Healthy Homes and Lead Poisoning Surveillance System (HHLPSS)

OMB Control No. 0920-0931 (Expiration Date: 05/31/2018)

Request for Extension

Supporting Statement Part A –

Justification

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Part A. Justification

Goal of the study: Improve health and quality of life by preventing disability through the control or elimination of lead exposure.

Intended use of the resulting data: To determine whether targeted screening strategies are indeed identifying children at high risk in contact with lead contamination sources.

Methods to be used to collect: Case management, home visits and healthy housing community outreach efforts.

Subpopulation to be studied: Infants and children up to 16 years of age in the U.S.

How data will be analyzed: Descriptive statistics such as means and ranges will be used to characterize the collected data.

A.1. Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) is requesting OMB approval for an 18-month extension for the Healthy Homes and Lead Poisoning Surveillance System (HHLPSS - OMB No. 0920-0931; expiration date: May 31, 2018).

This data collection is authorized under Sections 301(a) (Attachment 1), 317A and 318B of the 1944 of the Public Health Service Act (42 U.S.C. 241) as amended by the 1988 Lead Contamination Control Act (Attachment 1). In addition, this program is also authorized under Section 4002 of the Patient Protection and Affordable Care Act of 2010 (ACA), P. L. 111-148, (42 U.S.C. Section 300u-11) (Attachment 1).

The 60-day Federal Register Notice was published on November 8, 2017 (Attachment 2), and is further discussed in Section A8.

The sole purpose of this extension is to provide continuity of information collection for the 3rd year supplement, which represents the fourth and final year, of the CDC-RFA-EH14-1408PPHF14 cooperative agreement. This extension will last until the approval of the impending Childhood Blood Lead Surveillance (CBLS) and Adult Blood Lead Epidemiology and Surveillance (ABLES) - OMB Control No. 0920-NEW, which has been summarily submitted for OMB approval. This extension ICR will be discontinued at the end of the program period.

Background

The mission of CDC's Healthy Homes and Lead Poisoning Prevention Program (HHLPPP – hereafter, the "Program") is to improve health and quality of life by preventing disability through the control or elimination of lead exposure in homes and elsewhere and of exposure to other housing-related health hazards. The Program fulfills its mission in a multi-faceted manner, which includes providing financial and technical assistance to state, local, and territorial health departments for childhood lead poisoning prevention programs; providing a sound basis for policy decisions; and facilitating the integration of health issues in policies established by health, housing, and environmental agencies at the federal, state, local, and territorial levels. The significant and sustained decrease in blood lead levels among U. S. children is testament to the success of these activities. The CDC's ***National Center for Environmental Health*** (NCEH), through its experience with lead poisoning prevention and environmental health programs in states and communities, is recognized as a leader in the field of healthy housing by the World Health Organization, the U. S. Department of Housing and Urban Development, and the U. S. Environmental Protection Agency.

Among adults, lead exposure causes acute and chronic adverse effects in multiple organ systems ranging from subclinical changes in function to symptomatic life-threatening intoxication. Moreover, evidence indicates that lead exposure at low doses can lead to adverse cardiovascular and kidney effects, cognitive dysfunction, and adverse reproductive outcomes. Current research has found decreased renal function associated with BLLs at 5 µg/dL and lower, and increased risk of hypertension and essential tremor at BLLs below 10 µg/dL. The vast majority of elevated blood lead levels (BLLs) in the United States are workplace-related. Most lead exposures at work occur in the manufacturing, construction, services, and mining industries. The CDC's ***National Institute for Occupational Safety and Health*** (NIOSH) is responsible for making recommendations for the prevention of work-related illnesses and injuries. As of 2016, NIOSH considers BLLs ≥5 µg/dL among adults to be elevated.

The overarching goal of this information collection is to continue the HHLPSS at the state and national levels. Over the last three years, 7 states have adopted the HHLPPS and 13 are in beta-testing. These states continue to send the collected lead data to the Program. Currently, up to 40 state and local Childhood Lead Poisoning Prevention Programs (CLPPP) and the state-based Adult Blood Lead Epidemiology and Surveillance (ABLES) program sponsored by NIOSH report information (e.g., presence of lead paint, age of housing, and occupation of adults) to the HHLPSS. Linking these two systems through HHLPSS ensures that CDC can identify and intervene for occupational exposures, so-called 'take home' exposures when workers bring lead contaminated clothing or equipment home and expose children and childhood lead exposure from lead paint, contaminated water, soil, dust or consumer products.

