State of Minnesota Childhood Lead Poisoning Elimination Plan Update

July 2006

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List of Acronyms

ACOG – American College of Obstetricians and Gynecologists
ALCU – Asbestos/Lead Compliance Unit
BOMA – Building Owners and Managers Association
CBO – Community-based organization
CDBG – Community Development Block Grant
CDC – U.S. Centers for Disease Control and Prevention
CFH – Minnesota Department of Health Community and Family Health Division
CLEARCorps – Minnesota Community Lead Education and Reduction Corps
CLPPP – Childhood Lead Poisoning Prevention Program (CDC grant to MDH)
CPSC – Consumer Products Safety Commission
C&TC – Child and Teen Check-up (Minnesota equivalent of federal EPSDT)
DEED – Minnesota Department of Employment and Economic Development
DHS – Minnesota Department of Human Services
EBLL – Elevated Blood Lead Level (defined by Minnesota statute as > 10 ug/dL)
EIA Unit – Minnesota Department of Health Environmental Impacts Analysis Unit
EPA – U.S. Environmental Protection Agency
GIS – Geographic Information System
GMDCA – Greater Minneapolis Day Care Association
HRA – Housing and Rehabilitation Authority (local housing jurisdiction)
HUD – U.S. Department of Housing and Urban Development
LHR – Lead hazard reduction
LSWP – Lead-safe work practices
MA – Medical Assistance (Minnesota equivalent of Medicaid)
MCDA – Minneapolis Community Development Agency
MDH – Minnesota Department of Health
MHFA – Minnesota Housing Finance Agency
MPCA – Minnesota Pollution Control Agency
MVNA – Minnesota Visiting Nurse Association
NAHRO – National Association of Housing and Redevelopment Officials
NPCA – National Paint and Coatings Association
NRP – Neighborhood Revitalization Program
OSHA – Occupational Safety and Health Agency
PHA – Public Housing Authority
PHN – Public health nurse
RPO – Rental property owner
SRC - Sustainable Resources Center
WIC – Women, Infants and Children (Supplemental Nutrition Programs)

Additional definitions for lead in Minnesota can be found in statute (Minn. Stat. 144.9501) and in the MDH Childhood Blood Lead Case Management Guidelines for Minnesota at www.health.state.mn.us/divs/eh/lead.

The 2010 Childhood Lead Poisoning Elimination Plan Update
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Introduction

Although lead poisoning is preventable and rates are declining in Minnesota, children living in substandard, pre-1950 housing continue to be disproportionately affected by lead. The Minnesota Department of Health (MDH) Childhood Lead Poisoning Prevention Program (CLPPP) developed a plan to eliminate statewide childhood lead poisoning by 2010. This contributes to meeting the national goal established by the U.S. Centers of Disease Control and Prevention (CDC) of eliminating childhood lead poisoning as a public health problem by 2010. The Minnesota Department of Health (MDH), as a recipient of a CLPPP award from CDC, therefore assumed responsibility for developing, implementing and updating the statewide childhood lead poisoning elimination plan.

The initial goals for the planning process were to establish an advisory workgroup to publish and implement a statewide childhood lead poisoning elimination plan. The group also serves to monitor the process of the elimination plan and to leverage resources and enhance cooperative efforts toward this goal. The workgroup includes representation from various stakeholders involved in solving the jurisdiction's lead poisoning problem.

In addition to key staff from the MDH Lead Program, which includes the Environmental Impact Analysis Unit (EIA) and the Asbestos/Lead Compliance Unit (ALCU), the invitees included a diverse and inclusive membership. Particular attention was paid to planning housing-base primary prevention activities. Partners included federal, state, and local government; community based organizations; health care providers; housing, real estate, landlord, and tenant organizations; and other disciplines.

The advisory workgroup reviewed and voted on a vision and mission statement prepared by the MDH. The group also considered and agreed upon a Minnesota definition of childhood lead poisoning "elimination." The mission statement for the workgroup was:

"To provide technical expertise and advisory support to the MDH through the development of a strategic plan to eliminate childhood lead poisoning by 2010."

The vision statement, which serves as the statement of purpose for the workgroup, was:

"To create a lead-safe Minnesota where all children have blood lead levels below 10 ug/dL by the year 2010."

The elimination definition approved by the workgroup was:

"Lead poisoning will be considered eliminated when zero percent of at-risk children who are less than 72 months of age have blood lead levels $\geq$ 10 ug/dL." **

** The definition of elimination is subject to change due to at least three variables:
The definition of who is "at-risk" may change based on 1) changes in trends in elevated blood lead levels determined by ongoing analyses of blood lead surveillance and related data; 2) ongoing childhood lead poisoning prevention activities by governmental and nongovernmental agencies; and 3) changes to federal or state guidelines regarding acceptable levels of childhood blood lead.

This document updates the original plan, which was released in June 2004. The workgroup developed the original plan using five focus areas. Four of these focus areas are the same and one was eliminated and replaced with a new focus area.

Goal	Original Focus Area	Focus Area in Updated Plan
I.	Strategies for Lead Education and Training	Strategies for Lead Education and Training
II.	Strategies for Identifying at-Risk Properties and Children	Strategies for Identifying at-Risk Properties and Children
III.	Strategies to Better Coordinate Health and Housing Enforcement	Strategies to Better Incorporate Lead Paint Assessment and Control into Housing Activities and Infrastructure
IV.	Strategies to Identify Resources to Increase the Supply of Lead-Safe Housing in Minnesota	Strategies to Identify Resources to Increase the Supply of Lead-Safe Housing in Minnesota
V.	Strategies to Increase the Availability of Lead Liability Insurance for Contractors and Single- and Multi-Family Property Owners	Strategies to Respond to Emerging Issues, such as New Research, Legislation, Trends, Population Conditions and Other Developments

Plan Evaluation and Modifications

The outcomes presented in the work plan will be used as benchmarks for conducting ongoing evaluation of the elimination plan and developing new objectives and tasks. During the first and second years of the implementation phase, partners established key priorities based on the complete set of tasks in the plan.

An advisory group has been maintained to review plan progress and discuss any needed modifications to reach stated goals and objectives. The MDH currently convenes the Minnesota Collaborative Lead Education and Assessment Network (MCLEAN) twice a year (generally in April and October) for this purpose. Most members of the original workgroup regularly attend MCLEAN meetings. An overview of progress on the plan is a standard agenda item at all MCLEAN meetings, as is information about successful strategies and barriers to progress. An annual update on progress towards goals and objectives is prepared and posted each year on the MDH Lead Program Web site at www.health.state.mn.us/divs/eh/lead.

The plan will be formally updated every other year. In 2006, subgroups recruited from the MCLEAN membership met to discuss possible revisions to the work plan. Meetings in January and May focused on four of the five original goals. The consensus among subgroups was to eliminate goal five from the plan. However, the subgroups agreed to a new goal five, which is "Developing emerging strategies based upon new research, legislation, trends, population conditions and other developments." Each subgroup had

the opportunity to review the work plan modifications, as did the MCLEAN membership as a whole.

An essential aspect of meeting goals and objectives related to eliminating childhood lead poisoning will be retaining current grants and funding sources, with special emphasis on HUD Lead Hazard Reduction programs. Minnesota currently has federal HUD lead hazard reduction or other awards to Minneapolis, Hennepin County, St. Paul-Ramsey County (this grant includes work in Duluth/St. Louis County), and to the Minnesota Department of Employment and Economic Development. When funding barriers are identified for various aspects of the plan, available resources will be examined at the local, state, and federal level. In addition to ensuring sufficient funding to undertake primary prevention activities and core functions of the Lead Program, the plan also must look to develop sustainable funding resources in the future.

The evaluation of 2010 Plan implementation will be reported to the legislature as part of the regular biennial MDH report (stipulated by Minn. Stat. 144.9509) on the Lead Program. This report is posted in several formats on the MDH Web site. It is next due in January 2007.

All of the above documents will be used, in conjunction with current surveillance, census, health plan, and other demographic data, as information sources for ongoing evaluation and amendment of the plan. As adjustments are necessary, they will be presented at the MCLEAN quarterly meetings for discussion and approval. Upon reaching consensus, changes will be made to the plan. All changes to the plan will be noted on the MDH Web site and reported to CDC via semi-annual reporting as part of the CLPPP's responsibilities.

