Awardee Lead Profile Assessment (ALPA)

OMB Control No. 0920-1215, Expiration Date 02/28/2021

REVISION

Supporting Statement Part A –

Justification

Program Official: Perri Zeitz Ruckart, MPH
Title: Team Lead, Health Scientist
Program Development, Communications, and Evaluation Team
Lead Poisoning Prevention and Surveillance Branch (Proposed)
Division of Environmental Health Science and Practice
National Center for Environmental Health
Centers for Disease Control and Prevention
Phone: 770-488-3808
Email: afp4@cdc.gov
Fax: 770-488-3635

Date: 9/28/2020

Table of Contents

Part A. Justification

Goal of the study: The purpose of this annual assessment under the cooperative agreement is to identify: 1) jurisdictional legal frameworks governing CDC-funded childhood lead poisoning prevention programs in the United States and 2) strategies for implementing childhood lead poisoning prevention activities in the United States.

Intended use of the resulting data: The information collection instrument will be used to: 1) identify common characteristics of funded childhood lead poisoning prevention programs and 2) inform guidance, resource development, and technical assistance activities conducted by the CDC Childhood Lead Poisoning Prevention Program (CLPPP) in support of the ultimate goal, which is blood lead elimination in children. Assessment findings will be shared on the CDC CLPPP website and in response to inquiries by the public, press, and Congress. The dissemination of results will support the ability for both funded and non-funded jurisdictions to: 1) identify policies and other factors that support or hinder childhood lead poisoning prevention efforts, 2) understand what strategies are being used by funded state and local governments (or their bona fide fiscal agents) to implement childhood lead poisoning prevention activities, and 3) use this knowledge to develop and apply similar strategies to support the national agenda to eliminate childhood lead poisoning.

Methods to be used to collect: Data will be collected annually from the project managers of funded lead poisoning prevention programs of state and local governments (or their bona fide fiscal agents) using a web-based information collection instrument or a Microsoft Word document via email.

Populations to be studied: The population to be studied includes up to 50 state and up to 10 local governments as well as the District of Columbia (or their bona fide agents) that receive funding from the CDC CLPPP as part of their annual program performance requirements (n=61).

How data will be analyzed: Data will be analyzed by CDC staff using Epi Info™ 7 to calculate and organize descriptive statistics and qualitative response themes respectively.

A.1. Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) is requesting a three-year Paperwork Reduction Act (PRA) clearance for this revision information collection request (ICR) titled "Awardee Lead Profile Assessment (ALPA)." The information collected will allow the CDC Childhood Lead Poisoning Prevention Program (CLPPP) to: (1) identify common characteristics of funded childhood lead poisoning prevention programs, and (2) inform guidance, resource development, and technical assistance for the activities that the CLPPP conducts in support of its ultimate goal to eliminate blood lead in children.

Lead, a naturally occurring metal, is used in a wide variety of products around the globe. Lead paint is still found in many homes built before the 1978 ban on lead in residential paint was enacted in the U.S. (Jacobs et al, 2002). Lead paint in homes is the primary source of lead exposure in young children (Levin et al, 2008). Lead, extracted and used in consumer products and occupational settings, also contributes to morbidity and mortality in children and adults. To date, a safe blood lead level has not been identified. High blood lead levels can result in decreased academic achievement, decreased IQ, and behavioral problems in children. In extreme cases, lead poisoning can result in death. Children under six years of age are at an increased risk for adverse effects of lead exposure due to their accelerated development and behaviors, like hand to mouth tendencies, which contribute to exposure (National Institute of Environmental Health Sciences, 2015). Despite tremendous strides toward the elimination of lead poisoning in the United States, an estimated 535,000 children aged 1–5 years have blood lead levels at or above the reference value for blood lead, contributing to intellectual and behavioral shortcomings in children across the nation (Wheeler and Brown, 2013).

Since 1988, when the Lead Contamination and Control Act became public law (Attachment 1), the CDC has been charged with: 1) developing programs and policies to prevent childhood lead poisoning; 2) educating families, caregivers, and clinical providers about childhood lead poisoning; 3) providing funding to state and local health departments to collect surveillance data concerning childhood lead poisoning; and 4) supporting research to determine the effectiveness of prevention efforts at federal, state, and local levels (Centers for Disease Control and Prevention, 2015).