A.2. Purpose and Use of the Information Collection

Public Health Practice

HHLPSS is a systematic assessment tool of programmatic activities under the non-research healthy homes cooperative agreement. In fiscal year 2011, the budget authorization, appropriation line, and Branch name were changed to reflect Congress' intention that the Program expand from a sole focus on lead poisoning to a broad mission to improve the nation's capacity to identify and address housing-related health hazards.

The sole purpose of this information collection is "program planning or management" and to provide continuity of information collection for the third-year supplement which represents the fourth and final year of the CDC-RFA-EH14-1408PPHF14 cooperative agreement until the approval of the impending Childhood Blood Lead Surveillance (CBLS) and Adult Blood Lead Epidemiology and Surveillance (ABLES) - OMB Control No. 0920-NEW, which has been summarily submitted for OMB approval. This extension ICR will be discontinued at the end of the program period.

This information collection will help CDC NCEH to monitor the activities of the healthy homes programs to ensure that services are timely and consistent with the terms of the cooperative agreement.

Program Gains and Accomplishments

Forty years ago, more than 99% of the US population had elevated blood lead levels by today's standards (>5 µg/dL). The Lead Contamination Control Act of 1988 had a tremendous impact on public health because it supported the creation of childhood lead poisoning prevention programs to identify, monitor, and respond to cases of elevated blood lead levels in US children. Between 1991 and 2006, the percent of US children ages 1 to 5 years old with blood lead levels >10 µg/dL fell from 4.4% to 0.6%.

We can attribute much of this remarkable public health success to many of CDC's efforts including supporting state and local health departments to develop prevention and surveillance programs to identify and monitor where children are most likely to be exposed to dangerous levels of lead, developing safe renovation guidelines, and educating parents, the general public, and health care providers.

During the past three years, the HHLPPP met annually with CDC-RFA-EH14-1408PPHF14 cooperative agreement program managers, worked with them to identify children at highest

risk for lead exposure and targeted prevention activities to eliminate childhood lead poisoning in awardee jurisdictions.

During 2014-2017, the HHLPPP produced 17 peer-reviewed publications (see References). Additional examples of the CDC-RFA-EH14-1408PPHF14 cooperative agreement program accomplishments are below:

2014 (Year 1):

- JT Lewis Site Investigation/Epi-Aid with ATSDR, EPA, and Philadelphia Department of Health (Emergency Epidemic Investigations; OMB Control No. 0920-0008; expiration date 07/31/2014).

Awardee Activities:

- New York City identified lead hazards related to Bo Ying Compound, which is marketed for treatment of ailments in infants and children. The City reported its finding to the Food and Drug Administration (FDA). See Public Safety Alert at http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm416441.htm

2015 (Year 2):

- HHLPPP completed data analysis for the JT Lewis Site Investigation/Epi-Aid in conjunction with the US Environmental Protection Agency (EPA) and the Philadelphia Health Department. The final report is in development.

Awardee Activities:

- Rhode Island used the cooperative agreement to create reports for all schools in the state showing screening rates in all schools.

- New York City created and shared a poster for the Chinese community on Bo Ying Compound. The compound, marketed for treatment of ailments in infants and children, may contain excessive levels of lead. The poster has been distributed throughout the Chinese communities in New York City and Washington State, supporting lead poisoning prevention efforts and showing collaborative effort from the cooperative agreement.

- New Jersey: The program identified the need for a recovery project that increased residents' knowledge of the connections between health and housing; ensured a competent health, social services, and housing professional workforce that is

knowledgeable on the health impacts of housing conditions; and increased access to blood lead screenings for high-risk residents. The NJ Healthy Homes Training Center (HHTC), a public/private partnership between NJ DOH and Isles, Inc, a Trenton-based non-profit community development agency, developed a one-hour public education presentation "Creating a Healthy Home after a Hurricane or Flood" Local health departments conducted targeted screening using the LeadCare II blood lead analyzer. Statewide, in SFY2014, 2.9% of children less than 17 years of age had a blood lead level 5 µg/dL or greater. The recovery project identified a rate of 7.2% (95% confidence interval).

- Oklahoma: OCLPPP has had two meetings with the Oklahoma Health Care Authority (OHCA) to discuss a data sharing agreement to obtain a waiver of universal lead screening of all Medicaid children and focus on targeted screening for children who live in high risk areas. The purpose is to compare the rates of children being screened on Medicaid versus those not on Medicaid. This can be compared to national screening levels of children on Medicaid and to determine if there are areas in the state that have very low screening rates. These areas can be targeted to increase screening and ensure that decisions made on low risk and high risk areas are data-driven. This will also allow OCLPPP to explore option for billing for services such as environmental investigations for children covered by Medicaid.

