State of Minnesota Childhood Lead Poisoning Elimination Plan

August 2010

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Elimination Plan

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List of Acronyms

ALC Unit – Asbestos/Lead Compliance Unit (MDH)
CAP – Community Action Program (locally based organizations)
CDBG – Community Development Block Grant
CDC – U.S. Centers for Disease Control and Prevention
CLEARCorps –Community Lead Education and Reduction Corps (AmeriCorps program)
CLPPP – Childhood Lead Poisoning Prevention Program (CDC grant to MDH)
CPSC – Consumer Products Safety Commission
C&TC – Child and Teen Check-up
CUHCC - Community-University Health Care Center
DEED – Minnesota Department of Employment and Economic Development
DHS – Minnesota Department of Human Services (Medicaid agency)
DOLI – Minnesota Department of Labor and Industry
EBLL – Elevated Blood Lead Level
EIA Unit – Environmental Impacts Analysis Unit (MDH)
EPA – U.S. Environmental Protection Agency
GIS – Geographic Information System
HRA – Housing and Rehabilitation Authority (local housing jurisdictions)
HUD – U.S. Department of Housing and Urban Development
LSWP – Lead-safe work practices
LUG – Local Units of Government
MA – Medical Assistance (Minnesota equivalent of Medicaid)
MCLEAN – Minnesota Collaborative Lead Education and Assessment Network
MDH – Minnesota Department of Health
MDNR – Minnesota Department of Natural Resources
MEDSS – Minnesota Electronic Disease Surveillance System
MHFA – Minnesota Housing Finance Agency
MMHA - Minnesota Multi-Housing Association
MPCA – Minnesota Pollution Control Agency
MVNA – Minnesota Visiting Nurses Association
NAHRO – National Association of Housing and Redevelopment Officials
NPCA – National Paint and Coatings Association
OMMH – Office of Minority and Multicultural Health (MDH)
RRP – EPA Renovation, Repair, and Painting rule (issued 2008)
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.

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Introduction

Although lead poisoning is preventable and rates are declining in Minnesota, children living in substandard (as defined by building codes), pre-1950 housing continue to be disproportionately affected by lead. In response, the Minnesota Department of Health (MDH) Childhood Lead Poisoning Prevention Program (CLPPP), in collaboration with a wide range of partners, has coordinated the development of a plan to eliminate statewide childhood lead poisoning by 2010. The "State of Minnesota Childhood Lead Poisoning Elimination Plan" (Plan) 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 original Plan was released in 2004. Members of the Minnesota Collaborative Lead Education and Assessment Network (MCLEAN) meet routinely to evaluate ongoing efforts in the Plan. The MCLEAN meetings also provide an opportunity for sharing information, form collaborations, and learn about current lead issues. Attendees at MCLEAN meetings include federal, state, and local government; community based organizations; health care providers; housing, real estate, landlord, and tenant organizations; and other disciplines. All members listed on p. iii as "Childhood Lead Poisoning Elimination Plan Advisory Members" (Advisory Members) participate in MCLEAN meetings. In addition, key staff from the MDH Lead Program, which includes the Environmental Impact Analysis Unit (EIA) and the Asbestos/Lead Compliance Unit (ALCU), provided feedback on the Plan. Particular attention has been paid to developing and implementing housing-based primary prevention activities.

In 2004 a vision statement for the Plan was prepared along with a Minnesota definition of childhood lead poisoning "elimination." The vision statement and elimination definition remain valid in 2010. The vision statement is:

"To create a lead-safe Minnesota where all children have blood lead levels below 10 micrograms lead per deciliter whole blood (µg/dL) by the year 2010."

The elimination definition is:

*"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 $\underline{\geq}$ 10 µg/dL."*******

****** The definition of elimination is subject to change due to at least three variables: 1) changes in trends in elevated blood lead levels (EBLLs) 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.

As we enter 2010, there has been tremendous progress in lowering exposure to lead, both nationally and in Minnesota (a 65% reduction in EBLLs since 1995). While the CDC has issued the "Healthy People 2020" objective (EH HP2020-13) to "eliminate elevated blood lead levels in children" there is ongoing discussion in the lead community regarding what constitutes "elimination" at the national level. Commentators on the

proposed Healthy People 2020 objective noted that the definition of elimination should be qualified by adding "as a public health problem", which recognizes the impracticality of attaining zero lead exposure. CDC has also discussed (in informal meetings) using the National Health and Nutrition Examination Survey (NHANES) data to establish a national statistical threshold that would constitute no observed cases, or "elimination."

During the creation of the Plan in 2004 there was extensive discussion regarding the Minnesota definition of elimination. The consensus of the group in 2004 was that we should strive for "zero percent of at-risk children" as a goal while recognizing that lead is a common contaminant in the environment. Discussions held with the Advisory Members in 2010 confirmed that the Plan should retain the established definition of elimination.

This Plan contains background on lead exposure in Minnesota, an assessment of risk factors for lead, and an overview of modifications to the Plan proposed by Advisory Members. The 2010 version of the Plan updates the most recent version of the Plan, which was released in September 2008. An evaluation of the 2010 Plan will be prepared and distributed in 2011.