The CDC CLPPP provides allowable and available funding to U.S. state and local governments, or their bona fide fiscal agents, in the form of cooperative agreements. State and local programs are funded to develop, implement, and assess lead poisoning prevention activities. The CDC CLPPP also: 1) trains public health professionals on lead poisoning prevention and healthy homes principles; and 2) develops and implements internet technology solutions to conduct surveillance of childhood lead poisoning, providing a no-cost surveillance system for use by state and local lead poisoning prevention programs. All funded agencies are required to submit continuation applications and annual progress reports consistent with federal reporting requirements in response to the Governmental Performance and Results Act of 1993 (GPRA).

The current cooperative agreements, under the Notices of Funding Opportunity (NOFOs) entitled “Lead Poisoning Prevention- Childhood Lead Poisoning Prevention---financed partially by Prevention and Public Health Funds” (CDC-RFA-EH17-1701PPHF17) and “Childhood Lead Poisoning Prevention Projects, State and Local Childhood Lead Poisoning Prevention and Surveillance of Blood Lead Levels in Children” (CDC-RFA-EH18-1806), have been extended until

September 29, 2021 (Attachments 3a and 3b) to build upon national gains made by recipients under past cooperative agreements.

This information collection falls under the following program areas from the 10 essential public health services: 1) development of policies and plans that support individual and community health efforts; and 2) evaluating effectiveness, accessibility, and quality of personal and population-based health services.[1]

The CDC CLPPP also supports the following Healthy People 2020 goals:

- Environmental Health Goal: Promote health for all through a healthy environment.
    - Objective EH-8 - Reduce blood lead levels in children.
        - Objective EH-8.1 - Reduce blood lead level in children aged 1–5 years.
        - Objective EH-8.2 - Reduce the mean blood lead levels in children.
    - Objective EH-20 - Reduce exposure to selected environmental chemicals in the population, as measured by blood and urine concentrations of the substances or their metabolites.
        - Objective EH-20.3 - Reduce exposure to lead in the population, as measured by blood and urine concentrations of the substance or its metabolites.
        - Objective EH-22.1 - Increase the number of States, Territories, Tribes, and the District of Columbia that monitor diseases or conditions that can be caused by exposure to lead poisoning.

The CDC CLPPP is authorized under Sections 301(a), 317A, and 317B of the 1944 Public Health Service Act, as amended by the 1988 Lead Contamination Control Act. In addition, this program is 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); and under Section 2204 of the Water Infrastructure Improvements for the Nation (WIIN) Act of 2016 [Public Law No: 114-322] (Attachment 1). The 60-day Federal Register Notice (Attachment 2) was published on 7/20/2020 and is further discussed in Section A.8.

A.2. Purpose and Use of the Information Collection

The ALPA information collection will serve to 1) identify common characteristics of awarded childhood lead poisoning prevention programs and 2) inform guidance and resource development in support of the ultimate elimination goal. The dissemination of results obtained

[1] For more information on the National Public Health Performance Standards and the 10 essential public health services, see http://www.cdc.gov/nphpsp/essentialservices.html (Accessed 08/18/2016). The Core Public Health Functions Steering Committee developed the framework for the Essential Services in 1994. The committee included representatives from US Public Health Service agencies and other major public health organizations.

from this information collection will enable jurisdictions to 1) identify policies and other factors that support or hinder childhood lead poisoning prevention efforts; 2) understand what strategies are being used by funded state and local governments (or their bona fide fiscal agents) to implement childhood lead poisoning prevention activities; and 3) use this knowledge to develop and apply similar strategies to support the national agenda to eliminate childhood lead poisoning. Both funded and non-funded jurisdictions will be able to apply these principles to their childhood lead poisoning prevention programs. Findings will be shared on CDC's CLPPP website and in response to inquiries by the public, press, and Congress.

The details of the proposed revisions to this ICR are discussed in Section A.15, and are summarized here:

- CDC is requesting an increase in of 13 respondents from 48 to a maximum of 61 recipients, defined as state and local governments or their bona fide agents.

- The time to take the survey has increase from seven minutes in 2018 to 47 minutes per response.

    - In 2018-2019, CDC CLPPP administered the ALPA to funded programs. The information provided was a useful snapshot of the status of funded childhood lead poisoning prevention programs.