- Wisconsin-Minnesota Success Story: Fraser Shipyard Lead Investigation Plan. Renovations in early 2015 at the Fraser Shipyard on the Wisconsin-Minnesota border resulted in elevated blood lead levels (EBLLs) in three employees working on the project. The investigation and response resulted in a large-scale collaboration between the Minnesota Department of Health (MDH), the Wisconsin Department of Health Services (WI DHS), OSHA, and Wisconsin Local Public Health Agencies (LPHAs). The collaboration took a three-pronged approach to the situation: a survey to assess the worksite and take home risk of lead exposure and lead exposure related symptoms; blood-lead sampling by health departments in both states to track blood lead levels of workers and their families; and environmental sampling by a certified professional for residences and vehicles from confirmed cases. Of the 357 workers who were potentially exposed to lead hazards at the shipyard, 233 had at least one blood lead screening. Worker protection and medical monitoring has increased due to this incident, and policies and procedures have been reevaluated in light of the challenges faced throughout this event.

<u>2016 (Year 3):</u>

- The HHLPPP supported CDC's response to the lead contamination of drinking water in Flint, Michigan, including Emergency Operations Center (EOC) activation, data management, and community outreach.
    - Assisted Flint in response to the water contamination crisis with monitoring BLLs in more than 50% of the community's children under 6 years of age, connecting more than 90% of children with elevated BLLs to case management.
    - Created an activity book to offer parents an interactive way to talk to their kids about lead in water.
- Collaborated with leadership from the NCEH Communications team for an innovation project related to a CDC lead poisoning prevention program redesign (as part of the HHS Ignite Accelerator program).
- Provided data that supported the U.S. Department of Housing and Urban Development's plan to ban smoking in public housing.
- Raised awareness about lead poisoning during October's National Lead Poisoning Prevention Week via the tri-agency toolkit with customizable resources for state and local governments and organizations to develop their own campaigns.

<u>Awardee Activities:</u>

- The District of Columbia program worked with the Centers for Medicaid and Medicare Services (CMS) and the College of American Pathologists (CAP) to have labs report blood sample type as a requirement for maintaining accreditation—this success contributes to more-accurate surveillance of pediatric BLLs nationwide, improving the knowledge of the true burden of lead poisoning.
- New York City: In New York City, over 300,000 children under 6 years of age are tested annually. Since 2010, the number of children with blood lead levels at or above the 5 micrograms per deciliter (µg/dL) has decreased from 13,000 children in 2010 to 6,000 children in 2014. The lead surveillance program used small-area analyses to identify neighborhoods with higher blood lead levels. Within one neighborhood with a high rate of lead poisoning, the vast majority of children with the highest blood lead levels resided in an area home to a large Hasidic Jewish community. The lead program collaborated with local political and religious leaders and worked with trusted community based organizations to increase awareness about childhood lead poisoning prevention and all information was translated into Yiddish.

- Rhode Island: In 2011, four core cities in Rhode Island reported having three times the number of children with elevated blood lead levels ≥10 µg/dL compared to other Rhode Island cities and towns. An estimated 80% of Rhode Island homes were built before 1978 and likely contain lead-based paint hazards which can create lead dust hazards during renovations to these homes. Rhode Island implemented the US EPA's 2010 Lead-Based Paint Renovation, Repair and Painting (RRP) Rule that requires workers to be certified and trained in the use of lead-safe work practices, and requires renovation, repair, and painting firms to be licensed by the department of health. Following the first full year of the program, there were 225 fewer children in Rhode Island with elevated blood levels and 180 cases of RRP violations were prosecuted for failure to obtain lead-safe certificates for rental units.

- Louisiana: Louisiana state data demonstrated that some children attending Women and Infants Special Nutrition Projects (WIC clinics) do not receive routine health prevention services, and therefore are unlikely to receive blood lead testing at a medical clinic. The Louisiana lead program partnered with a New Orleans area WIC clinic to increase lead testing rates of children in Louisiana and to determine the percent of children tested during WIC clinic visits who had blood lead levels ≥5 µg/dL. By matching WIC client lists with surveillance data, the program demonstrated that WIC clinics are an efficient way to screen high-risk children who would not otherwise be tested. The program ensured blood lead testing for 1,395 children, 81% of whom had never had a previous test and has expanded to include WIC clinics in other high-risk areas of the state.