Background on Minnesota's Lead Poisoning Problem

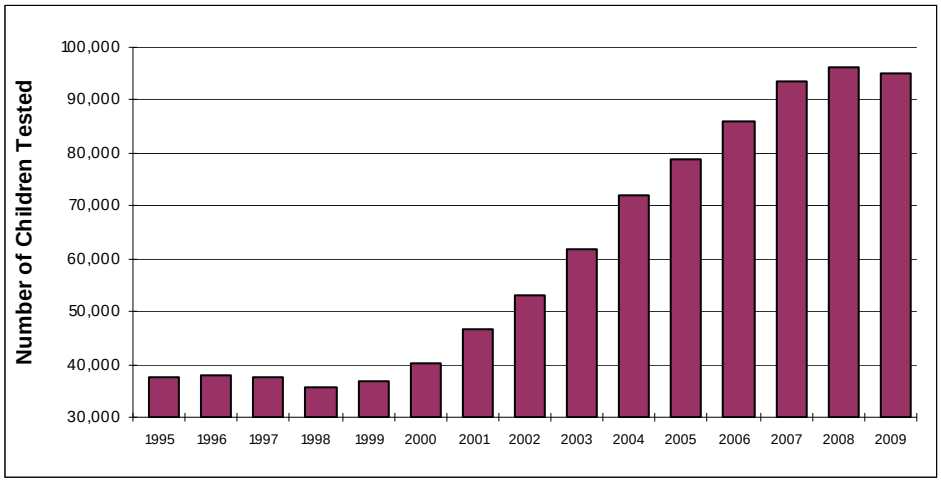
The State of Minnesota has consistently played a leading role in identifying and addressing public health issues related to lead exposure. Partners in lead poisoning prevention across Minnesota are committed to maintaining that leadership role and protecting the citizens of Minnesota from the potentially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

The 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 EIA Unit is responsible for lead-related surveillance activities, assists in monitoring elevated blood lead cases, coordinates education and outreach, and implements the CLPPP. The 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, Labor and Industry, Natural Resources, Housing Finance Agency (MHFA), Commerce, and Employment and Economic Development (DEED). 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 and CLEARCorps Minnesota, also perform essential tasks regarding education, training, and primary prevention pilot projects and assessments.

The MDH collects blood lead reports on all tested Minnesota residents, both children and adults. State guidelines on screening of children and pregnant women, case management, and clinical treatment help standardize practices and raise awareness of high-risk populations. These guidelines are regularly reviewed and updated based on new data and published literature.

Figure 1 illustrates the trend in the number of children tested in past years and gives some indication of how screening practices have improved significantly in Minnesota. 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 – 2009. Results include all test types (venous, capillary, and 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, presenting information 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 DEED 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 (C&TC), of which blood lead testing is a vital component, on children enrolled in Minnesota Health Care Plans, including Medical Assistance (MA).

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 children less than 72 months old with elevated blood lead tests reported to MDH from 1995 – 2009.

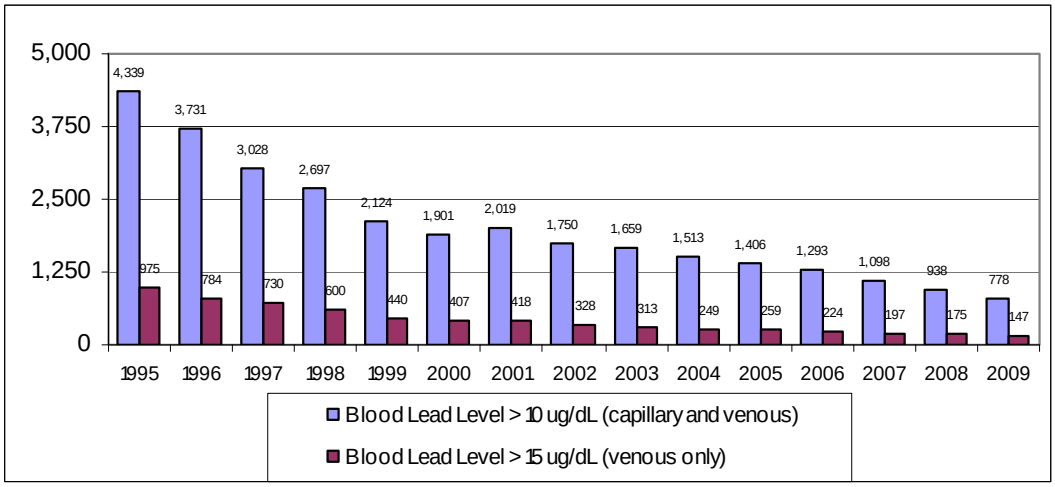


Table 1 presents the distribution of blood lead tests reported to MDH in 2009 based on concentration. The data show that 778 of the 94,972 children with reported tests (0.8 percent) were considered to be elevated, which is defined by Minnesota statute as greater than or equal to 10 µg/dL. The rate of venous blood lead tests requiring an environmental assessment (15 µg/dL or greater) for Minnesota for 2009 was 0.3 percent.

Table 1: Distribution of Blood Lead Levels in Minnesota Children in 2009. 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 (µg/dL)	< 5	5-9	10-14	15+	Total
Venous	12,535	1,187	193	147	14,062
Capillary/Unknown	70,893	9,579	308	130	80,910
Total	83,428	10,766	501	277	94,972

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. Specific methods for implementing the recently passed "Renovation, Repair, and Painting" rule from EPA are currently being developed.

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.

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

Lead programs across Minnesota strive 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. Programs across the State 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 1,000,000 tests in the system as of April 11, 2008. Of these tests, 864,313 were for kids under the age of six, and they were from 583,591 individual children. Data collection goes back to 1995 and is 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 (e.g., Countryside Lead Prevalence Study) and nationally has shown that an estimate of lead risk may be predicted based on two factors: living in a pre-1950 home and being enrolled in Medicaid. The data shown in Table 3 below are taken from the 2000 Census and DHS Medicaid 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, based on 2000 Census data.

	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 Medicare (5 yr. period)	44,000	63,000	160,000

The following responses to an elevated blood lead report are outlined 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 education materials identifying primary sources of lead poisoning may be provided to the family.
- If levels in children are 10 µg/dL or greater, follow-up or confirmation testing and educational intervention are 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 venous lead levels in a pregnant woman are 10 µg/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.