    - After reviewing past ALPA response, revisions to the survey were proposed to ease answering via the availability of standard responses and to capture additional relevant information (Attachments 4a and 4b).

    - Additionally, a training manual with explanations of each question will be provided to respondents (Attachment 4c).

- CDC is requesting an increase of annual burden hours, from 6 hours in 2018 to 48 hours.

If the ALPA information collection does not occur, CDC will be unable to 1) map specific and currently evolving characteristics of lead poisoning prevention programs throughout the U.S. (e.g., identifying blood lead levels (BLLs) that prompt public health action); 2) assess and share characteristics of lead poisoning prevention programs that lend to demonstrated success in preventing childhood lead poisoning; 3) assess gaps in, or achievements of, best practice approaches to lead poisoning prevention; and 4) develop resources for program improvement to ensure childhood lead poisoning elimination.

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

Data will be collected using a web-based link to an Epi Info 7™ survey (Attachment 4a) or using an emailed survey in Microsoft Word format (Attachment 4b). The data collection methods will allow all of respondents to complete and submit their responses electronically. These two methods were chosen to reduce the overall burden on respondents and does not require any special technical expertise or proprietary software. The information collection instrument was designed to collect the minimum information necessary for the purpose of this information collection.

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

There are no current information and data systems that meet the needs of the proposed information collection. The collection of this information will be part of a federal reporting requirement for funds received by awardees. Publicly available resource libraries and clearinghouses contain no information related to the information collection described under this effort. A literature search returned no results related to the same.

In 2015, the CDC National Center for Environmental Health (NCEH) partnered with professional organizations, such as the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the National Association of Local Boards of Health (NALBOH), along with the National Center for Health Statistics (NCHS) to ensure that the proposed ICR is not in conflict with collections they have or will have in the field within the same timeframe.

Thus, NCEH has determined that CDC has not systematically collected this information, barring the initiation of this information collection in the form of the 2015 pilot information collection among eight respondents; the associated one-time generic information collection among 35 respondents in 2016[2]; as well as the approved 2018 ALPA (OMB Control No. 0920-1215, expiration date 02/2021); and the most recent pilot of the modified ALPA among 9 respondents to reevaluate the time per response for this revision ICR. In addition, NCEH does not have a record of the information in any publicly accessible resource database.

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

This data collection will not involve small businesses.

[2] 2016 GenIC "Baseline Profile of State and Local Healthy Homes and Lead Poisoning Prevention Programs" (PROF-LEAD) under "Information Collections to Advance State, Tribal, Local, and Territorial (STLT) Governmental Health" (OMB Control No. 0920-0879; expiration date 03/31/2018).

A.6. Consequences of Collecting the Information Less Frequently

The information collection will occur annually per the requirements outlined in the CDC NOFOs mentioned previously (Attachments 3a-3c), as well as in future program announcements. The legislative landscape about lead poisoning prevention continues to evolve over time, as do the strategies employed by public health agencies as new best practices are identified. The annual ALPA survey is stipulated in the program announcement. [3]

Less frequent reporting would negatively impact: 1) the tracking of strategies in use by funded lead programs and, 2) the ability of CDC to assess and share the characteristics of lead poisoning prevention programs that lend to demonstrated success in preventing childhood lead poisoning. The annual reporting allows the CDC CLPPP to respond in a timely manner with up-to-date information to inquiries from stakeholders.

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

There are no special circumstances related to this information collection. 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 7/20/2020, vol 85, No. 139, pp. 43837 (Attachment 2). CDC/ATSDR did not receive public comments related to this notice

B. In the past three years, CDC did not consult any persons outside the agency to obtain their views on the availability of data, frequency of collection, the clarity of instructions, and record keeping, disclosure, or reporting format.

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

Respondents will not receive payments or gifts for providing information. The ALPA survey reporting is required on an annual basis (Attachments 3a-3c).

[3] In addition to the ALPA survey, annual performance measures for program NOFOs will be collected under the existing PRA clearance, "Blood Lead Surveillance System (BLSS)" (OMB Control No. 0920-0931; expiration date 05/31/2021).

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

On August 8, 2020, the CDC Chief Privacy Officer reviewed this submission and determined that the Privacy Act does not apply. Although activities involve the use of individually identifiable information (IIF) in the form of name and business email of the respondents; ALPA records will not be retrieved using IIF (Attachment 5).