- Washington: The Washington State Lead Poisoning Prevention Program convened an expert panel to develop risk-based childhood lead screening recommendations for use by clinicians in the state. The Program partnered with the Refugee Health Program to screen all refugee children between 6 months and 16 years of age as part of the refugee resettlement program. Over a three-year period from 2013 to 2016, they screened 3,275 children. Fourteen percent of the refugee children screened had elevated blood lead levels and 3% with blood lead levels greater than 10 µg/dL. These children were then able to be linked to appropriate follow-up services.

- Mississippi: The Mississippi Lead Poisoning Prevention and Healthy Homes Program used CDC cooperative agreement funds to partner with six communities identified as high-risk areas for lead poisoning: the City of Meridian, the City of Jackson, the City of Hattiesburg, the City of West Point, the City of Moss Point, and the City of Yazoo City. Between July 1 and December 31, 2015, city partners facilitated lead poisoning prevention and health homes trainings, planned and conducted healthy homes community planning meetings featuring focused discussion on childhood lead poisoning

prevention, and distributed health education materials to residents. Through focused campaigns, the communities distributed 2,000 lead poisoning prevention educational materials featuring details about lead testing and identifying lead sources. The communities also distributed 900 lead poisoning prevention toolkits to resident families. Since 2010,* Mississippi has experienced an 18% increase in children tested for lead.

- Ohio: In Marion County, Ohio, staff at the local health department have worked with the OHHLPPP epidemiologist to create customized maps for their area depicting the high risk census tracts. These maps are being used to create posters to display to the public at organized events.

2017:

- Illinois: Over the course of three years, the CLEAR-Win project assisted in lead-safe replacement of almost 8,000 windows at 379 properties containing 466 housing units. The 466 housing units included 251 children under the age of 6, the population most vulnerable to lead poisoning. In conjunction with Illinois' study, HUD analyzed a sample of nearly 100 homes remediated in the CLEAR-Win program, comparing lead dust sampling performed at baseline and at one year. Lead dust wipe samples were collected by HUD before CLEAR-Win commenced, immediately after (clearance sampling), and nominally one year after CLEAR-Win's work was completed. Between baseline and 1 year post intervention, geometric mean lead dust for interior floors, interior sills, and exterior troughs declined by 44%, 88% and 98% respectively. HUD's results of CLEAR-Win's pilot program in Illinois show that a state health department can successfully implement a window replacement program that dramatically reduces childhood lead exposure.

  Reference: CLEAR-Win Final Report 3/30/2016; Jacobs DE, Tobin M, Targos L, Clarkson D, Dixon S, Breysse J, et al. Window Replacement and Childhood Lead Exposure: Results from CLEAR-Win [unpublished]. Washington, DC: U.S. Department of Housing and Urban Development. 2015.

Detailed description of information collected in this approval period:

Data are collected during home visits for families referred by their primary health care provider, other social service provider, self-referred, or, as in the case of blood lead levels, reported by laboratories. In most funded cooperative agreement programs, blood lead testing and laboratory reporting of all blood lead levels is required by law (see for example: National

Conference of State Legislatures: State Lead Poisoning Prevention Statutes at http://www.ncsl.org/documents/environ/stlaws10.pdf).

Data regarding race/ethnicity are collected by the parent or self-report in the clinical office or during the home visit. All programs use the 5 category race variable found in Attachment 4. During meetings with the cooperative agreement partners, they agreed to and through our authority under the cooperative agreement, CDC requires programs to use the standardized healthy homes questions also found in Attachment 4. These include the questions related to asthma diagnosis and symptoms cognitively tested by the National Center for Health Statistics (NCHS). However, unlike NCHS, HHLPSS uses the clinically relevant age threshold of 6 years old as recommended by the National Heart Lung and Blood Institute.

Recipients of cooperative agreement awards are required to submit a summary data file within 90 days of the end of each quarter of the federal fiscal year. Data will be entered by the state, local, and territorial programs into a database (e.g. Microsoft SQL) which will also be password-protected by state IT security protocols and processes. State, local, and territorial programs will extract the HHLPSS data from their existing records and send the encrypted files electronically to Program staff at CDC.

How the information was used:

The information was used by CDC to monitor short-term trends, to monitor the progress toward elimination of housing hazards, and to oversee programmatic activities in a timely fashion.