Acknowledgements

This plan was the result of the hard work and dedication of the original workgroup and the subgroups, whose attention to detail and willingness to examine the complex and diverse issues underlying childhood lead poisoning has led to a comprehensive approach to eliminate lead as a pediatric health threat in Minnesota. Although designed as an inclusive plan that crosses many administrative boundaries, the planning effort and writing was primarily conducted by MDH using support from the CDC Childhood Lead Poisoning Prevention Cooperative Agreement US7/CCU522841-03.

Background on Minnesota's Lead Poisoning Problem

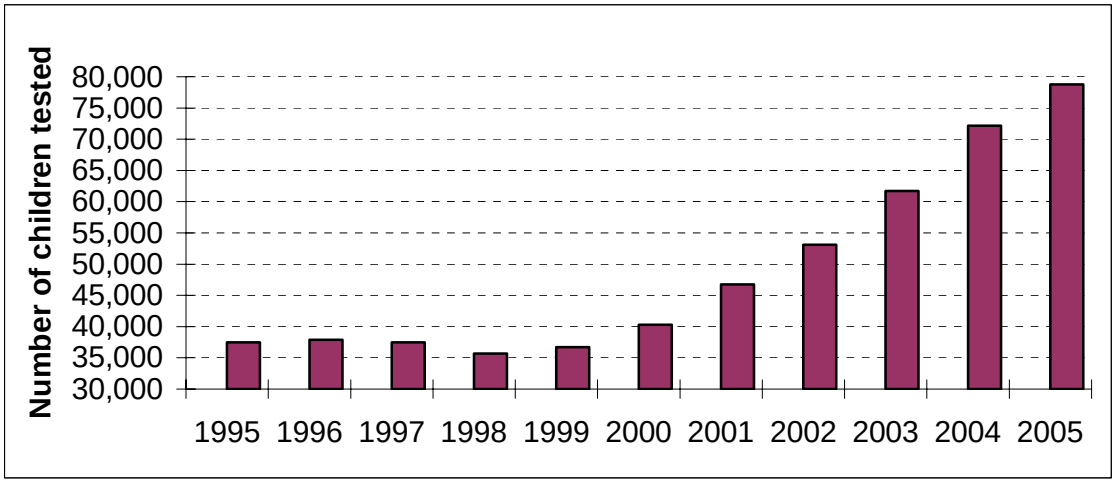
The State of Minnesota has consistently played a leading role in identifying and addressing public health issues related to lead exposure. Partners in lead poisoning prevention across Minnesota plan to maintain that leadership role and protect the citizens of Minnesota from the potentially devastating effects of exposure to high levels of lead.

The Minnesota Department of Health (MDH) is the lead state agency for childhood lead poisoning prevention efforts statewide. Lead poisoning prevention activities at MDH are housed within the Division of Environmental Health. The Environmental Impacts Analysis (EIA) Unit is responsible for lead-related surveillance activities and implements the CLPPP. The Asbestos/Lead Compliance (ALC) Unit is responsible for assuring compliance with state rules and statutes dealing with lead hazards. Other state agencies dealing with lead include the Pollution Control Agency, Agriculture, Occupational Safety and Health Administration, Labor and Industry, Natural Resources, Housing Finance Agency, Commerce and Employment and Economic Development. At the local level, cities of the first class and counties/local public health agencies have a wide variety of duties with respect to lead risk assessment and case management. Nongovernmental advocacy organizations, such as the Sustainable Resources Center (which houses CLEARCorps for Minnesota) and Project 504, also perform essential tasks regarding education, training, and primary prevention pilot projects and assessments.

The MDH collects blood lead reports on all Minnesota residents, both children and adults. State guidelines on screening, case management, clinical treatment and pregnancy help standardize practices and raise awareness of high-risk populations.

Figure 1 illustrates the trend in the number of children tested in past years and gives some indication of how screening practices have improved. Only data for children less than six years old are presented.

Figure 1: Number of children with blood lead tests reported to MDH from 1995 – 2005. Results include all test types (venous, capillary, unknown).



The dramatic increase in blood lead screening in Minnesota is the result of the combined efforts of local, state and federal government and private organizations recognizing the importance of testing children at high risk for lead poisoning and implementing innovative strategies to provide those services to an increasingly diverse and mobile population.

At the state level, the MDH Blood Lead Screening Guidelines for Minnesota were issued in 2000 and have been updated, distributed and promoted among health care providers statewide. In addition, the MDH produces annual reports on blood lead testing, breaking information down by county to provide local partners with data about their jurisdictions. The MDH also enforces lead regulations, trains and certifies lead professionals, and collaborates with the Department of Employment and Economic Development on U.S. Department of Housing and Urban Development (HUD) lead hazard control grants. The Minnesota Department of Human Services (DHS) established targets and financial incentives for health plans to perform complete Child and Teen Checkups, of which blood lead testing is a vital component, on children receiving Medical Assistance.

Other screening efforts have included targeted projects in Minneapolis, St. Paul-Ramsey County, Hennepin County, rural counties in west-central Minnesota, WIC clinics in high-risk counties, and specific screening projects for refugees and immigrants. As shown in Figure 2, the number of confirmed elevated blood lead levels reported to MDH has been gradually declining over time, consistent with national trends.

Figure 2: Number of elevated venous blood lead tests reported to MDH from 1995 – 2005. This is not the same as the number of children tested (some have multiple tests).

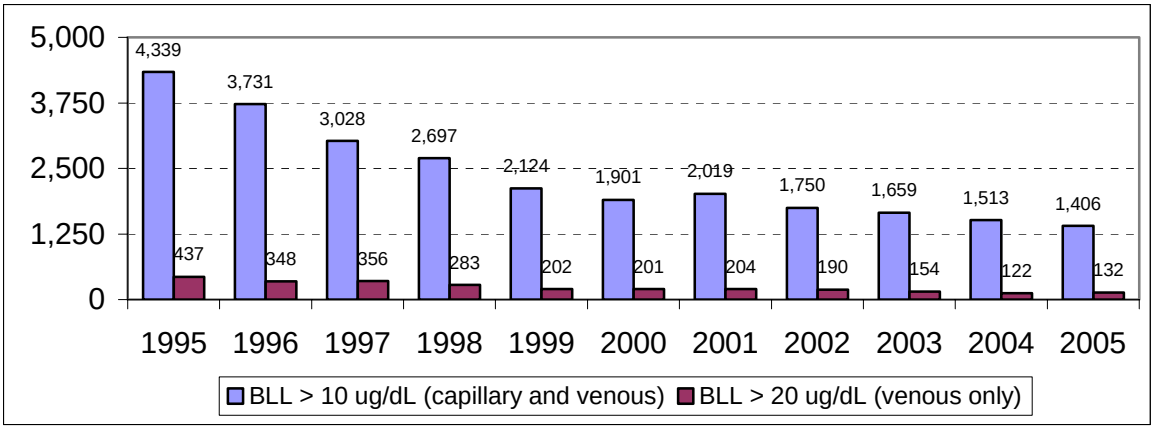


Table 1 presents the distribution of blood lead tests reported to MDH in 2005 based on concentration. The data show that 1,406 of the 78,761 children with reported tests (1.8 percent) were considered to be elevated, which is defined by Minnesota statute as greater than 10 ug/dL. The confirmed venous elevated blood lead test rate for Minnesota for 2005 was 0.8 percent.

Table 1: Distribution of Blood Lead Levels in Minnesota Children in 2005. Data are number of children in a given range. If a child had multiple tests, the highest venous level was chosen, followed by the highest capillary level if no venous test was performed.

Blood Lead Level (ug/dL)	< 5	5-9	10-14	15-19	20+	Total
Venous	12,680	1,573	363	127	132	14,875
Capillary/Unknown	56,207	6,895	566	117	101	63,886
Total	68,887	8,468	929	244	233	78,761

Compliance monitoring ensures that lead hazard reduction is completed consistent with state statutes and best public health practices. This involves working with assessing agencies and licensed lead workers to address exposure issues (e.g. lead paint removal, window replacement). Training is provided, inspections performed, and assessments audited as needed to ensure that public health concerns are addressed. Health education is performed within the lead programs using well-established information sources (such as a routinely updated Web site) and targeted outreach opportunities.

The complete list of assessing agencies in Minnesota is presented in Table 2 below. These are the governmental agencies with authority to conduct enforceable lead risk assessments on elevated blood lead cases. Many of these groups, along with nonprofit, private, and other organizations, also conduct advisory risk assessments across the state for concerned households on a voluntary basis, regardless of blood lead level.