The CDC Chief Privacy Officer also completed a privacy impact assessment (PIA) (Attachment 5). Controls described are adequate for protecting the aggregated and non-sensitive data being collected through Epi Info 7™ or Microsoft Word. Data will be protected with appropriate controls as described in the system documentation for the Epi Info Web Survey, an authorized CDC information collection system.

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

No personal or sensitive data will be collected. The NCEH/ATSDR Human Subjects Contact has determined that the data collection is not research involving human subjects and IRB approval is not required (Attachment 8).

This information will be collected in fulfillment of the non-research program requirements under current and future NOFOs. Participation is required for satisfactory performance.

A.12. Estimates of Annualized Burden Hours and Costs

a) Estimated annualized burden hours

Data will be collected from up to 61 respondents - specifically, lead poisoning prevention program project managers of state and local governments or their bona-fide fiscal agents.

The estimate for burden hours for the revised Awardee Lead Profile Assessment (ALPA) is based on pilot testing of a draft ALPA survey which was updated based on responses from the 2018 and 2019 ALPA data collections as well as current data needs. We estimate the time per response to be the same regardless of mode (EIWS or Microsoft Word format), that is, 47 minutes per response (Attachments 4a and 4b). The total annual time burden requested is 48 hours.

CDC anticipates that the majority the respondents, 60 respondents (98 percent), will choose the web survey due to the ease of use, and that 1 respondent (2 percent) will choose the email survey. The estimates of the number and percentage of respondents by mode of data collection are based on previous data collections. In the past, respondents only used the email survey if

they had technical difficulties with the web survey, which was rare. This represents a change in distribution from the 2018 estimates, which were initially assumed as 83.3 percent for the web survey and 16.7 percent for the email survey.

Table 1: Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
State and Local Governments (or their bona fide fiscal agents)	ALPA Web Survey	60	1	47/60	47
	ALPA Email Survey	1	1	47/60	1
Total					**48**

b) Estimated annualized cost to respondents

Estimates for the average hourly wage for respondents are based on the Bureau of Labor Statistics Occupational Employment and Wages, May 2019, for Medical and Health Services Managers (https://www.bls.gov/oes/current/oes119111.htm). Based on DOL data, an average hourly wage of $55.37 is estimated for all respondents. Table 3 (below) shows estimated annualized burden costs.

Occupation Code & Title	Job Description
11-9111 – Medical and Health Services Managers	Plan, direct, or coordinate medical and health services in hospitals, clinics, managed care organizations, public health agencies, or similar organizations.

Table 2: Estimated Annualized Burden Costs

Type of Respondent	Form Name	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
State and Local Governments (or their bona fide fiscal agents)	ALPA Web Survey	47	$55.37	$2,602.39
	ALPA Email Survey	1	$55.37	$43.37
Total				**$2,645.76**

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

There will be no direct costs to the respondents other than their time to participate in the information collection. The respondents are participating in this information collection as a program requirement.

A.14. Annualized Cost to the Federal Government

The annualized cost to the federal government for ALPA is $2,419,324, and is based on the following:

- The annual FY21 cooperative agreement program budget for surveillance activities is estimated to be $1,650,000.
    - This cooperative agreement cost is based on the five-year FY21 program budget of $110,000,000 (Attachment 3c).
    - One-half of the program budget is estimated to support program management and one half of the program budget is estimated to support surveillance activities, or $55,000,000 per program area for five years, or $11,000,000 per year.
    - We estimate that 85 percent of the annual program management activities will be related to performance measures ($9,350,000), while 15 percent of the annual cost of program management will be attributed to activities related to the ALPA survey ($1,650,000).
- The annual federal personnel salary cost for surveillance activities is $769,324.
    - This salary estimate is based on a total annual cost of $1,282,206, based on the following positions: Program Chief, Deputy Program Chief, 6 Project Officers, 1 IT Specialist, 2 Epidemiologists, 1 Communications Specialist[4]. Overall, 60 percent of NCEH personnel time is dedicated to program management ($769,324) and 40 percent of their time is dedicated to surveillance activities ($512,882).
- There are no annual travel or contract costs related to the ALPA collection.