Why it needs to be collected again with little change:

The sole purpose of this information collection for the 3rd year supplement which represents the fourth and final year of the CDC-RFA-EH14-1408PPHF14 cooperative agreement until the approval of the impending Childhood Blood Lead Surveillance (CBLS) and Adult Blood Lead Epidemiology and Surveillance (ABLES) - OMB Control No. 0920-NEW, which has been summarily submitted for OMB approval. This extension ICR will be discontinued at the end of the program period.

A.3. Use of Improved Information Technology and Burden Reduction

Reporting data to the Program using the HHLPSS will not result in any federally-sponsored burden on residents of the homes that are visited.

The HHLPSS software extracts these data fields from the data currently collected by the state, local, and territorial healthy home programs. These programs collect far more extensive data during home visits than are reported to the Program. For example, for a typical lead paint hazard inspection, while the home visitor records the lead concentration and paint conditions of all painted surfaces inside and outside the house, HHLPSS only collects 8 data fields related to the lead inspection (See Attachment 4).

State ABLES programs: 1) collect data on adult BLLs from laboratories and physicians through mandatory reporting; 2) assign unique identifiers to each adult to account for multiple BLL records, to protect individual privacy, and to permit longitudinal analyses; and 3) follow-up on adults with BLLs ≥25 µg/dL with laboratories, health-care providers, employers, or workers to ensure completeness of information (e.g., the industry where the adult is employed and whether the exposure source is occupational, non-occupational, or both). All respondents (state, local, and territorial programs) will submit data electronically to CDC.

A.4. Efforts to Identify Duplication and Use of Similar Information

The HHLPSS is a program management system designed to provide information on health and housing parameters and how they are addressed, and to record and transmit data. No other survey collects all of the elements that are collected through HHLPSS. HHLPSS data are also used by State ABLES programs to monitor blood lead levels among adults. Unlike the nationally representative CDC surveys such as the National Health and Nutrition Examination Survey (NHANES), National Health Interview Survey (NHIS), Behavioral Risk Factor Surveillance System (BRFSS), and the U.S. Census American Housing Survey (AHS), HHLPSS can provide more specific information about addresses and is available in real time. HHLPSS can also be used to provide insight into trends in local areas as well as to understand the relationship with demographic and housing characteristics among those for whom measurements are available. This allows federal, state and local partners to use all the available data to target resources, to determine priorities and to modify these priorities if necessary. In addition, only HHLPSS can be used for program management and to evaluate the effectiveness of housing interventions in specific addresses as they are implemented via the state, local, and territorial programs funded by the Program.

A.5. Impact on Small Businesses or Other Small Entities

The collection of this information does not directly impact small businesses or small entities.

A.6. Consequences of Collecting the Information Less Frequently

Respondents will submit data on healthy homes and child blood lead levels to CDC on a quarterly basis. Adult blood lead levels will be sent to CDC on an annual basis. NIOSH will analyze adult blood lead data. The collection of this data with this frequency is necessary in order for CDC to monitor short-term trends, to monitor the progress toward elimination of housing hazards, and to oversee programmatic activities in a timely fashion. There are no technical or legal obstacles to reducing burden.

A.7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

There are no special circumstances with this information collection package. This request fully complies with the regulation 5 CFR 1320.5.

A.8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A. A 60-day Federal Register Notice was published in the *Federal Register* on November 8, 2017, vol. 82, No. 215, pp. 51841 (Attachment 2). CDC did not receive public comments related to this notice.

B. During the design phase of creating HHLPSS, CDC's NCEH Healthy Homes and Lead Poisoning Prevention Program consulted with scientists and program managers from in 2009. We discussed availability of data and frequency of collection issues with this subject matter expert (Table A8.1).

Table A8.1. List of experts consulted regarding study design and frequency of data collection

Name	Title	Affiliation	Contact information	Year of Consultation
Peter Ashley, DrPH	Director, Policy and Standards Division	U.S. Dept. of Housing and Urban Development (HUD)	Peter.J.Ashley@hud.gov Phone: 202-402-7595	2009

A.9. Explanation of Any Payment or Gift to Respondents

Data submission is required by CDC's NCEH under the CDC-RFA-EH14-1408PPHF14 cooperative agreement (Attachment 5).

A.10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

A.10.1. Privacy Impact Assessment Information

The NCEH/ATSDR PRA Contact has reviewed this submission and has determined that the Privacy Act does apply. The applicable Privacy Act System of Records Notice is SORN 09-20-0136 "Epidemiologic Studies and Surveillance of Disease Problems" (https://www.cdc.gov/SORNnotice/09-20-0136.htm). On October 4, 2017, the NCEH/ATSDR Information Systems Security Officer (ISSO) conducted an annual review of the HHLPSS and determined that the previously approved Privacy Impact Assessment for the Childhood Blood-Lead Poisoning Surveillance System (Attachment 9) is sufficient for the extension of this information collection. The Childhood Blood-Lead Poisoning Surveillance System and HHLPSS are the same system used to collect data from state, local, and territorial programs.

