

# **Wisconsin Childhood Lead Poisoning Elimination Plan 2010**

Department of Health and Family Services  
Division of Public Health  
Bureau of Environmental and Occupational Health  
Wisconsin Childhood Lead Poisoning Prevention Program  
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Wisconsin must identify and seek new and expanded resources to control lead hazards, especially in older dwellings occupied by families with young children.

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## **I. Mission**

Wisconsin has adopted the mission to eliminate childhood lead poisoning in Wisconsin by 2010.

### **Purpose**

Lead poisoning of our children is a devastating phenomenon that is largely preventable. A group of concerned and committed citizens convened in 2004 including representatives of state, federal and local agencies plus advocates and family representatives. They grappled with numerous complexities regarding what causes lead poisoning and how best to manage and eliminate the factors that contribute to this problem among children in Wisconsin communities. The fact that Wisconsin exceeds the national average for the proportion of children with lead poisoning is an alarming statistic that only strengthens our resolve as a state to successfully remedy this problem. This plan intends to strategically and concisely lay out approaches that Wisconsin will take to achieve the mission with a primary focus on first year efforts. This plan was developed with the knowledge of today and over time will flex whether to adopt other efforts as new opportunities arise, embrace new partners, or to address new knowledge.

## **II. Background on the Childhood Lead Poisoning Problem in Wisconsin**

During the 1980s, evidence accumulated in the scientific community that lead was damaging to young children at blood lead levels previously thought to be safe. Because of increased information and public pressure, a new federal law (Title X Residential Lead-based Paint Hazard Reduction Act of 1992) was enacted in 1992 that committed the federal government to a much larger role in preventing lead poisoning. The law: a) requires lead safety to be addressed in all HUD housing programs, b) requires the EPA to establish standards for lead safety and to develop standards for a trained workforce, and c) requires private property owners to provide information about potential lead exposure hazards to all potential new tenants or buyers. Conceptually, Title X sets a strategic framework to address lead paint hazards by acknowledging a distinction between the presence of lead and the presence of lead paint hazards and by acknowledging a distinction between permanent and temporary measures to address lead hazards.

In 1991, the federal Centers for Disease Control and Prevention began funding Wisconsin for lead poisoning prevention activities, including blood lead testing, case management, and education. As a result of increased testing, many more Wisconsin children were identified with lead poisoning. It quickly became apparent that local health departments received insufficient resources to follow up and investigate lead hazards in the homes of all lead poisoned children.

The Wisconsin State Legislature received this information and advocacy pressure from parents and non-profit organizations, such as the March of Dimes and the Council on Developmental Disabilities. As a result, the Legislature strengthened state law and provided additional resources to enable the Department of Health and Family Services (DHFS) and local health departments to better respond to the increased need for lead poisoning prevention and follow-up services. For example, a requirement was established to report all children's blood lead test results. Also, funding available to local health departments for lead poisoning prevention activities was increased from zero dollars to \$1,200,000 annually. This funding was decreased to \$879,100 annually in the subsequent state budget.

In 1994, Wisconsin received a HUD grant for six million dollars to correct lead hazards in 511 low- to moderate-income dwellings. Wisconsin was one of 12 grantees to participate in this national evaluation project. This project required exhaustive research and multiple measures of lead dust in homes and blood lead levels of occupant children. Ultimately, Wisconsin demonstrated great success in reducing lead dust levels and protecting children from increases in blood lead levels. Since then, the State of Wisconsin and agencies in Milwaukee, Kenosha and Sheboygan have received competitive grant funds for lead hazard control efforts in private housing.

Since 2000, DHFS has developed the capacity to evaluate and interpret surveillance information such as blood lead test results; local health department case management and lead hazard property investigation reports; insurance coverage; census data, and tax assessor data to determine time trends, risk factors and program needs to strengthen the lead program effectiveness. The available data clearly demonstrate four compelling needs.

First, Wisconsin should accelerate efforts to provide blood lead tests to all children enrolled in Medicaid. Not only is this required under federal law, but if children at high risk for lead poisoning can be identified earlier, then intervention efforts have a greater probability of success.

Second, Wisconsin must recognize that currently available resources are insufficient to evaluate lead hazards in the homes of all lead poisoned children. Current state law and current funding support the local health departments to investigate only the most severely poisoned children. For example, in 2002 there were 4,460 children identified as lead poisoned in Wisconsin. However, under current state law, local health departments were required and funded to investigate the homes of only 642 or 14% of these children - those with the most severe lead poisoning.