A.15. Explanation for Program Changes or Adjustments

The details of the proposed revisions to this ICR are summarized here:

- CDC is requesting an increase in of 13 respondents from 48 to a maximum of 61 recipients, defined as state and local governments or their bona fide agents.

[4] Based on OPM Atlanta Locality Pay for Grade and Step 5 Salary Table at https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/20Tables/html/ATL.aspx.

- The time to take the survey has increase from seven minutes per response in 2018 to 47 minutes per response.

    - In 2018-2019, CDC CLPPP administered the ALPA to 53 funded programs. The information provided was a useful snapshot of the status of funded childhood lead poisoning prevention programs.

    - After reviewing past ALPA response, revisions to the survey were proposed to ease answering via the availability of standard responses and to capture additional relevant information (Attachments 4a and 4b).

    - Additionally, a training manual with explanations of each question will be provided to respondents (Attachment 4c).

- CDC is requesting an increase of annual burden hours, from 6 hours in 2018 to 48 hours.

The time to take the survey has increased from 7 minutes per response in 2018 to 47 minutes per response due to a revision of the survey. Survey questions with text box answers were modified to gateway questions with multiple choice answer options. Specific terms and phrases were modified for conciseness and clarification and a training manual was created to reduce ambiguity. Additionally, questions about primary prevention and lead elimination were added to the survey.

This revised time estimate per response is based on pilot tests of the revised survey among 9 respondents, and includes the time needed to review the ALPA Training Manual, which is a new addition in this revision ICR. Thus, CDC is requesting an increase in the total annual time burden from 6 hours in 2018 to 48 hours.

Table 3: Changes to the ALPA Surveys (Attachments 4a and 4b)

Original Question No.	Original Question	Suggested Revision	New Question No.
1	Agree to participate in the assessment	None	1
2	Program Title	None	2
3	City of Program Headquarters	None	3
4	State of Program Headquarters	Switch answer entry from text box to drop box with state abbreviations	4
5	Does your jurisdiction have legislation mandating blood lead	1. Question is for state legislation; add separate question for local legislation in Section 3	5

	screening and/or testing for Medicaid-enrolled children?	2. Replace “other” answer option with “unknown” 3. Combine question with #12 by adding answer options for universal and/or targeted screening 4. Add answer options for select age range covered or all ages covered	
6	Does your jurisdiction have legislation mandating blood lead screening and/or testing for non-Medicaid-enrolled children?	1. Question is for state legislation; add separate question for local legislation in Section 3 2. Replace “other” answer option with “unknown” 3. Combine question with #14 by adding answer options for universal and/or targeted screening 4. Add answer options for select age range covered or all ages covered	6
7	Does your jurisdiction have legislation mandating blood lead screening and/or testing for pregnant women?	1. Question is for state legislation; add separate question for local legislation in Section 3 2. Replace “other” answer option with “unknown” 3. Add answer options for screening only or testing only	7
8	Does your jurisdiction have legislation mandating the existence or operation of a childhood lead poisoning prevention program?	1. Question is for state legislation; add separate question for local legislation in Section 3 2. Replace “other” answer option with “unknown” 3. Add answer options for allowed or not allowed	8
9	Does your jurisdiction have a reporting law for blood lead levels?	1. Question is for state legislation; add separate question for local legislation in Section 3 2. Replace “other” answer option with “unknown” 3. Add answer options for select age range covered or all ages covered 4. Add answer options for specific BLLs	9
10	Does your jurisdiction	1. Question is for state legislation;	10

	have an electronic reporting law for laboratories?	add separate question for local legislation in Section 3 2. Replace “other” answer option with “unknown” 3. Omit specification for laboratories 4. Add answer options for allowed or not allowed	
11	Does your jurisdiction have a lead paint abatement law?	1. Question is for state legislation; add separate question for local legislation in Section 3 2. Replace “other” answer option with “unknown” 3. Add answer options for type of regulation 4. Add answer options for what triggers the law	11
-	-	Add gateway questions and questions 5-11 for local legislation	12 - 20
12	What is your jurisdiction’s mandated blood lead screening and/or testing strategy for Medicaid-enrolled children less than 6 years (72 months) of age?	Question should be combined with #5	-
13	What is your jurisdiction’s practiced blood lead screening and/or testing strategy for Medicaid-enrolled children less than 6 years (72 months) of age?	1. Switch from text box to gateway question 2. Add answer options for how the strategy is practiced differently than the mandate 3. Add answer options for barriers	21
14	What is your jurisdiction’s mandated blood lead screening and/or testing strategy for children less than 6 years (72 months) of age not enrolled in Medicaid?	Question should be combined with #6	-
15	What is your jurisdiction’s practiced blood lead screening and/or testing strategy for children less	1. Switch from text box to gateway question 2. Add answer options for how the strategy is practiced differently	22