Overview of the data collection system

Data will be collected quarterly on healthy homes and child blood lead levels by CDC. Adults blood lead levels will be sent to CDC on an annual basis. NIOSH will analyze adult blood lead data. Attachment 4 provides a comprehensive list of all of the healthy homes and lead poisoning surveillance variables that will be collected by CDC via HHLPSS.

Under cooperative agreement, the state, local, and territorial programs enter their data into a secured HHLPSS website that is housed internally on their premises (cookies are not applicable to this website).

The CDC Program staff will explain to the funded surveillance programs that the intended uses of the data are for assessing trends in lead and housing data, and also to evaluate programmatic benchmarks (e.g., case management and referrals for housing-related problems) of their funded programs.

Items of information to be collected (Tables A.10.1 and A10.2)

Table A10.1. Home and health information collected by HHLPSS.

Type of Data	Will be collected under HHLPSS
Blood Lead Test Data	X
Race / ethnicity	X
Lead related housing characteristics (e.g. age of home, measurements of lead concentration in paint or oil)	X
Safety features (e.g. child safety locks, smoke detectors, show grab bars, window guards)	X
Other housing characteristics (e.g. water and mold damage, insect and rodent infestations, structural problems)	X
Behavioral characteristics (e.g. smoking in the home, unvented combustion appliances)	X

Resident Health (e.g. asthma of children or adults, recent childhood injuries in the home)	X

Table A10.2. Information In Identifiable Form (IIF) collected in HHLPSS.

IIF Category collected by state, local, and territorial health departments	IIF Category sent to the CDC
Name	
Date of birth	X
Phone numbers	
Medical information and notes	X
Email address	
Home address	

CDC staff receives de-identified electronic files with date of birth, medical and biological information of each child. Each adult is given by the state a unique identifier and only date of birth is included in the dataset.

<u>How the information will be shared and for what purpose</u>

The Program staff will explain to the funded surveillance programs with whom information may be shared (i.e., to HUD and/ or EPA for enforcement of the Federal Lead Disclosure Rule Section 1018 of Title X and the Lead-Safe Housing Rule (45 CFR 164.512(b)), and the legal authority for the data collection (i.e., through the Public Health Service Act). See Attachments 6 and 7, respectively.

As described in more detail in Supporting Statement B, CDC NCEH will share the de-identified data and/or results of the surveillance with interested parties through its website, publications, and peer-reviewed manuscripts. The limitations as well as the strengths of HHLPSS data will be described in each of the venues including that HHLPSS is not derived from a population-based representative sample. Specifically, consistent with the existing terms of clearance for this collection, the following language will ***always*** accompany any aggregate statistics that the federal government disseminates, including reports or testimony to Congress, on its web site, or as the justification for policy decisions or budget requests.

These data were collected for program management purposes. The data are not generalizable at the national, state, or local level. Furthermore, because inclusion criteria vary across grantees, comparisons of aggregate statistics across programs can be misleading (i.e., state policies and practices for blood lead testing vary and local priorities drive decisions regarding which homes receive assessments for other housing hazards). However, descriptive statistics can be used to compare changes over time in a given area when the method by which housing

units are chosen for inclusion remains the same. With a thoughtful understanding of the approach used to include housing units in a given location, HHLPSS can be used to make associations between the number of individuals in a given area and a specific housing hazard or health condition and geographic descriptors such as poverty, age of housing, tenancy, and health conditions.

Each of the participating state, local, and territorial health departments will have access only to their respective program's identifiable data. Each awardee may share address information with HUD and EPA for their use in assessing compliance and enforcing regulations to protect children's health.

Impact the proposed collection will have on respondent privacy

If there were a breach of security for any of the above IIF at CDC, some effect on the respondent's privacy could occur; however, there are a variety of safeguards in place as described below in Information Security.

Whether individuals are informed that providing the information is voluntary or mandatory

Blood lead tests are performed under state regulations for blood lead screening and are thus mandatory. However, providing information about the mandate in clinical affairs is not uniform.