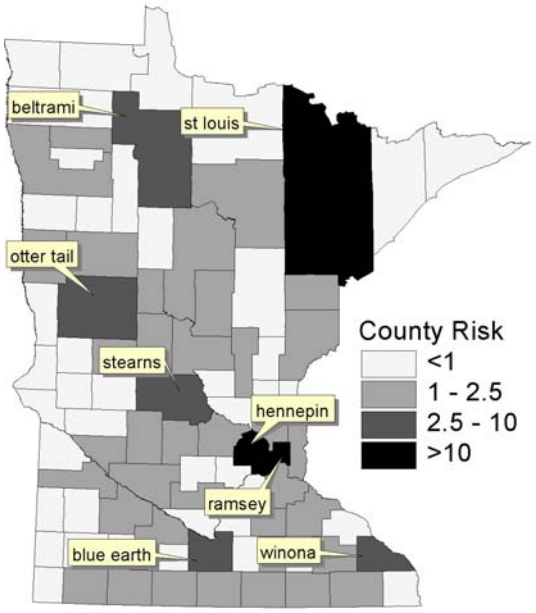
Although Minnesota has mandatory reporting from all facilities analyzing blood lead levels, blood lead testing is not universal, and the data collected by the surveillance system are not representative of all Minnesota children. Data are collected only when a health care provider orders a blood lead 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 2009 data, 19 percent of the children in the Minnesota blood lead surveillance database reside in Minneapolis and St. Paul even though these cities contain only 15 percent of the state population of children. 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 57 percent of the Medicaid-eligible population in Minnesota did not receive a blood lead test in 2009. Although ongoing data matching shows that this trend is improving (83 percent did not receive a blood lead test in 1999), 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 µg/dL and 0.7 percent at or above 20 µg/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:

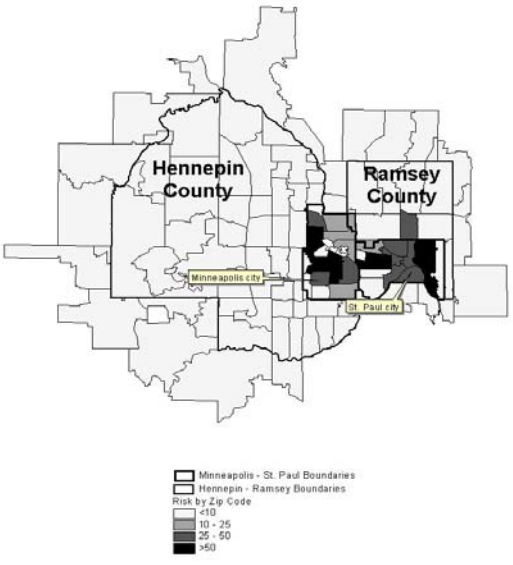
Minnesota Relative Lead Risk by County



Surveillance data from MDH has shown that 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.

Figure 4:

Mpls./St. Paul Relative Lead Risk by Zip Code



Even within urban counties, most elevated blood lead tests are identified in Minneapolis and St. Paul. In 2007, 88 percent of the children with blood lead levels > 10 µg/dL, and 95 percent of the children with blood lead levels > 15 µg/dL in Ramsey county lived in St. Paul, and 84 percent of the children with blood lead levels > 10 µg/dL and 84 percent of the children with blood lead levels > 15 µg/dL in Hennepin county lived in Minneapolis.

In addition to statewide relative lead risk, city-specific data were examined to more specifically determine the most at-risk areas for lead poisoning. Lead poisoning risk data by zip code for St. Paul and Minneapolis are presented in Figure 4. 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 elevated test results 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."

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 in the Thomas-Dale neighborhood has nearly twice as many elevated blood lead cases as the other 55 combined. 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. 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.

In addition to housing-based lead, there has been a great deal of attention paid to other sources of lead in recent years. In Minnesota, this has included tracking recalls of products with lead, passing legislation in 2007 banning lead in children's jewelry (see: https://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=S1262.3.html&session=ls85), working on addressing lead in upland game shot and hunter-donated venison, providing national leadership on using lead-free wheel weights and fishing tackle, and raising awareness of lead in traditional/imported products in immigrant populations.

Plan Evaluation and Modifications

The measures presented in the "Implementation Goals" table (pp. 14-35) are used as benchmarks for conducting ongoing evaluation of the Plan and developing new objectives and tasks. The MDH currently convenes the MCLEAN twice a year (generally in April and October) to review Plan progress and discuss any needed modifications to reach stated goals and objectives. 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. Additional meetings with Advisory Members are called as needed to review and update specific Goals.

A bi-annual evaluation of the Plan (most recently completed in 2009) assessing progress towards goals and objectives is prepared and posted on the MDH Lead Program Web site at www.health.state.mn.us/divs/eh/lead.

Lead poisoning prevention efforts are ongoing throughout the year and are conducted by a wide range of collaborating partners, including federal agencies, public health agencies (both state and local), housing agencies, health plans, health care providers, advocacy

organizations, legislators, and concerned citizens. Highlighted activities completed/continued since the 2009 evaluation of the Plan include:

- Minneapolis and SRC provide the EPA "Renovate Right" pamphlet to hardware stores, reuse centers, lumber yards, and community centers.
- Surveillance data was used to target clinic outreach efforts in Minneapolis to encourage screening (MDH Screening Guidelines recommend universal screening for Minneapolis) and awareness of case management practices.
- Coordination meetings included the Lead Testing Task Force, the Minneapolis/Hennepin County Lead Workgroup and regular meetings between MDH and SRC.
- St. Paul/Ramsey County public health completed training for contractors to develop capacity for lead safe work practices.
- SRC and CLEARCorps conducted a wide array of community education and outreach activities targeted to diverse communities. These events frequently offered lead testing, which was coordinated with health plans.
- Minneapolis provided LSWP training to facilitate compliance with a city ordinance addressing chipping and peeling paint.
- MDH worked with the legislature and many partners in the lead compliance community to begin implementation of the EPA RRP rule.
- Minneapolis and SRC instituted a "Lunch and Learn" series (CEUs available) targeting clinics, nurses, physicians, and health plan administrators.

