Lead Poisoning Prevention Program, Childhood Lead Poisoning Primary Prevention Program (15 counties), Healthy Neighborhood Program (some counties), and reimbursement through Article Six Public Health Law General Public Health Work funding. When the definition of elevated blood lead level was lowered to 5 µg/dL or greater, the state also allocated an additional $9.7 million to Article Six state aid. This investment falls short of the funding needed and also places the majority of the cost burden on the local tax levy, including 100% of fringe costs associated with any new staff hired to provide public health interventions and case management for the additional children requiring services.

We recommend that all monies allocated for funding the expanded mandate (current and future) be appropriated into the Lead Poisoning Prevention program of the New York State Department of Health. We further recommend that this funding then be distributed to the local health departments through existing grant mechanisms to support implementation the expanded mandate. Allocating existing and new investments to support the lower EBLL through this program will allow local health departments to secure and maintain the necessary staffing and other resources required accomplish the goals set forth by the state mandate, whilst ensuring that New York State keeps its promise to property taxpayers through its enactment of a permanent property tax cap.

B. Funding Options

After consulting with local health departments and other stakeholders, NYSACHO presents the following options that could be directed to fund the lower blood lead level mandate of 5 µg/dL, to ensure the vision of the legislature and governor to protect children from lead poisoning is realized and the long-term outcomes of this expanded mandate reach fruition. Recommendations for consideration include:

1. Utilizing Health Care Reform Act (HCRA) Resources
2. Utilizing General Fund resources
3. Introducing a lead poisoning prevention fee on paint
4. Surcharge fee on homeowner's insurance and renter's insurance
5. Utilizing Master Settlement Agreement (MSA) funds for secondary and tertiary prevention

Conclusion

Lead poisoning is a problem with ready solutions that lack only the resources needed for implementation. We urge the legislature to identify funding first to support current and future lead poisoning primary and secondary prevention activities. Primary prevention can significantly reduce the secondary costs of lead poisoning, and most importantly protect children from life-altering damage. NYSACHO thanks the legislature for its ongoing leadership on this public health issue and we are committed to working with you to identify the resources needed to move your efforts forward.

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[1] Staffing Up: Workforce Levels Needed to Provide Basic Public Health Services for All Americans. De Beaumont PHNCI October 2021. https://debeaumont.org/staffing-up/

[2] https://www.health.ny.gov/environmental/lead/docs/2009-08_guidelines_lhu_children_elevated_blood_lead.pdf