Table 2: Assessing Agencies in Minnesota

MDH (82 Counties)	City of Bloomington	Dakota County
City of Minneapolis	St. Paul-Ramsey County	St. Louis County
City of Richfield	Hennepin County	Stearns County

Lead programs across Minnesota are required to devise unique and innovative approaches to institutional and scientific problems. These include forming cooperative workgroups to solicit input prior to generating guidelines, cooperating with other agencies to meet common goals, conducting research to address information gaps, and overseeing lead hazard reduction efforts to ensure complete and timely resolution of lead orders. Diverse populations are targeted to help address public health disparities. This spirit of creativity and risk-taking is fostered, resulting in programs that are flexible, responsive, and well grounded in the core public health functions of assessment, assurance, and policy/planning.

Assessment of Minnesota Lead Risks

The MDH maintains an extensive blood lead surveillance system for the purpose of monitoring trends in blood lead levels in adults and children in Minnesota. There are 757,528 tests in the system as of January 1, 2006. Of these tests, 646,428 were for kids under the age of six, and they were from 443,834 individual children. The data go back to 1995 and are used to help identify populations at risk for elevated blood lead levels, ensure that screening services are provided to groups with the highest risk of lead poisoning, and provide environmental and medical follow-up to children with elevated blood lead levels.

Work in Minnesota and nationally has shown that an estimate of lead risks may be performed based on two risk factors: living in an old home and being enrolled in Medicaid (e.g. MNCare). The data shown in Table 3 below are taken from the 2000 Census and DHS Medicaid/MNCare enrollment figures for 2001. These figures do not take into account homes that have already been made lead-safe and assume that the proportion of children is constant across different ages of homes. Children were defined as individuals less than 72 months of age. The number of children is based on a five-year period, assuming approximately 67,000 children per year group.

Table 3: Housing and population characteristics for Minnesota lead risk factors

	Built <1950	**Built <1960**	**All Homes**
# Housing Units in year 2000	560,322 (27%)	810,152 (39%)	2,065,946
# Children in Minnesota < 72 mo. (5 yr. period)	180,000	330,000	660,000
# Enrolled in MA/MNCare (5 yr. period)	44,000	63,000	160,000

The following responses to an elevated blood lead report are currently presented in Minnesota Statute (MS 144.9504) and the MDH Childhood Blood Lead Case Management Guidelines for Minnesota (updated in 2006):

- ✓ If levels are less than 10 µg/dL, information is entered into the surveillance database, and no additional follow-up is recommended (although partners offer education and followup).
- ✓ If levels of children are 10 µg/dL or greater, follow-up or confirmation testing and educational intervention is called for. This includes giving the children's parents or guardian a letter, bringing in the child for follow-up or confirmation testing, and providing information on how to reduce and/or avoid exposure to lead in the environment.
- ✓ If levels in a pregnant woman are 10 ug/dL or greater or are 15 µg/dL or greater for children, environmental follow-up is required. This includes a

housing risk assessment and may also include an education visit from a public health nurse, enforcement orders, lead hazard reduction or remediation, and clearance testing.

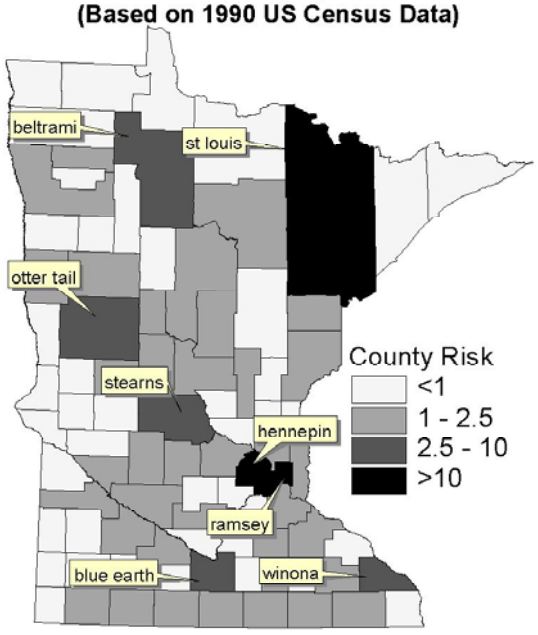
- ✓ Levels of 60 µg/dL or greater indicate a medical emergency, and immediate action is taken.

Although Minnesota has mandatory reporting from all facilities analyzing blood lead levels, blood lead testing is not universal, and the data collected by the surveillance system are not representative of all Minnesota children. Data are collected only when a health care provider orders a blood lead test or a child is screened in the community by request of the parent or guardian. The percentage of children tested varies greatly from county to county and from year to year.

Based on 2005 data, 27 percent of the children in the Minnesota blood lead surveillance database reside in large cities even though these cities contain only 15 percent of the state population. Therefore, the database contains fairly reliable information on the prevalence of lead poisoning in urban areas of Minnesota. Evidence shows, however, that some populations statewide are clearly at risk. For example, it is estimated that 70 percent of the Medicaid-eligible population in Minnesota did not receive a blood lead test in 2004. Although ongoing data matching shows that this trend is improving, it remains well short of the goal of 100 percent screening in Medicaid populations. In addition, a study conducted in a representative rural area of Minnesota showed lead poisoning rates of 2.1 percent at or above 10 ug/dL and 0.7 percent at or above 20 ug/dL, which is slightly below the rate reported to the MDH surveillance system but relatively consistent with national prevalence estimates.

Statewide Lead Poisoning Risk Estimates

Figure 3: Minnesota Relative Lead Risk by County (Based on 1990 US Census Data)



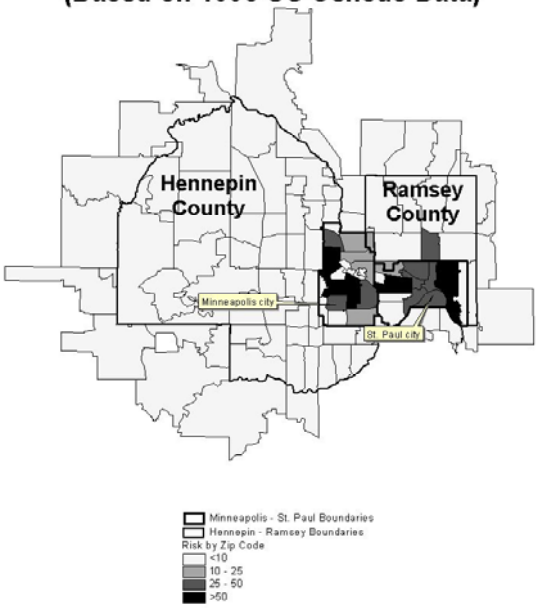
The most important factors related to lead poisoning risk in Minnesota are the percentage of children in poverty and the percentage of homes built before 1950. Both of these characteristics were used, in conjunction with the population of children under six, to estimate the population-adjusted lead poisoning risk for individual geographic areas. For each geographic area the "County Risk" equals the number of children less than six years of age multiplied by the fraction of children in poverty multiplied by the fraction of homes that were built prior to 1950. The resulting number is NOT the expected number of EBLLs or percentage of EBLLs. It is simply a population-adjusted factor for comparing lead risk between counties or zip codes. Using the statewide county-level risk estimation, three counties have the greatest potential for lead poisoning (Figure 3). Of these, two counties contain the largest

cities in Minnesota, Minneapolis (Hennepin) and St. Paul (Ramsey). Current state screening guidelines recommend screening of all children in Minneapolis and St. Paul at one and two years old. The other county at highest risk is St. Louis County, which contains the second largest urban area in Minnesota, the city of Duluth. Five counties are in the moderate category of lead poisoning risk (Beltrami, Otter Tail, Stearns, Blue Earth, and Winona). The remaining counties in Minnesota are at lower risk for significant numbers of lead-poisoned children.

Even within urban counties, most elevated blood lead tests are identified in Minneapolis and St. Paul. In 2005, 95 percent of the children with blood lead levels > 10 µg/dL, and 97 percent of the children with blood lead levels > 20 µg/dL in Ramsey county lived in St. Paul, and 84 percent of the children with blood lead levels > 10 µg/dl and 87 percent of the children with blood lead levels > 20 µg/dl in Hennepin county lived in Minneapolis.