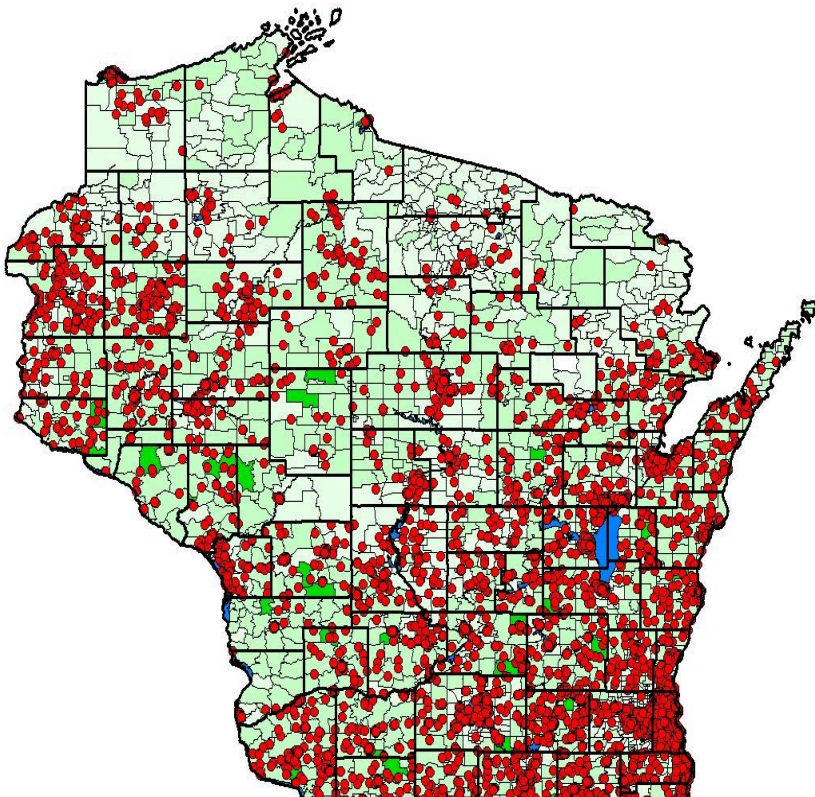
Third, to truly prevent the disease we must focus our attention on the condition of housing units that are occupied by families with young children. We must recognize that property owners, property managers, housing industry programs, and parents have the capacity to prevent lead poisoning. We will continue to fail if we use the public health system only to develop housing interventions in response to lead poisoned children.

Fourth, there are real economic benefits that can be realized by eliminating childhood lead poisoning beyond the fact that all children deserve to grow up lead-free. The annual cost savings to Wisconsin by eliminating lead poisoning is estimated at \$14,037,259. This estimate is based on a model developed at the University of Rochester in New York, that factors in the costs of special education, medical treatment, juvenile justice, and lost future income for children who suffer from lead poisoning. (See Appendix 1 for a copy of the cost savings model.) Since the model uses data on the number of lead poisoned children that have been identified and, since testing rates for the highest risk children in Wisconsin are relatively low, this may be a conservative estimate of the cost savings that would result from elimination of the disease.

### III. Extent of the Childhood Lead Poisoning Problem in Wisconsin

Wisconsin has had a blood lead reporting law since 1994 that requires reporting of all blood lead test results. Laboratories report the blood lead test results to the Department of Health and Family Services, Wisconsin Childhood Lead Poisoning Prevention Program (WCLPPP). The WCLPPP maintains a database of this blood lead data, which consists of complete data on the children who are tested.

The rate of lead poisoning among Wisconsin children is nearly 3 times the national average. In 2002, 6.2% of Wisconsin children less than 6 years of age who were tested had a blood lead level of 10  $\mu\text{g}/\text{dL}$  or more. This compares to a national average of 2.2% as determined by the 1999-2000 National Health and Examination Survey (NHANES).



**Figure 1. Each red dot represents the address associated with one or more lead poisoned child (blood lead levels greater than or equal to 10 mcg/dL).**

In September 2003 the Centers for Disease Control and Prevention (CDC) published a national blood lead surveillance report that provided data for 43 states. According to the CDC report, in 2001 Wisconsin had the sixth highest number of lead poisoned children when compared to other states.