	than 6 years (72 months) of age not enrolled in Medicaid?	than the mandate 3. Add additional question for barriers	
-	-	Add questions about primary prevention and targeted interventions	23 - 26
16	Administrative – At what confirmed blood lead level do you initiate the following actions according to your jurisdiction's case definition for elevated blood lead level for children less than 6 years (72 months) of age?	Create table for mandated BLL and practiced BLL	27
17	Assessment and Remediation of Residential Lead Exposure – At what confirmed blood lead level do you initiate the following actions according to your jurisdiction's case definition for elevated blood lead level for children less than 6 years (72 months) of age?	Create table for mandated BLL and practiced BLL	28
18	Medical Assessment and Interventions – At what confirmed blood lead level do you initiate the following actions according to your jurisdiction's case definition for elevated blood lead level for children less than 6 years (72 months) of age?	Create table for mandated BLL and practiced BLL	29
19	Nutritional Assessment and Interventions – At what confirmed blood lead level do you initiate	Create table for mandated BLL and practiced BLL	30

	the following actions according to your jurisdiction's case definition for elevated blood lead level for children less than 6 years (72 months) of age?		
20	Developmental Assessment – At what confirmed blood lead level do you initiate the following actions according to your jurisdiction's case definition for elevated blood lead level for children less than 6 years (72 months) of age?	Create table for mandated BLL and practiced BLL	31
21	Comments	Omit question	-
-	-	Add additional question about actions implemented by local health departments	32-33
-	-	Combine Medicaid funding questions into one question	34

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

The data collection instrument will be fielded to the state and local lead poisoning prevention program project managers in May 2021 and annually through May 2024. The timeline is consistent with other cooperative agreement report timelines. Data collection will take approximately 3 weeks to complete. Data will be cleaned and analyzed by a CDC Health Scientist using Epi Info™ 7. Data will be tabulated by jurisdiction, and posted to CDC's CDC CLPPP website, and distributed in response to inquiries by the public, press, and Congress.

<u>Project Time Schedule per Year after PRA clearance is obtained</u>

- ❑ Conduct annual information collection .....(Response period 4 weeks)
  - o Invitation email sent 30 days before the Awardee Lead Profile Assessment is due
  - o Follow-up email sent 10 days before the Awardee Lead Profile Assessment is due

- ❑ Code, quality control, and analyze data.....(4 weeks)
- ❑ Prepare reports .....(5 weeks)
- ❑ Disseminate results/reports .....(6 weeks)

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

The display of the OMB expiration date is appropriate.

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

There are no exceptions to the certification. These activities comply with the requirements in 5 CFR 1320.9.

References

Jacobs, D. E., Clickner, R. P., Zhou, J. Y., Viet, S. M., Marker, D. A., Rogers, J. W., ... & Friedman, W. (2002). The prevalence of lead-based paint hazards in US housing. *Environmental health perspectives*, *110*(10), A599.

Levin, R., Brown, M. J., Kashtock, M. E., Jacobs, D. E., Whelan, E. A., Rodman, J., ... & Sinks, T. (2008). Lead exposures in US children, 2008: implications for prevention. *Environmental Health Perspectives*, *116*(10), 1285.

Centers for Disease Control and Prevention (CDC). "CDC's Childhood Lead Poisoning Prevention Program." Available at http://www.cdc.gov/nceh/lead/about/program.htm. Accessed on 8/9/15.

National Institute of Environmental Health Sciences (NIEHS). "Lead." Available at http://www.niehs.nih.gov/health/topics/agents/lead/. Accessed on 8/9/15.

Wheeler, W. and Brown, M.J. (2013). Blood lead levels in children aged 1-5 years— United States, 1999-2010. *MMWR Morb. Mortal. Wkly. Rep 62(13)*, 245-248.