Lead poisoning risk data by zip code for St. Paul and Minneapolis are presented in Figure 4. These city-specific data have been used to determine the most at-risk areas for lead poisoning. Both Minneapolis and St. Paul are classified as "cities of the first class" and are therefore designated as assessing agencies by Minnesota Statute and are responsible for lead risk assessment and case management. Local data show that positive tests in Minneapolis tend to concentrate in the Near North and Phillips Communities. Near North is one of the poorest in the City, has the greatest number of subsidized housing units, and is home to the highest ratio of Minneapolis' children under age six. Most families are below the 80 percent poverty level, and are eligible for Medicaid programs. Nearly 90 percent of the housing stock in the Near North Community was built prior to 1950, 52 percent are rental units, and 34 percent of housing is classified as "Below Average."

Figure 4: Mpls./St. Paul Relative Lead Risk by Zip Code (Based on 1990 US Census Data)



The City of St. Paul is divided into more than 80 individual census tracts. During the past five years, one or more children residing in 56 of these census tracts have been identified as having an elevated blood lead level. Of these 56 census tracts, a single census tract has nearly twice as many elevated blood lead cases as the other 55. The age and condition of housing within this target area is very consistent. Nearly 90 percent of the homes were built prior to 1940. Local data indicates that 95 percent of these homes contain lead based paint and 84 percent have deteriorated lead-based paint. Most have deteriorated paint on window components, the major source of lead exposure. This census tract is very near a major interstate. It has high levels of lead in the soil and many deteriorated houses throughout its neighborhoods.

The Updated Plan for Elimination of Childhood Lead Poisoning by 2010

The broad goals of the updated 2010 Plan to eliminate childhood lead poisoning includes:

I. Developing strategies for lead education and training.
II. Developing strategies for identifying at-risk properties and children.
III. Developing strategies to better incorporate lead paint assessment and control into housing activities and infrastructure.
IV. Developing strategies to identify resources to increase the supply of lead-safe housing.
V. Emerging strategies based upon new research, legislation, trends, population conditions and other developments.

Each of these goals, along with specific objectives, tasks and measures are presented in the grid below. The Plan strongly advocates a collaborative, housing-based approach to primary prevention of childhood lead exposure, while still incorporating ongoing programs that are based on secondary prevention models. This is consistent with the federal elimination strategy to act before children are poisoned (primary prevention), intervene early when children have blood levels less than 10 ug/dL but rising (primary prevention), care for lead-poisoned children (secondary prevention), conduct research, and measure progress to refine lead-poisoning prevention strategies.

The updated plan differs from the original plan in several respects:

- The subgroups requested that tasks outlined in the updated plan be categorized to indicate their priority or status. Four categories were used for tasks: ongoing, in planning or implementation, scheduled for later fiscal years, or successful in one jurisdiction, extend to other jurisdictions. This eliminated the "current" versus "new" task designations in the original plan.
- The subgroups requested that the term "sponsor agency" previously used to indicate an organization's responsibility for implementation, to "responsibility to implement."
- Specified funding for each task has been eliminated, since sources of financial support for childhood lead poisoning prevention activities can be fluid.
- The "intended outcome" column has been replaced with "measure," to reflect measurable outcomes related to the specific tasks. These measures will need to be evaluated in subsequent plan updates to ensure that they are realistic and achievable.
- While specific measures include projected dates of completion or landmarks, the work plan does not outline on which year the task will be completed in many cases. The subgroups, consisting of organizations dealing with reorganized services, staff changes, budgets and priorities, advised only that the tasks considered most important to the mission be considered top priority.
- The subgroups reported several places in the plan where tasks were redundant and requested consolidation of many items.
- Goal III was broadened to include efforts to incorporate lead poisoning prevention into infrastructure to make for sustainable progress. Goal III is "Strategies to Better

Incorporate Lead Paint Assessment and Control into Housing Activities and Infrastructure."

- Goal V, "Strategies to Assess the Availability of Lead Liability Insurance for Single-Family Property Owners, RPOs and Contractors," was eliminated. Pending federal regulations will to some degree reduce the necessity of such insurance. In addition, the subgroups agreed that this goal was too narrowly focused, in comparison to the others.
- An additional goal was added to encompass emerging research and information, as well as new legislative requests, population shifts, trends in surveillance data, and non-housing sources of lead that are not addressed elsewhere in the plan. Because of a lead fatality in Minnesota related to a lead-containing consumer product and the interest such products have generated publicly, developing a better method of dealing with imported lead-containing products was a priority for the subgroup.
- Annual reporting on 2010 Plan progress should include a list of those tasks that have been completed.

The role of the organization(s) listed under "responsibility to implement" is to develop models by completing new or ongoing projects that achieve the measurable outcomes or to organize collaborating agencies to examine the issue and implement reasonable approaches. If a task involves a statewide aspect or requires transfer of successful approaches to other jurisdictions, generally a state agency is listed as one of those organizations responsible to implement.

This updated plan includes several elements recommended by the CDC in its review of the initial 2010 Plan:

- CDC recommended that the members of the task force and implementation group, all of whom are represented in MCLEAN, include medical providers, real estate interests, banking interests, community members from high-risk areas and parents of lead-poisoned children. MCLEAN members include all of the major health plans (Medica, HealthPartners, Metropolitan Health Plan, UCare Minnesota, Blue Cross/Blue Shield); real estate interests (Minnesota Multi-Housing Association, Minnesota Association of Realtors); and community members from high-risk areas (Rep. Keith Ellison, D-Minneapolis). Representatives from the banking industry have been invited, but were not interested in participating in the 2010 planning. An element of the plan (Goal 5, Obj. E6) deals with assessing interest among parents of lead-poisoned children in planning 2010 strategies.
- CDC recommended that the plan contain prioritization of primary prevention efforts on properties with multiple EBLLs (Goal 2, Obj. C11), objectives for increased blood lead testing of children on Medical Assistance (Goals 2, Obj. A2, B1), and reimbursement by Medicaid of environmental case management (Goal 4, Obj. C2).
- CDC recommended targeting efforts in high-risk areas, and several plan elements focus on the highest risk communities and populations.
- Measures are included for all plan objectives and tasks.

The final draft updated *2010 Childhood Lead Poisoning Elimination Plan* was placed on the MDH Web site for comment by stakeholders in early June. It will be distributed to partners electronically and will be placed on the MDH Web site for download after comments have been incorporated.

Comments

The following issues were raised by comments received on the updated 2010 Plan:

Comment: Emphasis should be on pre-1978 housing without regard to the income or financial status of the child.
Response: Children of any economic status living in older housing with lead paint are at risk of childhood lead poisoning. However, children living in poverty can have additional risk factors, such as housing in deteriorating condition, inadequate nutrition or insufficient health care coverage. In addition, federal law requires blood lead screening for children on Medicaid.

Comment: Table I does not necessarily reflect the true number of EBLLs, since elevated capillary tests often are found to be less than 10 ug/dL on venous confirmation testing.
Response: The commenter is correct in observing that many capillary EBLLs are likely on venous confirmation testing to be less than 10 ug/dL. Table I is a snapshot in time using the data available.

Comment: More attention should be paid to two groups of children coming in from outside the United States, adopted children and immigrant children.
Response: Based upon the existing Blood Lead Screening Guidelines, children adopted from other countries should already be tested during routine intake screening as they enter the U.S. or during well-child visits scheduled by their adoptive families. Reaching immigrant children is much more difficult. Goal II, Obj. B, Task 6 does address that high-risk population, as does Goal V, Obj. E, Tasks 2, 3, 4 and 5.

Comment: Table III is confusing and the numbers in the final row that reflect children in older housing or on MA are inaccurate.
Response: The final row of the table has been removed from the updated 2010 Plan.

Comment: While children and pregnant women should be the focus of the 2010 Plan, adult chronic lead exposures and lead's role as a probable cancer-causing agent should be reflected in the Plan as reasons for lead-safe work practices.
Response: The updated 2010 Plan contains strategies to prevent "take home" lead from affecting children whose parents work with lead.

Comment: While cities of the first class have higher at-risk populations for childhood lead poisoning, communities in Greater Minnesota do not have housing inspection or code enforcement to monitor the housing stock. Initiatives to prevent lead poisoning are important in Greater Minnesota, where housing stock is old and in deteriorating condition.

Response: The updated 2010 Plan requires the routine examination of risk factors and re-examining the blood lead screening guidelines. Those guidelines apply equally to rural and urban children, and a child living in Greater Minnesota who is on MA, living in pre-1978 housing, or recently immigrated to the U.S. should be tested. The Plan also includes a Lead-Safe Cities Project, involving intensive work with pilot communities to develop housing ordinances and capacities to find and deal with lead paint deterioration.