Lead poisoned children have been identified in every Wisconsin county.

Figure 1 represents the statewide distribution of children who were identified with lead poisoning from 1995 – 2001. In 2002 alone, there were 4,460 children identified to have lead poisoning in Wisconsin. In that year, nearly 82,000 children were tested, which is approximately 20% of Wisconsin children less than 6 years of age.

The WCLPPP has utilized the blood lead data to identify 13 high risk communities in Wisconsin that have the largest numbers of lead poisoned children and the highest rates of lead poisoning (See Table 1). These 13 communities account for 82% of all lead poisoned children.

**Table 1. Wisconsin Communities at High-Risk for Lead Poisoning;  
Annual Average 1999 – 2001**

<b>Community</b>	<b># Children (ages 0-5 yrs.) Tested</b>	<b># Children with Blood Lead Levels <math>\geq 10</math> mcg/dL</b>	<b>Proportion of Children with Blood Lead Levels <math>\geq 10</math> mcg/dL</b>
Milwaukee (city)	21,958	3,935	18%
Sheboygan Co.	1,155	110	10%
Beloit (city)	1,069	102	10%
Racine (city)	3,244	292	9%
Oshkosh (city)	749	51	7%
Kenosha Co.	1,404	89	6%
Manitowoc Co.	932	57	6%
Marathon Co.	1,199	73	6%
Brown Co.	2,014	100	5%
Fond du Lac Co.	1,190	63	5%
Rock Co.	1,315	65	5%
La Crosse Co.	1,181	53	4%
Waukesha Co.	3,082	86	3%
<b>Total - High-Risk Communities</b>	<b>40,482</b>	<b>5,076</b>	<b>12.5%</b>
<i>Statewide Total</i>	<i>73,664</i>	<i>6,204</i>	<i>8%</i>

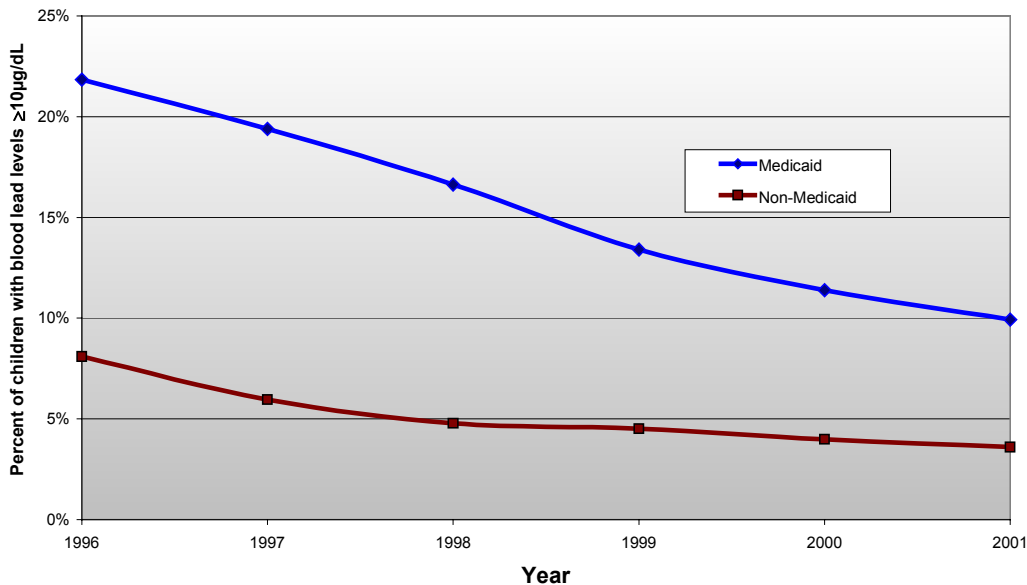
### Risk factors for lead poisoning in Wisconsin

Several risk factors are associated with an increased risk for lead poisoning in Wisconsin. These factors include:

- Family income
- Race/ethnicity
- Age of child
- Age of house

**Family Income.** The WCLPPP uses enrollment in the Medicaid Program as an indicator of low family income since this program primarily serves low-income families. The WCLPPP has been sharing data with the Medicaid Program since 1996. Blood lead data is matched with Medicaid enrollment data. From this matched dataset, the WCLPPP determines, of the children tested, who was enrolled in Medicaid and who was not enrolled. In 2002, 56% of children tested were enrolled in Medicaid and 85% of children who were diagnosed with lead poisoning were