MCLEAN Group Review and Comment

In 2010, the Advisory Members also met to discuss possible revisions to the Implementation Goals. A series of meetings in the summer of 2010 gathered all the Advisory Members to review and amend each of the goals. Meetings on April 6 (which was the regularly scheduled MCLEAN meeting) and July 16, 2010 were used to solicit comments from Advisory Members on all aspects of the Plan. In addition, summaries of objectives were sent to key collaborating partners (St. Paul/Ramsey County, Minneapolis, Hennepin County, Sustainable Resources Center) requesting feedback and MDH Lead Program staff reviewed the Plan during a meeting on July 1, 2010. Written comments were also provided throughout the review/development period by a number of organizations. Recommendations and follow-up comments from all meetings have been incorporated into the Implementation Goals table found at the end of this document.

The updated Plan differs from the 2008 version of the Plan in several respects:

- While the primary focus of the Plan remains housing-based lead, Goal V was completely re-written to address the impending transition of lead programs to a "healthy homes" approach. The 2010 version of the Plan includes 14 brand new healthy homes tasks under four new objectives in Goal V.
- The Advisory Members once again requested removal of several tasks that were completed or deemed too problematic to implement. Therefore the number of individual tasks was again reduced, from 106 to 97.

- Lead poisoning prevention activities continue to be incorporated in to routine program activity at the state and local level, as reflected in the increasing number of tasks that are "ongoing" (green). In the 2010 version of the Plan, 67 percent of the tasks are green status, while an additional 25% are yellow status (in planning or implementation). Only 8 percent of tasks are rated as red status (later fiscal years). This compares to 44 percent, 37 percent, and 19 percent green, yellow, and red status, respectively in the 2006 version of the Plan (the 2004 version was not color coded).

Table 4 contains an overview of changes to individual goals between the 2008 and 2010 versions of the Plan. Specific tasks are found in the Implementation Goals table found at the end of this report.

Table 4: Summary of changes to 2010 Plan compared to 2008 Plan based on recommendations from advisory members.

Goal I: Lead education and training	Assessment of videos for rental property owners (A6) and first-time home buyers (A7) were combined in to a single task. EPA will take responsibility for "do-it-yourselfer" education (C3 deleted). Status of statewide education campaign (E1) changes to green. Karen fact sheets (E2) completed and task changed to reflect need for additional languages. Tasks added (from old Goal V) to public education objective include working with institutes of higher learning, addressing other housing-based hazards, recalls of lead contaminated products, and awareness of lead in venison.
Goal II: Identifying at-risk properties and children	Data sharing agreements (A3) established and will be maintained. Screening priorities (B5, B6) combined in to a single task. Deleted tasks assessing insurance coverage (B12; not feasible) and clinic education (B11; done elsewhere in the Plan). Section 8 task (C3) completed and removed from Plan.
Goal III: Incorporating lead paint assessment and control into housing activities and infrastructure	LSWP were incorporated in to the state building code (A2 changed red to green) and in to weatherization protocols (C1 completed and deleted). Implementation of the EPA RRP rule is ongoing (A3 changed yellow to green). Lead hazard inspection task moved from objective B to objective C. Development of supplemental projects (SEPs; B4) deleted due to transition to healthy housing model. Task added (C3) to encourage collaboration with Fire Departments and Inspection Departments on lead awareness and prevention.
Goal IV: Identifying resources to increase the supply of lead-safe housing	CAP training on LSWP and weatherization (A5) is now part of US Dept of Energy, MN Dept of Commerce, and EPA RRP standards, so task completed and deleted. Housing contact list and interactive online map of housing resources (A6, A7) tasks both deleted due to the excessive effort needed to create and maintain. Task relating to the Minneapolis transient lead ordinance (A8) changed from red to yellow status. Assessing multiple units based on a single blood lead result (A9) deleted due to a lack of an enforcement mechanism. Task B2 deleted due to limited support for lead hazard reduction from foundations. Task C3 amended to target lead hazard control. Task C5 moved to the new Goal V (Healthy Housing).
Goal V: Strategies to Develop and Implement a Program to Address Housing-based Health Threats Using Established Lead Program Capacities.	This goal was re-written to incorporate steps for the transition of lead programs to healthy homes. Tasks from the 2008 Plan were either deleted (B1, B2, C1, C4, D1, E1, E2, E3) or relocated in to earlier goals/objectives (A1, C2, C3, C5, E3). Objectives and tasks are consistent with recommendations from the National Center for Healthy Housing "CLPPP Transitions" training.

Implementation

The final draft of the 2010 version of the Plan was distributed to partners electronically for final review. The completed document will be placed on the MDH Web site for download after comments have been incorporated. It also will be distributed electronically to the MCLEAN email list.

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), the Minnesota Department of Health (in collaboration with the DEED Small Cities program) and to SRC (Lead Elimination Action Program). 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 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 2011.

All available published literature and reports will be used, in conjunction with current surveillance, census, 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 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.

General Comments Received

There were many comments received verbally and in writing that addressed specific parts of the Implementation Goals on pp. 15 – 37 of this Plan. Those specific comments have been summarized in Table 4 above and incorporated in to the Plan as discussed in MCLEAN Group Review meetings.

A number of partners also submitted comments that addressed common themes throughout the document. For example, it was pointed out that there is growing evidence that blood lead levels below 10 ug/dL can have significant impacts on children's development. While we have had great success at lowering lead levels in Minnesota, these new findings suggest that there is no "safe" level of lead for young children. Housing-based primary prevention efforts were strongly supported, along with promoting the use of non-lead products whenever practical, increasing training for LSWP and

general lead awareness in the general public, and continuing to use surveillance data to identify and target high-risk populations for lead education.