Comment: More attention should be paid to dust from vinyl products exposed to UV rays, which have been tested at 800-1,700 mcg/sq. ft. We should not be installing a new lead hazard.
Response: This information will be evaluated by the Principal Investigator and added to the next update of the 2010 Plan, if warranted.

Comment: The EPA R&R rule, as written, would not accomplish lead hazard reduction in many at-risk housing units, nor does it provide assurance that a property is lead safe.
Response: The MDH and City of Minneapolis-Hennepin County Joint Lead Task Force commented upon these aspects of the plan.

The MDH would like to thank all the partners who volunteered for the subgroups and met to debate different methods for ending childhood lead poisoning in Minnesota. With their continued leadership in protecting the health and housing of the state's children, these partners ensure that the plan is statewide, inclusive and successful in achieving the elimination of a serious public health threat.

Ongoing	**In Planning or Implementation**	**Scheduled for Later Fiscal Years**	**Successful in One Jurisdiction, Extend to Other Jurisdictions**

2010 Childhood Lead Poisoning Elimination Plan for Minnesota
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Goal I.
Strategies for Lead Education and Training.

Objective A.
Increase awareness of and compliance with the Federal Pre-renovation Disclosure Law 406(b) and 1018 Disclosure Law among targeted audiences and the general public.

Tasks	Responsibility to Implement	Measure
1. Provide information on 406(b) and 1018 (in the form of "Protect Your Family from Lead in Your Home" EPA/CPSC/HUD brochures) with all building permits, rental licenses and paint inspection orders that pertain to pre-1978 properties.	MDH Lead Program and City Housing and Inspection Departments	Ten percent of Metro cities with populations greater than 30,000 will routinely provide 406(b) and 1018 information with city documents by July 2007.
2. Provide information on 406(b) and 1018 at all events and exhibits attended by the general public.	MDH Lead Program and **ALL PARTNERS**	All partners will provide the EPA/CPSC/HUD brochures at all education, training and outreach venues by December 2006.
3. Provide information on 406(b) and 1018 in homestead application materials that reach all Minnesota property owners.	MDH Lead Program and County Tax Assessors	Survey counties by June 2007 to determine the feasibility of providing disclosure information in homestead applications.

Tasks	Responsibility to Implement	Measure
4. Provide information packets on 406(b) and 1018 to housing rehabilitation agencies, community action programs and neighborhood housing groups, to include camera-ready copies of the EPA/CPSC/HUD pamphlet, "Protect Your Family from Lead in Your Home" and instructions on how to download from the Web site.	MDH Lead Program working with housing organizations.	Complete information mailing by March 2007.
5. Provide training on 406(b) and 1018 through building associations and other professional contractor groups.	MDH Lead Program, working with Building Owners and Managers Association, contractor groups	Assess feasibility of linking information on 406(b) and 1018 on organizations' Web sites by June 2007.
6. Provide one-hour lead refresher workshops including 406(b) and 1018 information for the Department of Commerce (approximately 10/year).	MDH Lead Compliance, Dept. of Commerce	Provide workshops weekly or every other week between January and March each year.
7. Conduct 406(b) and 1018 training through the Sustainable Resources Center and by subsidizing private training contractors to perform training.	MDH Lead Program, SRC	SRC and private training contractors will offer eight-hour training for rehab and renovation contractors and CLEARCorps staff at least six times each year.
8. Provide one-on-one education to at-risk families regarding 1018 disclosure requirements and options for noncompliance or retaliation through the Tenant Remedies Act, Minn. Stat. 504(b).	Project 504	At-risk families will be aware of their legal rights and options when renting properties with potential lead hazards.
9. Distribute EPA/CPSC/HUD brochure to property owners and real estate professionals to increase awareness of and compliance with 1018 requirements.	MDH Lead Program, NAHRO, real-estate professional groups	Assess feasibility of linking information on 1018 to organizations' Web sites by June 2008.

Tasks	Responsibility to Implement	Measure
10.Develop or distribute a video that includes 406(b) and 1018 information to rental property owners.	MDH Lead Program, HRAs (for Section 8), working with NAHRO and Minnesota Multi-Housing Association	Assess existing videos for rental property owners and develop a plan for reproduction/distribution by June 2007.
11.Provide community and housing education programs for first-time homeowners with information about 406(b) and 1018 and/or the EPA/CPSC/HUD brochure.	MDH Lead Program, community education programs statewide	New home buyers attending community education and other "first home" events will receive information on lead by June 2009.
12.Disseminate lead disclosure and lead-safe work practices information during "Truth in Housing" inspections on all pre-1978 properties.	Public and private housing inspectors	Lead information will be routinely provided by 90 percent of housing inspectors by June 2010.
Objective B. **Ensure that health care providers statewide know and follow current guidelines on blood lead screening, medical case management and treatment.**		
1. Review, update and disseminate state guidelines for blood lead screening (children and pregnant women), case management and treatment.	MDH CLPPP and consulting health provider partners	Guidelines will be reviewed and updated regularly and placed on the MDH Web site for use by partners.
2. Target education and training on blood lead testing and case management to specific clinics in high-risk geographic areas (i.e., Minneapolis and St. Paul) in which testing rates are low.	MDH CLPPP, Health Plans, DHS, SRC	Identify clinics in which testing rates are low by January 2007. Work with clinic managers to provide education and training on blood lead screening and case management by January 2008. Work with clinic managers in rural higher risk counties by January 2009.

Tasks	Responsibility to Implement	Measure
3. Educate physicians in high-risk counties about blood lead screening requirements for at-risk children.	MDH CLPPP, County Health Departments	Mail physicians practicing in high-risk counties the current set of blood lead screening, case management and treatment guidelines by June 2007.
4. Develop anticipatory guidance for childhood blood lead levels below 10 ug/dL.	MDH CLPPP, consulting health provider partners	Guidelines will be issued in June 2007.
5. Provide annual surveillance reports to health care providers to ensure that data trends, new information and analysis are available to them.	MDH CLPPP	Surveillance reports are issued, posted on the MDH Web site in June of each year.
6. Ensure that health providers can consult with an experienced case manager on specific patients or problems.	MDH CLPPP	State Case Monitor is available to assist local public health agencies and health providers on an ongoing basis.
Objective C. **Train property owners and contractors in lead-safe maintenance and work practices.**		
1. Promote lead-safe work practices training offered by the National Paint Coatings Association and other licensed trainers to property owners (including Section 8) and contractors.	NPCA, MDH Lead Compliance, County Health and Housing Departments, MHFA, others	The NPCA will conduct at least two trainings annually through 2011.
2. Continue to approve training courses and license/certify lead professionals.	MDH Lead Compliance	All requirements for an EPA-delegated program will be met.
3. Conduct quarterly lead-safe work practices training for rehab contractors/workers.	St. Paul/Ramsey County Public Health and Duluth Housing Rehab Authority	Rehab workers will be able to attend lead-safe work practices within a short timeframe.

Tasks	Responsibility to Implement	Measure
4. Develop lead-safe training or education presentations or tools for the "do-it-yourselfer" audience through hardware stores and other events.	MDH Lead Program, SRC, Local Housing Authorities	One major hardware chain will agree to partner on a lead education presentation by January 2007.
Objective D. **Increase the supply of licensed and certified lead professionals, including lead sampling technicians.**		
1. Provide six worker, supervisor, and sampling technician trainings over 42 months.	MDH Lead Compliance/DEED	Six trainings will be completed by March 2007.
2. Contract with licensed training firms to offer subsidized training to encourage remodelers, housing inspectors, and others to become lead professionals.	SRC/Hennepin County Housing	SRC and Hennepin County Housing have contracted with licensed firms to offer training.
3. Train at least four minority/small business contractors in lead-safe work practices and provide on-the-job training in 30 units.	St. Paul – Ramsey County Public Health	Four contractors will have certified lead supervisors and 30 houses will be completed by June 2007.
4. Conduct semi-annual lead sampling technician training for certified home inspectors and truth-in-sale housing evaluators.	St. Paul/Ramsey County Public Health	At least 30 home inspectors and truth-in-housing evaluators will become lead sampling technicians annually.
5. Support lead supervisor and lead sampling technician training statewide.	MDH Lead Program, local housing agencies, local public health departments	Each county will have at least one lead sampling technician available to do clearance testing by June 2009.