Opportunities to consent, if any, to sharing and submission of information

No consent form for collection of this data is required as the data are part of state, local, and territorial surveillance efforts. Consent to share with other federal agencies is not required when it involves enforcement of the Federal Lead Disclosure Rule Section 1018 of Title X and Lead-Safe Housing Rule (45 CFR 164.512(b)) (Attachment 6).

Requirements for Disclosure of Known Lead-Based paint and/or Lead-Based Paint Hazards in Housing (24 CFR Part 35, Subpart H and 40 CFR Part 745, Subpart F) (Attachment 7). These joint HUD and EPA regulations require lessors of virtually all pre-1978 dwellings to disclose known information about lead hazards and provide an approved educational pamphlet to prospective tenants.

How the information will be secured

All collected data is secured in a password protected surveillance system. Only authorized state, local and territorial programs and CDC staff will have access to the raw data in HHLPSS. Additionally, data from state, local, and territorial programs are uploaded using encryption software. Encrypted data files will be sent electronically to CDC. Physical controls will also be implemented. Data will be stored on highly-secured CDC servers in Atlanta, GA. Access to all CDC campuses is restricted by armed guards. The servers are housed in a secure computer room complete with climate control, emergency power, and an uninterruptible power supply

(UPS). Daily back-ups and integrated security are implemented through the CDC computer services infrastructure. All data access is password-protected, and all network communications use encryption. All servers and PCs that are part of the CDC infrastructure are protected by both host-based firewalls and software in order to prevent the undetected installation of "spyware".

Whether a system of records is being created under the Privacy Act.

This submission has been reviewed by the CDC Information Collection Review Office (ICRO), which has determined that the Privacy Act does not apply.

A.11. Institutional Review Board (IRB) and Justification for Sensitive Questions

The HHLPSS is a surveillance system that does not include research involving human subjects and is, therefore, exempt from IRB approvals (See Attachment 8).

Sensitive Questions:

Questions that could be considered sensitive by at least a segment of the population such as information on pregnancy, smoking and injuries such as ever having been scalded because of water in the home are being asked about the individuals living in the homes as part of home inspections and blood lead assessment, and these variables are integral to accomplishing the purpose of this surveillance system. Table A11.1 describes the specific use of the possibly sensitive questions.

Table A11.1. Questions of a possibly sensitive nature

Questions (possibly sensitive)	Specific uses of information
Pregnant at time of test? (at time of blood lead test)	To assess prevalence of pregnant women with elevated blood lead, this provides important data for clinical follow up of women and their fetuses.
Race/ethnicity?	For targeting resources to subpopulations with high risk for elevated blood lead or housing risk factors
In the past 6 months, has anyone been scalded by the water in this home?	To assess efficacy of outreach activities and other interventions to decrease water temperature settings in the home

Do you (inspector) smell a musty odor anywhere in the home?	To assess risk for mold, evaluate effectiveness of related referrals and health education. Mold sampling is highly technical and recent publications have shown that mold odor is a predictor not only of mold exposure but is predictive of respiratory symptoms in some populations.
Does anyone who lives in this home smoke?	To assess risk for exposure to smoking, evaluate effectiveness of related referrals and health education. Smoking affects particulate matter in homes and can affect respiratory symptoms of residents.
Do you see evidence of cockroaches (bodies or fecal pellets)	To assess prevalence of cockroach exposures and efficacy of any interventions.
Do you see evidence of rodents (bodies, fecal pellets or gnaw marks)?	To assess prevalence of rodent exposures and efficacy of any interventions.

A.12. Estimates of Annualized Burden Hours and Costs

A. The respondents will be CDC cooperative agreement fund recipients from official state or territorial health departments, and/or departments of the environment who have received funds for developing and implementing a healthy homes and lead poisoning prevention program. The funded programs vary from year-to-year base upon conclusions of CDC objective review panels and the amount of funding available. Past experience with awardees funded by the Program informed the estimate of burden hours for the responses listed in Table A12.1. Data will be collected quarterly on healthy homes and child blood lead levels by CDC. Adults blood lead levels will be sent to CDC on an annual basis. NIOSH will analyze adult blood lead data. To maximize the burden hour estimates, we assumed that all awardees would submit quarterly reports.

Table A12.1. Estimated Annualized Burden Hours

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
State, Local, and Territorial Health Departments	Healthy Homes and Lead Poisoning Prevention Surveillance System (HHLPSS) Variables	40	4	4	640
Total					640

B. Cost to respondents is estimated to be $38.39 per hour (Table A12.2). This is based on the median hourly rate of pay for a computer programmer in 2016 (http://www.bls.gov/oes/current/oes151131.htm) to extract and format data, initiate computer runs, and verify and transmit data to CDC.