Several partners once again pointed out that lead education and lead hazard control work in Minnesota are almost entirely dependent on federal funding. Federal grant programs are competitive and subject to budget and policy changes, e.g. federal funding is moving beyond lead and toward broad healthy homes goals including lead. Under current conditions, if HUD funding were not available lead hazard control programs in Minnesota would basically cease, and education programs would be greatly curtailed

The general consensus of the Advisory Members was that there would continue to be large, long-term costs to the people of Minnesota if additional actions were not sustained to eliminate exposure to lead.

Childhood lead poisoning prevention has been a long-term priority of the MDH and partners across the State. While significant gains have been made, as shown through surveillance data, much remains to be done. The MDH Lead Program will continue to advocate for needed funds to ensure that children are protected from exposure to lead.

The 2010 Goals for Elimination of Childhood Lead Poisoning

The updated Plan to eliminate childhood lead poisoning that is being released in 2010 contains the following five goals:

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. Strategies to Develop and Implement a Program to Address Housing-based Health Threats Using Established Lead Program Capacities.

Each of these goals, along with specific objectives, tasks and measures are presented in the Implementation Goals table below. The Plan continues to strongly advocate 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 µg/dL but rising (primary prevention), care for lead-poisoned children (secondary prevention), conduct research, and measure progress to refine lead-poisoning prevention strategies.

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. The MDH ALC Unit is responsible for overseeing statewide lead compliance activities consistent with EPA, HUD and state rules, while the MDH EIA Unit is responsible for operating the statewide surveillance database and coordinating education efforts consistent with CDC CLPPP funding requirements. The "MDH Lead Program" refers to the combined efforts of both the ALC and EIA Units.

The MDH lead program is currently collaborating with other areas in the Environmental Health Division and across MDH to implement a "Healthy Homes, Healthy Places" planning effort. The goal of the effort is to examine methods to address multiple housing-based environmental health risks using "healthy homes" concepts. Ensuring that homes are dry, clean, well ventilated, pest-free, contaminant-free, safe, and maintained will help make indoor environments healthier. Efforts to make indoor environments healthier are expected to:

- improve health, productivity, and quality of life of residents,
- reduce health care costs from common housing-related illnesses and injuries, and
- help diminish health disparities for at-risk populations

Addressing the broad range of housing deficiencies and hazards associated with unhealthy and unsafe homes will require a comprehensive coalition of public health professionals and targeted training. Successful methods and policies for Healthy Homes, Healthy Places may be more easily established using expertise gained from ongoing lead poisoning prevention efforts. Therefore, Goal V of the Plan was rewritten to address establishment of a Healthy Homes program within MDH based on the current Lead Program.

Acknowledgements

This Plan was the result of the hard work and dedication of the original workgroup and the advisory members, 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 5H64EH000138-04.

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State of Minnesota Childhood Lead Poisoning Elimination Plan
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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), 1018 Disclosure Law, and Renovation, Repair and Painting rule 402(c)(3) among targeted audiences and the general public.

Tasks	Responsibility to Implement	Measure
A1. Provide information on 406(b) and 1018 in the form of "Protect Your Family from Lead in Your Home" EPA/CPSC/HUD brochure to local units of government, realtors, contractors, property owners, and outreach/housing venues.	ALL PARTNERS	MDH will provide and track copies of "Protect Your Family form Lead in Your Home" EPA/CPSC/HUD brochure as requested by June 2012.
A2. Provide information on 406(b) and 1018 at all events and exhibits attended by the general public.	ALL PARTNERS	All partners will provide the EPA/CPSC/HUD brochures at education, training and outreach venues by June 2012.
A3. Provide general information and presentations on 406(b) and RRP through building associations, real estate organizations, professional contractor groups, and other interested entities.	MDH ALC Unit, DOLI, Building owners and managers associations, contractor groups	Provide "Renovate Right" brochure, presentations, information, and CEUs as requested.

Tasks	Responsibility to Implement	Measure
A4. Conduct LSWP training through the Sustainable Resources Center, other certified training providers, or by subsidizing private training contractors to perform training.	SRC, certified trainers	SRC and private training contractors will offer eight-hour training for rehab and renovation contractors and volunteer organizations at least six times each year.
A5. Provide one-on-one education to at-risk families regarding 1018 disclosure requirements and options for noncompliance or retaliation.	MMHA, landlord associations	At-risk families will be aware of their legal rights and options when renting properties with potential lead hazards.
A6. Assess existing videos and other multi-media platforms for entities impacted by federal rules and develop a plan for reproduction/distribution.	MDH ALC Unit, HRAs (for Section 8), NAHRO and MMHA	Currently available materials are reviewed and recommendations made at MCLEAN meetings
Objective B. **Ensure that health care providers statewide know and follow current guidelines on blood lead screening, medical case management and treatment.**		
B1. Review, update and disseminate state guidelines for blood lead screening (children and pregnant women), case management and treatment.	MDH EIA Unit and consulting health provider partners	Guidelines will be reviewed and updated regularly and placed on the MDH Web site for use by partners.

Tasks	Responsibility to Implement	Measure
B2. 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 EIA Unit, Health Plans, DHS, SRC, Minneapolis Health and Family Support, MVNA	Identify clinics in which testing rates are low by June 2011. Work with clinic managers to provide education and training on blood lead screening and case management by June 2012. Work with clinic managers in rural higher risk counties by June 2012.
B3. Educate physicians in high-risk counties about blood lead screening requirements for at-risk children.	MDH EIA Unit, Local Public Health departments, Health Plans	Provide information to physicians practicing in high-risk counties the current set of blood lead screening, case management and treatment guidelines by June 2012.
B4. Provide annual surveillance reports to health care providers to ensure that data trends, new information and analysis are available to them.	MDH EIA Unit	Surveillance reports are issued, posted on the MDH Web site in June of each year.
B5. Ensure that health providers can consult with an experienced case manager on specific patients or problems.	MDH EIA Unit	State Case Monitor is available to assist local public health agencies and health providers on an ongoing basis.