Tasks	Responsibility to Implement	Measure
Objective E. **Provide messages to the general public that make the connection between childhood lead poisoning and lead paint in pre-1978 housing.**		
1. Conduct survey research with the University of Minnesota Statewide Survey to determine whether Minnesotans understand the connection between lead poisoning and housing.	MDH CLPPP	Survey results will be available by January 2009.
2. Develop a statewide public information campaign on primary prevention of childhood lead poisoning.	MCLEAN partners	Campaign messages, materials will be ready for roll-out in January 2009, with assessment of results in January 2010.
3. Adapt or develop educational materials that provide the basic message about primary prevention and are translated into multiple languages.	MDH Lead Program, partners	ECHO broadcast/CD will be completed by December 2006. Other basic brochures on general lead issues, pregnancy will be translated by December 2006.
4. Maintain and enhance a comprehensive lead information Web site with material for both the general and professional audience.	MDH Lead Program	The MDH Lead Program Web site will be updated at least monthly with new and updated information.
5. Provide statewide, bicultural education on lead poisoning prevention and housing issues, along with cleaning services and instruction, to families with blood lead levels both above and below the 15 ug/dL intervention level.	SRC	Families statewide can access lead poisoning prevention education in English and Spanish by June 2006. Families will have access to cleaning and instruction services, even if children's BLL is below the intervention level.

Completed | In Planning or Implementation | Scheduled for Later Fiscal Years | Successful in One Jurisdiction, Extend to Others

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Goal II.
Strategies for Identifying At-Risk Properties and Children

Objective A.
Continue to maintain and improve the statewide blood lead surveillance system.

Tasks	Responsibility to Implement	Measure
1. Complete formal evaluation of surveillance system annually.	MDH CLPPP	Using the CDC's "Guidelines for Evaluating Surveillance Systems," the CLPPP will evaluate annually.
2. Complete data matching between blood lead information system (BLIS) and Medical Assistance data from the Minnesota Department of Human Services (DHS) annually.	MDH CLPPP, DHS	The data match will be completed annually, showing an increase of at least 10 percent per year in the rate of testing among Medicaid eligible children.
3. Develop data sharing agreements with health plans to help identify gaps in blood lead screening or testing.	MDH CLPPP, Health Plans	Develop data-sharing agreements with all health plans by June 2008.
4. Evaluate use of the CDC's Lead Program Area Module when it is released as a replacement for the BLIS system.	MDH CLPPP	The MDH will decide on conversion to the Lead PAM by January 2007.
5. Develop the capacity to geo-code blood lead surveillance data for use of local public health departments.	MDH CLPPP	Geo-coding will be available for Minnesota blood lead data by June 2008.

Tasks	Responsibility to Implement	Measure
6. Conduct data matching between the BLIS data and Hennepin County Lead Program to help ensure data accuracy and quality.	MDH CLPPP, Hennepin County Lead Program	Conduct data matching on an ad hoc basis.
7. Work with MDH NEDSS staff to achieve the goal of 100 percent electronic data reporting, ensuring that all results (including those less than 10 ug/dL) are provided in a timely manner.	MDH CLPPP, NEDSS, Labs	Electronic reporting from one of the two outstanding labs will be available by June 2006. Greater than 95% of reporting will be done electronically by June 2008.
8. Make blood lead surveillance data available to local public health departments via the Internet, if data privacy and security concerns can be adequately addressed.	MDH CLPPP, Legislators, EH Division Management	Internet access of blood lead data will be available to local public health departments by June 2009.
9. Ensure that medical case managers have access to environmental investigation data to best work with children and families.	MDH Lead Program, Medical Case Managers, Environmental Assessment Agencies	All medical case managers will have access to housing data pertaining to their cases by June 2007.
10.Improve annual surveillance report with GIS and blood lead results from 5-9 ug/dL.	MDH CLPPP	The state's annual surveillance report includes blood lead results of 5-9 ug/dL. GIS data will be integrated into the surveillance system by June 2008.
11.Review professional literature to identify new risk factors for childhood lead poisoning and relay this information to partners.	All partners	Partners will relay information about new or emerging risk factors for childhood lead poisoning via the MCLEAN e-list and other formal and informal methods.
12.Mail compliance reports to all labs reporting blood lead analysis to the MDH.	MDH CLPPP	Compliance reports will be mailed to all reporting labs annually.
13.Mail annual letter to clinics including results of blood lead and MA data matching to remind clinics to screen one and two year old MA patients.	MDH CLPPP	Letters to clinics will be provided annually.

Objective B.
Promote blood lead screening for at-risk children and pregnant women and increase compliance with existing screening, case management, treatment and pregnancy guidelines.

Tasks	Responsibility to Implement	Measure
1. Promote blood lead screening of Medicaid/MA eligible children through the statewide immunization registry.	MDH CLPPP, MDH Immunization Registry	A pop-up reminder to health care providers will flag Medicaid/MA eligible children for blood lead testing by June 2006.
2. Continue DHS targets and incentive pay to health providers for complete Child and Teen Checkups (including blood lead screening) on Medicaid/MA eligible children.	DHS, C&TC, Health Plans	DHS will increase screening targets included in contract with health providers each year.
3. Evaluate pilot projects to incorporate blood lead testing on children in WIC clinics and make recommendations about incorporating lead screening and testing in WIC clinics statewide.	MDH CLPPP, MDH WIC Clinic Coordinator, Hennepin County, St. Paul – Ramsey County Public Health, Minneapolis Department of Health and Family Support	Recommendations on blood lead testing in WIC clinics will be completed by June 2007.
4. Develop plans to address corrective action orders issued to health providers that do not meet screening targets and continue contracts that provide incentives to health providers meeting C&TC targets.	DHS, Health Plans	All plans will take steps to meet C&TC targets by June 2007.
5. Continue to develop High Intensity Targeted Screening (HITS) projects in Minneapolis, St. Paul and other areas with high-risk populations.	MDH CLPPP, Minneapolis Dept. of Health and Family Support, St. Paul-Ramsey County Public Health, SRC, public health departments in other high-risk areas.	• Hennepin County HITS project focused on WIC clinics will be completed by June 2006. • St. Paul-Ramsey Public Health HITS projects in WIC clinics and with immigrant populations will be completed June 2006.

Tasks	Responsibility to Implement	Measure
6. Conduct blood lead screening and education activities for high-risk children and pregnant women through licensed daycares, reproductive health services, and other community settings statewide.	SRC, Health Plans, GMDCC, City of Minneapolis, St. Paul-Ramsey County Public Health, Hennepin County, local health departments	All partners will work cooperatively to find opportunities to screen and educate children and pregnant women at high risk for lead poisoning.
7. Explore whether immunization cards provided to parents can include a reminder to test blood lead at recommended ages.	MDH, local health departments	Assess feasibility of including blood lead testing on the cards by January 2007.
8. Encourage health plans to send a chart flag for lead testing (initial and follow-up) to clinic administrators for inclusion in chart.	Health Plan, SRC, clinic administrators	By 2008, 50 percent of clinics will include chart flags to remind about lead testing.
9. Continue to match MDH blood lead surveillance data with MDH Refugee Health Data and track trends in the immigrant/refugee communities in Minnesota.	MDH CLPPP, MDH Refugee Health, Hennepin County, immigrant/refugee groups statewide	Elevated blood lead levels among immigrant/refugee groups will be comparable to blood lead levels among Minnesota-born population by June 2010.
10. Continue targeted mailings to health care providers when guidelines for blood lead screening, case management, treatment and pregnancy are updated.	MDH CLPPP	Screening, case management and treatment guidelines will be familiar to all health professionals dealing with children or pregnancy.

Objective C. **Use data about housing age, population and income to identify properties that may have lead hazards, perform risk assessments and implement primary prevention.**		
Tasks	**Responsibility to Implement**	**Measure**
1. Use GIS mapping to determine high-risk areas for lead exposure and children in need of blood lead testing.	Hennepin County Lead Program, MDH CLPPP, Dakota County, other partners	Hennepin County and Dakota County will continue to provide GIS mapping within their jurisdictions. MDH CLPPP will integrate GIS capability into BLIS or convert to the Lead PAM by June 2008.
2. Develop a statewide system to collect and analyze environmental case management data.	MDH Lead Program, assessing agencies, other partners	The MDH Lead Program will develop, in cooperation with partners, a basic reporting procedure by June 2007.
3. Encourage Section 8 property owners to access technical assistance and funding resources available from state and local lead poisoning prevention programs if inspections identify lead hazards.	Local housing authorities	Information on technical and funding assistance for lead hazard control will be made available to Section 8 property owners in the Metro area by June 2008.
4. Develop a Lead Safe Cities model for adaptation by rural Minnesota cities that includes a range of primary prevention strategies, tools, and model ordinances.	MDH Lead Program, League of Minnesota Cities, other partners	The MDH CLPPP will work with two rural Minnesota cities on a pilot project beginning July 2006.
5. Work to educate tenants of multiple-unit buildings with known lead hazards about landlord responsibilities and enforcement options.	Project 504, Legal Aid	Tenants seeking assistance in weighing legal options to reduce lead exposure will have resources.
6. Continue performing primary prevention risk assessments and dust wipe sampling in homes where children have blood lead levels of less than 10 ug/dL.	SRC	SRC will conduct primary prevention risk assessments for 150 homes annually.