Table A12.2. Estimated Annualized Burden Costs

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
State, Local, and Territorial Health Departments	Healthy Homes and Lead Poisoning Prevention Surveillance System (HHLPSS) Variables	40	4	4	640	$38.39	$24,570
Total							$24,570

A.13. Estimates of Other Total Annual Cost Burden to Respondents and Record Keepers

The cost estimate includes the following:

a) A total capital and start-up cost component – approximately $40,000 for computer hardware and software required for HHLPSS. Many of the state, local, and territorial programs (e.g., health departments) already have existing equipment that can also be used for HHLPSS.

b) A total operation, maintenance, and purchase of services – maintenance of HHLPSS is approximately $5,000 per year. However, many of the state, local, and territorial programs (e.g., health departments) already have existing computer servicing and software contracts in place that can also be used for HHLPSS.

A.14. Annualized Cost to the Federal Government

The CDC Program has congressional appropriation for lead and healthy homes-related activities. The Program's FY 2017 operating budget is $14,500,000. In FY17, the total overall operational and maintenance costs for HHLPSS is $650,000 for a firm, fixed-price contract (which includes $10,000 estimated travel to support state and local health departments). The contract will support five (5) contract support specialists ranging from database administrator to direct user support, and will focus primarily on management and operations of the system, along with a finite amount of development and upgrades related to state/local health agency user requests. Other tasks include the data extraction, formatting, and processing to validate data submitted to CDC. Additionally, two federal employees have major responsibility for oversight of the national surveillance system management and data analysis.

Table A14.1. FY17 – HHLPSS

HHLPSS Child Blood Lead System (firm fixed price contract)	$640,000.00
Travel (to support health departments)	$10,000.00
Total Costs	**$650,000**

A.15. Explanation for Program Changes or Adjustments

This is an extension of a previously approved data collection. The burden has not changed from the burden shown in the current inventory.

A.16. Plans for Tabulation and Publication and Project Time Schedule

Each state, local, and territorial program has developed a plan for timely analysis and dissemination of summary data to appropriate state-level agencies and individuals. CDC will analyze the national data set and on an annual basis will disseminate results to the state, local, and territorial programs and to a broader audience via public health publications and other media (Table A16.1). CDC will also provide this information to Executive Program officials, Congress, healthy homes constituents, and other federal, state, and local agencies. The dissemination of these results will always include the following caveats:

These data were collected for program management purposes. The data are not generalizable at the national, state, or local level. Furthermore, because inclusion criteria vary across grantees, comparisons of aggregate statistics across programs can be misleading (i.e., state policies and practices for blood lead testing vary and local priorities drive decisions regarding which homes receive assessments for other housing hazards). However, descriptive statistics can be used to compare changes overtime in a given area when the method by which housing units are chosen for inclusion remains the same. With a thoughtful understanding of the approach used to include housing units in a given location, HHLPSS can be used to make associations between the number of individuals in a given area and a specific housing hazard or health condition and geographic descriptors such as poverty, age of housing, tenancy, and health conditions.

Table A16.1. Project Time Schedule

Activity	Time Schedule
States will submit data files quarterly, except for reporting of adult blood lead levels which will be submitted semi-annually	June 1, 2018
Analyze data	June 1, 2019
Disseminate publication/Data	December 1, 2019

The analysis plan includes descriptive statistics to show prevalence of environmental exposures and health outcomes (i.e., peeling paint in homes, presence of carbon monoxide and smoke alarms, elevated blood lead levels, and asthma). Statistical approach is described in Part B.

A.17. Reason(s) Display of OMB Expiration Date is Inappropriate

Exemption from displaying the expiration date for the OMB approval of forms is not being requested.

A.18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

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List of Attachments

Attachment 1: HHLPSS Authority Authorizing Legislation

Attachment 2. 60-Day Federal Register Notice

Attachment 3. 2013 HHLPSS Deployment (if still required)

Attachment 4. Healthy Homes and Lead Poisoning Prevention Surveillance System (HHLPSS) Variables

Attachment 5. CDC-RFA-EH14-1408PPHF14 Corporative Agreement

Attachment 6. Enforcement of Federal Lead Disclosure Rule Section 1018 of Title X and Lead-Safe Housing Rule (45 CFR 164.512(b)

Attachment 7. HUD Lead Safe Housing Rule (24 CFR 35)

Attachment 8. Research Determination

Attachment 9. Privacy Impact Assessment