Tasks	Responsibility to Implement	Measure
Objective C. **Train property owners, contractors, and building inspectors in lead-safe maintenance and work practices.**		
C1. Continue to approve training courses and license/certify lead professionals.	MDH ALC Unit	All requirements for an EPA-delegated Compliance will be met.
C2. Develop tools for lead-safe training or education presentations for the "do-it-yourselfer" audience through hardware stores and other events.	EPA	Identify a local or national partner for lead education by June 2011.
Objective D. **Increase the supply of licensed and certified lead professionals, including lead sampling technicians.**		
D1. Facilitate funding for or provide worker, supervisor, and sampling technician training.	MDH ALC Unit, DEED, Hennepin County, HUD, St. Paul/Ramsey County Public Health, SRC	Six trainings will be completed by June 2012.
D2. Provide on-the-job training to minority/small business contractors in lead-safe work practices.	St. Paul – Ramsey County Public Health, MDH EIA Unit, SRC	Four additional minority/small business contractors will have certified Lead Supervisors by June 2012.
D3. 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.

Objective E. **Provide messages to the general public that make the connection between childhood lead poisoning and lead paint in pre-1978 housing or other routes of exposure.**		
Tasks	**Responsibility to Implement**	**Measure**
E1. Develop a statewide public information campaign on primary prevention of childhood lead poisoning.	ALL PARTNERS	Campaign messages, materials will be ready for roll-out in January 2011, with assessment of results in June 2012.
E2. Adapt or develop educational materials that provide the basic message about primary prevention and are translated into multiple languages.	MDH EIA Unit, MDH OMMH	MDH translate lead fact sheets into language as recommended by MDH OMMH.
E3. Maintain and enhance a comprehensive lead information Web site with material for both the general and professional audience.	MDH Lead Program	MDH Web site will be updated as needed with new and updated information.
E4. Provide statewide, bi-cultural 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, MDH, CLEARCorps	Families statewide can access prevention information in English and Spanish by June 2012. Families access services, even if children's BLL is below the intervention level.
E5. Develop educational materials identifying other housing-based hazards to be used in conjunction with lead education efforts	MDH	Multi-issue fact sheets developed and distributed by June 2011

Tasks	Responsibility to Implement	Measure
E6. Partner with institutes of higher education to provide education to students on the risk factors for lead poisoning and the screening guidelines.	MDH, St. Paul-Ramsey	Lead poisoning prevention awareness introduced to class syllabus by June 2012.
E7. Refer information about packaging used for children's products that includes lead to the MPCA for education, enforcement and recall.	ALL PARTNERS	MPCA will continue product recalls for lead-containing children's products.
E8. 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 June 2012 to make lead product and packaging information available online.
E9. Develop and implement procedures to characterize and identify risks from lead in donated venison programs.	MDH, MDA, MDNR	Education and exposure prevention measures in place by November 2010.

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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
A1. Complete formal evaluation of surveillance system annually.	MDH EIA Unit	Using the CDC's "Guidelines for Evaluating Surveillance Systems," the MDH CLPPP will evaluate annually.
A2. Complete data matching between blood lead information system (BLIS) and Medical Assistance data from the Minnesota Department of Human Services (DHS) annually.	MDH EIA Unit, DHS	The data match will be completed annually and will be reported in the annual surveillance report.
A3. Sustain data sharing agreements with all interested Health Plans to help identify gaps in blood lead screening or testing.	MDH EIA Unit, Health Plans	Data-sharing agreements with all interested health Plans are reviewed by June 2012.
A4. Evaluate use of the MEDSS when it is released as a replacement for the BLIS system.	MDH EIA Unit	The MDH will decide on conversion to MEDSS by June 2011.
A5. Develop the capacity to geo-code blood lead surveillance data for use of local public health departments.	MDH EIA Unit, Hennepin County	Geo-coding will be available for Minnesota blood lead data by June 2012.

Tasks	Responsibility to Implement	Measure
A6. Conduct data matching between the BLIS data and Hennepin County Lead Program to help ensure data accuracy and quality.	MDH EIA Unit, Hennepin County Lead Program	Conduct data matching on an ad hoc basis.
A7. Work with MDH MEDSS 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 EIA Unit, MEDSS staff, reporting labs	Electronic reporting from one of the two remaining labs that report on paper will be available by June 2011. Greater than 85% of reporting will be done electronically by June 2012.
A8. Make blood lead surveillance data available to local public health departments via the Internet.	MDH EIA Unit, MEDSS staff	Internet access of blood lead data will be available to local public health departments by June 2012.
A9. Ensure that medical case managers have access to environmental investigation data to best work with children and families.	MDH ALC Unit, Medical Case Managers, Environmental Assessment Agencies, MEDSS staff	All medical case managers will have access to housing data pertaining to their cases by June 2011.
A10. Improve annual surveillance report with GIS and blood lead results from 5-9 ug/dL.	MDH EIA Unit	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 2011.
A11. 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.

Tasks	Responsibility to Implement	Measure
A12. Mail compliance reports to all labs reporting blood lead analysis to the MDH.	MDH EIA Unit	Compliance reports will be mailed to all reporting labs 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.**		
B1. Promote blood lead screening of Medicaid/MA eligible children through the statewide immunization registry.	MDH EIA Unit, MDH Immunization Registry	A reminder to health care providers will flag Medicaid/MA eligible children for blood lead testing by June 2012.
B2. 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.
B3. Provide recommendations about incorporating lead screening and testing to interested WIC clinics.	MDH EIA Unit, MDH WIC Clinic Coordinator, Hennepin County, St. Paul – Ramsey County Public Health, Minneapolis Department of Health and Family Support	Recommendations supplied as needed.
B4. 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 2012.