Tasks	Responsibility to Implement	Measure
7. Conduct informational seminars for code enforcement officials and Section 8 inspectors to encourage referrals of at-risk housing occupied by young children to local lead programs.	St. Paul/Ramsey County Public Health, assessing agencies	Assessing agencies will develop relationships with code enforcement and Section 8 inspectors and provide information.
8. Develop database to record properties that received lead hazard reduction through a HUD Round XI Grant	HUD Grantees	Each HUD Grantee will maintain a database of properties that received lead hazard reduction dollars by June 2007.
9. Request lead hazard control funding from HUD through the Small Cities Development Program for eligible properties.	DEED, MDH Lead Program	The current SCDP grant program will operate through March 2007. Another application will be made for HUD funding in 2007.
10. Require lead risk assessments when state or local housing funds are used to renovate properties built before 1978.	MHFA	Renovation projects will comply with the policy established by MHFA requiring lead paint risk assessment.
11. Analyze EBLL data to determine the locations of housing units that poison multiple children and focus primary prevention efforts on those units.	MDH Lead Program	Analyze data annually.

Completed or Ongoing | In planning or implementation | Scheduled for later fiscal years | Successful in One Jurisdiction, Extend to Others

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Tasks	Responsibility to Implement	Measure
Goal III. **Strategies to Better Incorporate Lead Paint Assessment and Control into Housing Activities and Infrastructure.**		
Objective A. **Ensure that lead paint assessment, control and compliance is integrated into housing code and policy.**		
1. Ensure that programs and properties receiving HUD funding are aware of and in compliance with current HUD policies on lead paint assessment, lead safe work practices, and disclosure laws.	HUD, HUD Grantees, DEED, MHFA	HUD will continue to provide direction to grantees on lead paint issues in pre-1978 housing.
2. Integrate lead paint assessment and lead-safe work practices into statewide building and maintenance code applying to pre-1978 housing.	MDH Lead Program, Minnesota Department of Commerce, Builders' Association of Minnesota, Minnesota Area Housing Code Officials	Lead paint assessment and lead-safe work practices will be integrated into statewide building and maintenance code by June 2010.
3. Ensure that renovation and remodeling contractors are aware of and in compliance with the draft and final Renovation and Remodeling Rules.	EPA, MDH Lead Program, Contractor Groups	Renovation and remodeling contractors will receive information about the draft R&R rules by June 2006.
4. Conduct an analysis of the state building codes to determine whether they reflect best practices for lead paint in pre-1978 housing.	MDH Lead Program	An analysis will be completed by June 2008.

Tasks	Responsibility to Implement	Measure
5. Encourage local governments to incorporate lead paint inspection and compliance responsibilities into Housing Inspection Departments.	MDH Lead Program, AMC, LMC, elected officials	Develop a model based upon City of Minneapolis inspections for use in other jurisdictions by June 2007.
6. Develop a model for incorporating lead paint assessment, lead-safe work practices and disclosure into rental property licensing.	MDH Lead Program, LMC, elected officials	MDH CLPPP will assess City of Minneapolis's practice to develop a lead-safe cities model during a pilot project to begin July 2006.
7. Encourage local housing inspection officials to become certified lead sampling technicians able to take clearance samples, especially in rural areas where certified lead professionals are not as readily available.	MDH Lead Program, local housing inspectors, LMC	The number of lead sampling technicians in rural Minnesota will increase by 10 percent by June 2007.
Objective B. **Ensure compliance with and enforcement of lead paint laws.**		
1. Provide compliance assistance to regulated parties and licensed entities.	MDH Lead Compliance	The MDH provides ongoing assistance as an EPA-authorized program.
2. Enforce lead licensing requirements and regulated lead work practices.	MDH Lead Compliance	The MDH enforces regulated lead work practices and licensing requirements on an ongoing basis.
3. Continue to provide information about and promote compliance with federal lead requirements e.g. HUD 1012/1013, 1018, EPA 406(b), OSHA.	MDH Lead Compliance, housing and health authorities, others	Information about federal lead requirements will continue to be available to interested audiences.
4. Provide compliance oversight of HUD/DEED Lead Hazard Control Grant activities regulated under 1012/1013.	MDH Lead Compliance	The MDH provides ongoing compliance oversight of HUD 1012/1013.

Tasks	Responsibility to Implement	Measure
5. Develop Supplemental Environmental Project (SEP) proposals to make available as part of federal or state lead enforcement actions.	Project 504, MDH Lead Compliance	A plan will be developed and on file as of June 2007.
6. Develop legislative or administrative methods to allow MDH to analyze blood lead data by location and provide the locations of multiple EBLL cases for compliance follow-up.	MDH CLPPP, Minnesota Attorney General, U.S. Dept. of Justice, HUD, Minnesota Legislature	Continue to work within Minnesota Data Practices Act to assist in investigating housing with multiple EBLL cases.
Objective C. **Identify partners who inspect family housing (single and multi) and encourage them to implement lead paint assessment and lead-safe work practices policies.**		
1. Work to establish a partnership with the Department of Commerce to determine the feasibility of housing code inspectors becoming lead sampling technicians, including the visual identification of deteriorated lead paint as part of their work write-ups, and including lead-safe work practices (by weatherization crews) in project specs.	MDH Lead Program, Dept. of Commerce, CAP agencies	Meet with Commerce and survey CAP agencies to determine their current policies and willingness to work with lead programs by June 2007.
2. Work with Truth in Housing inspectors to encourage the inclusion of visual identification of deteriorated paint surfaces and lead sampling as part of their services to customers.	MDH Lead Program, Minnesota Realtors Association, private inspection individuals and firms.	Develop relationships with realtors and inspectors to assess this approach by June 2008.
3. Develop information on lead paint assessment and lead-safe work practices for county tax assessors who evaluate housing and property managers who deal with tax-forfeit properties.	MDH Lead Program, AMC, county tax assessors	Assess interest among county tax assessors by June 2008.

Completed or Ongoing | In Planning or Implementation | Scheduled for Later Fiscal Years | Successful in One Jurisdiction, Extend to Others

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Goal IV.
Strategies to Identify Resources to Increase the Supply of Lead-Safe Housing in Minnesota.

Objective A.
Improve coordination among DHS, CAP, DEED, HUD, USDA, SRC, MHFA, FHA, public health and lead hazard control programs.

Tasks	Responsibility to Implement	Measure
1. Develop relationships with USDA and rural development agencies to incorporate lead-safe work practices into homeowner education that accompanies efforts to rehab properties for the elderly and very low-income families.	USDA, Rural Development Agencies, MDH	Explore homeowner education requirements for the USDA rural development agencies by January 2009.
2. Continue to implement HUD lead hazard control requirements in all state-funded housing programs with a health and safety component.	MHFA	Implementation will continue in standard loan programs, deferred loan programs, home improvement programs and others.
3. Develop a geographic matrix or online map of all existing programs available in Minnesota for funding housing rehab and assess lead policies associated with each.	MDH Lead Program, other partners	Research and collect information for statewide matrix by June 2008.

Tasks	Responsibility to Implement	Measure
4. Ensure that HUD funding for lead hazard control activities is available statewide for qualifying families with children with blood lead levels of 15 ug/dL or greater.	MDH Lead Program, DEED, St. Paul – Ramsey County Public Health, Hennepin County Housing, City of Minneapolis Housing, and other cooperating partners.	Maintain all HUD grants in green light status. Apply for HUD funding during the current and future SuperNOFAs.
5. Work cooperatively with Community Action Programs to ensure that weatherization programs (especially window replacement) follow best practices for lead safe work.	Community Action Programs, MDH Lead Program, SRC and other partners.	Provide assessment of current CAP practices and models of successful partnerships by January 2007.
6. Develop a comprehensive e-list that includes health and housing contacts and provide periodic updates on new lead regulations, resources, training and emerging issues.	MDH Lead Program	Develop an e-list from the MCLEAN list base and provide periodic updates beginning in July 2006.
7. As part of geographic matrix or online map (see Task 4), ensure that housing organizations representing immigrant/refugee groups, tribes, and other racially and culturally diverse groups are included.	See Task 4.	See Task 4.
8. Work with HUD to ensure that efficiency units in which children under six may reside, either temporarily or permanently, are eligible for lead hazard control services if other units in the building have documented lead hazards.	HUD	HUD will consider the implementation of lead hazard control activities in efficiency units by June 2009.
Objective B. **Leverage private and nonprofit funding mechanisms to identify and control lead paint hazards.**		
1. Seek funding through AmeriCorps/CLEARCorps for lead hazard reduction and education in Minnesota.	SRC, NPCA	Continue applying for AmeriCorps/CLEARCorps lead hazard control and education funding.