Tasks	Responsibility to Implement	Measure
B5. Continue to develop targeted screening projects and educational activities in Minneapolis, St. Paul and other areas with high-risk populations.	ALL PARTNERS.	All partners will work cooperatively to find opportunities to develop targeting screening projects.
B6. Encourage Health Plans and C&TC to promote initial and follow-up lead testing for Medicaid children.	MDH, DHS, Health Plans, Local Public Health departments	By June 2012, 80% of Medicaid children receiving a well-child visit at ages 1 and 2 will receive a blood lead test.
B7. Encourage Health Plans to send a chart flag for lead testing (initial and follow-up).	Health Plans, SRC, C&TC	By June 2012, 50 percent of clinics will include chart flags to remind about lead testing.
B8. Continue to match MDH blood lead surveillance data with MDH Refugee Health Data and track trends in the immigrant/refugee communities in Minnesota.	MDH EIA Unit, 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 2012.
B9.Continue to raise awareness among health care providers about guidelines for blood lead screening, case management, treatment and pregnancy.	MDH EIA Unit, Minneapolis, SRC	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 areas that may have lead hazards, perform risk assessments and implement primary prevention.**		
Tasks	**Responsibility to Implement**	**Measure**
C1. Use GIS mapping to determine high-risk areas for lead exposure and children in need of blood lead testing.	Hennepin County Lead Program, MDH EIA Unit, Dakota County	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 MEDSS by June 2011.
C2. Develop a statewide system to collect and analyze environmental case management data.	MDH Lead Program, Assessing Agencies, MEDSS	The MDH Lead Program will develop, in cooperation with partners, a basic reporting procedure by June 2011.
C3. 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 2012.
C4. Work to educate tenants of multiple-unit buildings with known lead hazards about landlord responsibilities and enforcement options.	MDH, Housing Link, Community Stabilization, MMHA, Legal Aid	Tenants seeking assistance in weighing legal options to reduce lead exposure will have resources.

Tasks	Responsibility to Implement	Measure
C5. Continue performing primary prevention risk assessments and dust wipe sampling in homes where children live.	SRC, HUD Lead Grantees, CDBG Grantees, Deferred Rehab Loan Prog, Minneapolis.	All agencies may conduct primary prevention risk assessments.
C6. Request lead hazard control funding from HUD through the Small Cities Development Program for eligible properties.	DEED, MDH Lead Program	The current SCDP grant will operate through October 2012. Another application will be made for HUD funding in 2012.
C7. Require lead risk assessments when state 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.
C8.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 as requested.

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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 inspection, control and compliance are integrated into housing code and policy.**		
A1. 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	Lead paint issues in pre-1978 housing are addressed consistent with current policy.
A2. Integrate lead-safe work practices into statewide building and local maintenance code applying to pre-1978 housing.	MDH Lead Program, DOLI	Lead paint assessment and lead-safe work practices will be assessed as part of statewide building and maintenance code by June 2012.
A3. Ensure that renovation and remodeling contractors are aware of the Renovation and Remodeling Rules, including compliance with state laws requiring compliance with RRP a requirement for contractor licensing in pre-1978 residential properties and permitting agency verification of RRP certification.	EPA, MDH Lead Program, Contractor Groups, DOLI,	Renovation and remodeling contractors will receive information about the RRP rules by June 2011.
A4. Encourage local governments to incorporate lead paint inspection and compliance responsibilities into Housing Inspection Departments.	MDH Lead Program, Association of Minnesota Counties, LUG, elected officials	Develop a model based upon City of Minneapolis inspections for use in other jurisdictions by June 2012.

Tasks	Responsibility to Implement	Measure
A5. Encourage local housing inspection officials to become certified lead sampling technicians able to take samples, especially in rural areas where certified lead professionals are not as readily available.	MDH Lead Program, local housing inspectors, LUG	The number of lead sampling technicians in rural Minnesota will increase by 10 percent by June 2012.
Objective B. **Ensure compliance with and enforcement of lead paint laws.**		
B1. Provide compliance assistance to regulated parties and licensed entities.	MDH ALC Unit	The MDH provides ongoing assistance as an EPA-authorized program.
B2. Enforce lead licensing requirements and regulated lead work practices.	MDH ALC Unit	The MDH enforces regulated lead work practices and licensing requirements on an ongoing basis.
B3. Continue to provide information about and promote compliance with federal lead requirements e.g. HUD 1012/1013, 1018, EPA 406(b), OSHA, RRP.	MDH ALC Unit, housing and health authorities	Information about federal lead requirements will continue to be available to interested audiences.
B4. Proceed with State implementation related to the EPA RRP	MDH Lead Program	Collaborating partners are consulted with and needed rules/statutes are amended

Tasks	Responsibility to Implement	Measure
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.**		
C1. Survey Truth in Housing programs to determine the feasibility of inclusion of visual identification of deteriorated paint surfaces 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 2012.
C2. Develop the capacity to geo-code blood lead surveillance data for use of local public health departments.	MDH EIA Unit, Hennepin County	Geo-coding will be available for Minnesota blood lead data by June 2012.
C3. Contact Fire Marshals, City Inspection Departments, or other organizations that conduct home safety visits, to incorporate awareness of lead safe practices in to routine visits.	MDH Lead Program	By June 2012 at least one Fire Department and one Inspection agency has been contacted regarding including lead in routine visits.

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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
A1. 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 2011.
A2. 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.
A3. Explore the use of MEDSS at MDH for tracking and distribution of statewide environmental data on lead.	MDH Lead Program	Research and collect information for statewide collection and distribution of lead information using MEDSS by December 2011

Tasks	Responsibility to Implement	Measure
A4. Ensure that HUD funding for lead hazard control activities is available for qualifying families.	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.
A5. Review current Minneapolis ordinance regarding transient lead releases (e.g. sandblasting, nuisance dust, power washing) from rehabilitation work for possible implementation statewide	Minneapolis, MDH Lead Program, Minnesota Legislature	Ordinance reviewed, barriers identified, and enforcement mechanism identified.
Objective B. **Leverage private and nonprofit funding mechanisms to identify and control lead paint hazards.**		
B1. Seek nongovernmental funding for lead hazard reduction and education in Minnesota.	SRC, MPCA	Continue applying for lead hazard control and education funding.
B2. Develop relationships with volunteer, non-profit and for-profit developers, remodelers and remediators to educate on lead-safe work practices utilizing the EPA RRP rule.	LUG's, Small Cities, DEED, HUD, Hennepin County, MDH Lead Program, SRC	Gather information on volunteer, non-profit and for-profit developers, remodelers and remediators to determine where to disseminate information on lead-safe work practices by June 2011.

Tasks	Responsibility to Implement	Measure
B3. Ensure that moderate-income families within funded jurisdictions are aware of Small Cities Program Fund or other housing resources for housing rehabilitation.	DEED, MHFA, MDH Lead Program, Local housing agencies, Local Public Health departments doing case management of EBLs.	Ongoing programs meet recruitment levels and perform LSWP on all appropriate projects.
B4. Continue working with non-English media outlets to develop public health programming regarding childhood lead poisoning or lead-safe work practices.	ALL PARTNERS	Research and develop at least four proposals by June 2012.
B5. 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	Promote and track ECHO DVD distribution by June 2011.
Objective C. **Evaluate potential legislation that would provide sustainable funding sources for lead surveillance and lead hazard control.**		
C1. Track bills that are introduced in each Minnesota Legislative Session and provide impact analysis or technical assistance to authors.	MDH Lead Program, other partners with legislative interests	MDH will continue to track bills and provide analysis and assistance.
C2. Propose legislation permitting use of Medicaid funding for environmental risk assessment and case management.	DHS, City of Minneapolis, Hennepin County, others involved in Medicaid	Federal waivers will be pursued consistent with applicable procedures.

Tasks	Responsibility to Implement	Measure
C3. Investigate the feasibility of providing funds for lead hazard control from a fee on retail paint	SRC	Bill introduced in 2005, reintroduced in 2006. New bills tracked as needed.
C4. Develop sustainable long-term funding source for the statewide blood lead surveillance system by 2012.	Minnesota Legislature, MDH	Recommendations for sustainable funding options will be included in the biennial report to the legislature, deliverable in January 2012.
C5. 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 2011 session how to increase funding with affordable terms and conditions for lead hazard reduction in the homes of low- and very-low income occupants.
C6. Ensure that moderate-income families are aware of MHFA Fix-up Fund for window replacement.	MHFA, ALL PARTNERS	Include information about available funds in general resources about housing funds for moderate income families.
C7. 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.	Minnesota Legislature	Necessary bills drafted, funding sources identified, legislation introduced and passed.

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Goal V.
Strategies to Develop and Implement a Program to Address Housing-based Health Threats Using Established Lead Program Capacities.

Objective A.
Identify and assess at-risk populations, including health and housing issues.

Tasks	Responsibility to Implement	Measure
A1. Summarize community demographics, condition of housing stock, and health trends based on available data.	MDH, Local Public Health agencies	Surveillance and published data used to generate summary document by 2012.
A2. Communicate with MDH Office of Minority and Multicultural Health and representatives of diverse populations to prioritize health concerns related to housing.	MDH, Local Advocacy Organizations	Priority populations identified.
A3. Review current Minnesota State Comprehensive Plan	MDH, DEED, MHFA	Trends and priorities in established State Plan reflected in healthy homes program development.

Tasks	Responsibility to Implement	Measure
Objective B. **Catalog available resources, including training, education, policies, program experiences, and funding.**		
B1. 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.
B2. Promote attendance at the "Essentials for Healthy Homes Practitioners" training course.	SRC, MDH, Local Health Departments	Number of certified Healthy Homes Practitioners in Minnesota increases annually.
B3. Review past healthy homes applications in Minnesota to identify successful methods, policies, and evaluation measures	MDH, SRC, Minneapolis	Consensus reached on best practices for priority health concerns.
B4. Compile a list of potential funding sources for healthy homes implementation, including federal, state, foundation, non-profit, and in-kind.	ALL PARTNERS	Applications/proposals completed to secure funding.
Objective C. **Strategic Partnerships.**		
C1. MCLEAN participation list reviewed to characterize range of partners involved and identify additional expertise needed for healthy homes	MDH	Additional partners added to MCLEAN list
C2. Collaborative workgroup established, routine meeting time and place set, and invitations sent to interested parties	MDH, with input from ALL PARTNERS	Collaborative workgroup established and meetings held.

Tasks	Responsibility to Implement	Measure
C3. Workgroup membership routinely reviewed to ensure appropriate organizations are involved and new organizations recruited, with a special emphasis on those conducting home visits.	MDH, with input from ALL PARTNERS	New members added
Objective D: Integrate recommendations and data in to a comprehensive Strategic Plan for Healthy Housing, Healthy Places in Minnesota		
D1. Data from Objective A assessed and summarized to identify target populations for chosen interventions	MDH, with input from ALL PARTNERS	Data summary prepared
D2. Data from Objectives B and C assessed and summarized to characterize scope of healthy homes interventions, referrals available, and constraints on program response	MDH, with input from ALL PARTNERS	Consensus on scope and constraints on interventions established
D3. Evaluation measures established for chosen interventions to document health benefit and establish expected outcomes	MDH, with input from ALL PARTNERS	Evaluation measures established and routinely monitored
D4. Minnesota Healthy Housing Strategic Plan established and reviewed biennially	MDH, with input from ALL PARTNERS	Plan posted on MDH website