Tasks	Responsibility to Implement	Measure
2. Assess the feasibility of applying for foundation funding to provide gap coverage for lead hazard control activities in types of housing not eligible for other public or private programs (including homeless shelters, drop-in centers, senior centers, and other buildings).	SRC, MDH CLPPP	Survey foundations to determine whether grant applications for lead hazard control activities are appropriate by June 2008.
3. Approach Habitat for Humanity to establish a policy on lead-safe work practices that Habitat can integrate into its activities in pre-1978 renovation work.	Twin Cities Habitat for Humanity Chapter, other Habitat Chapters statewide	Approach Habitat for Humanity's Twin Cities chapter and discuss before June 2007.
4. Develop relationships with private developers proposing renovation of buildings with lead-paint hazards and inform them of requirements and resources for lead-safe work.	MDH Lead Program	A needs assessment of redevelopment interests will be completed in June 2008.
Objective C. **Evaluate potential legislation that would provide sustainable funding sources for lead surveillance and lead hazard control.**		
1. Track bills that are introduced in each Minnesota Legislative Session and provide impact analysis or technical assistance to authors.	MDH Lead Program, other partners	MDH will continue to track bills and provide analysis and assistance.
2 . Propose legislation permitting use of Medicaid funding for environmental risk assessment and case management.	DHS, City of Minneapolis, Hennepin County, others	Bill language will be introduced in the 2006 Legislative Session.
3. Investigate the possibility of using existing state hazardous waste cleanup funding (such as Superfund or brownfields redevelopment money) to address lead hazard control problems in aging multi-unit housing.	MPCA/OEA	Assess the possibility of using cleanup funding for lead paint cleanup by June 2009.
4. Investigate the feasibility of providing a tax reduction for lead hazard control work.	Minnesota Legislature	Bill introduced in 2005, re-introduced in 2006.

Tasks	Responsibility to Implement	Measure
5. Develop sustainable long-term funding source for the statewide blood lead surveillance system by 2010.	Minnesota Legislature	Recommendations for sustainable funding options will be included in the biennial report to the legislature, deliverable in January 2007.
6. Include lead hazard control activities in applications for funding for Healthy Homes initiatives.	All Partners	Monitor pending grant applications through EPA, CDC, HUD and other grant application information sites
7. Consider increasing funding for lead hazard reduction in the homes of low- and very-low income owner-occupants.	MHFA	Examine during preparation of next biennial budget during 2007 session how to increase funding with affordable terms and conditions for lead hazard reduction in the homes of low- and very-low income occupants.
8. Ensure that moderate-income families are aware of MHFA Fix-up Fund and Rehabilitation Loan Program for window replacement.	MHFA, All Partners	Include information about these funds in general resources about housing funds for moderate-income families.

Completed or Ongoing | In Planning or Implementation | Scheduled for Later Fiscal Years | Successful in One Jurisdiction, Extend to Others

Goal V.
Strategies to Respond to Emerging Issues, such as New Research, Legislation, Trends, Population Conditions and Other Developments.

Objective A.
Improve blood lead screening and testing through focused educational efforts with providers and insurers.

Tasks	Responsibility to Implement	Measure
1. Update Minnesota's blood lead screening guidelines to require blood lead screening (i.e., asking screening questions and ordering testing based upon risk factors) or testing (if screening questions will not be asked) on children of recommended ages statewide.	MDH, partners and providers	This approach will be explored in guidelines to be developed by June 2007.
2. Identify and educate health care providers (individuals or clinics) that do not follow the statewide screening guidelines.	ALL PARTNERS	Partners will identify five clinics where blood lead screening guidelines are not followed and the MDH or partners will offer on-site education by December 2007.
3. Revive partnership with the medical schools (U. of M., UMD, and Mayo) to provide education to students on the risk factors for lead poisoning and the screening guidelines.	MDH	MDH will approach the U. of M. Medical School to revive the partnership by December 2007.
4. Investigate which insurance carriers or policies will not cover blood lead testing or other preventive health care.	ALL PARTNERS	Research and collect information by June 2008.

Tasks	Responsibility to Implement	Measure
Objective B. **Reduce childhood lead exposures by educating adults with EBLLs or lead-intensive occupations about "take home" lead.**		
1. Restore process of contacting adults with blood lead levels of 25 or more to provide education and resources and suggest screening children in the home.	MDH	MDH will resume adult contacts drawn from ABLES database in January 2007.
2. Provide information about the potential impacts of lead exposure during pregnancy to women in industries in which lead is used.	EPA, OSHA	Integrate lead-in-pregnancy information into EPA communication planning process underway in 2006.
3. Work cooperatively to provide adults working in conditions of lead exposure with information about potential hazards via the "take-home lead" fact sheet.	MDH, Labor and Industry	MDH will develop a project with Labor and Industry to provide workers in lead industries with the "take-home" lead fact sheet.
Objective C. **Develop methods to prevent children from exposure to lead-containing products.**		
1. Outline the critical path that would be followed by the State of Minnesota to remove a lead-containing children's product from sale.	MDH, MPCA, Commerce	Define the steps to remove lead-containing children's products from sale by December 2006.
2. Refer information about packaging used for children's products that intentionally includes lead to the MPCA for education, enforcement and recall.	MPCA, ALL PARTNERS	MPCA will achieve product recalls for two lead-containing children's products by June 2007.
3. Develop or partner with a Web site that lists products or packaging with confirmed lead content exceeding CPSC guidelines for use by health care providers, merchants, lead professionals and the general public.	MDH, MPCA	MDH and MPCA will develop a plan by March 2007 to make lead product and packaging information available online.

Objective D. **Encourage technologies for accurate, effective and cost-efficient lead detection, lead hazard control, lead clearance testing and surveillance.**		
Tasks	**Responsibility to Implement**	**Measure**
1. Support testing and accreditation for NITON sampling equipment that can provide immediate results of dust and paint samples on site.	EPA, CDC, HUD, MDH in Minnesota	Federal agencies will pursue testing and accreditation.
2. Ensure that lead partners in Minnesota and other states are updated on progress in technologies that can break up lead paint using light pulses.	HUD	HUD will continue to test and evaluate light pulse lead removal technologies.
Objective E. **Develop effective communication channels to reach immigrants/refugees and other populations at higher risk for lead poisoning.**		
1. Develop a pilot project to include lead-safe housing and education information in an affordable housing registry.	Hennepin County Housing, Housing Link	Hennepin County and Housing Link will include lead information for property owners and prospective renters by June 2007.
2. Support an information phone line (possibly in cooperation with DHS) allowing health-related questions in languages spoken by Minnesota's immigrant/refugee populations.	MDH, DHS	Continue to work among state agencies to develop a phone line for response in many languages.

Tasks	Responsibility to Implement	Measure
3. Cooperate with faith communities to provide a "train the trainer" public health awareness event for immigrants/refugees who prefer receiving health information from respected members of their own communities.	MDH, SRC, CUHCC	Develop an outreach event involving local mosques sponsoring a public health day for Somalis by March 2007.
4. Explore the possibility of working with Hispanic/Latino radio stations to develop public health programming regarding childhood lead poisoning or lead-safe work practices.	SRC, MDH	Research and develop a proposal by March 2007.
5. Strengthen the Emergency Communication and Health Outreach (ECHO) Minnesota Collaborative to ensure a recognized channel for immigrants/refugees to receive emerging public health information.	MDH, St. Paul – Ramsey County Public Health, City of Mpls. Healthy Homes and Lead Hazard Control, EPA, health plans	Complete ECHO segment on lead and lead hazards by November 2006.
6. Assess interest among parents of lead-poisoned children in attending MCLEAN by contacting community organizations serving lead-poisoned children and their families.	MDH	Provide an assessment by March 2007.