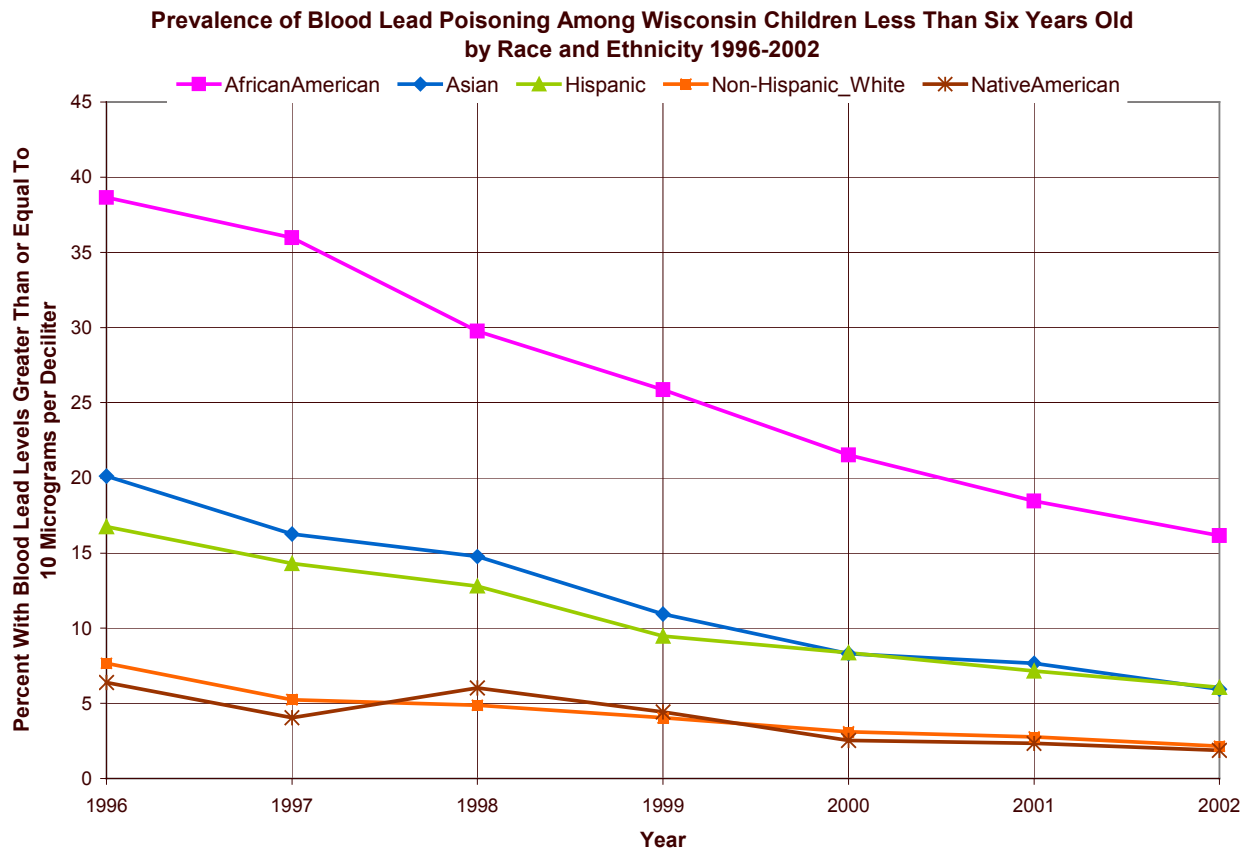
**Prevalence of Lead Poisoning in Wisconsin Among Children  
Ages 0 to 5 Years, 1996 - 2001**



**Figure 2. Prevalence of lead poisoning among children ages 0-5 years by Medicaid enrollment status, 1996 – 2001.**

enrolled in Medicaid. Figure 2 presents data on the rate of lead poisoning among children who were enrolled in Medicaid to those who were not enrolled. Since 1996, children on Medicaid have had consistently higher rates of lead poisoning. The risk to those children continues to be 3 times higher than to those who are not enrolled.

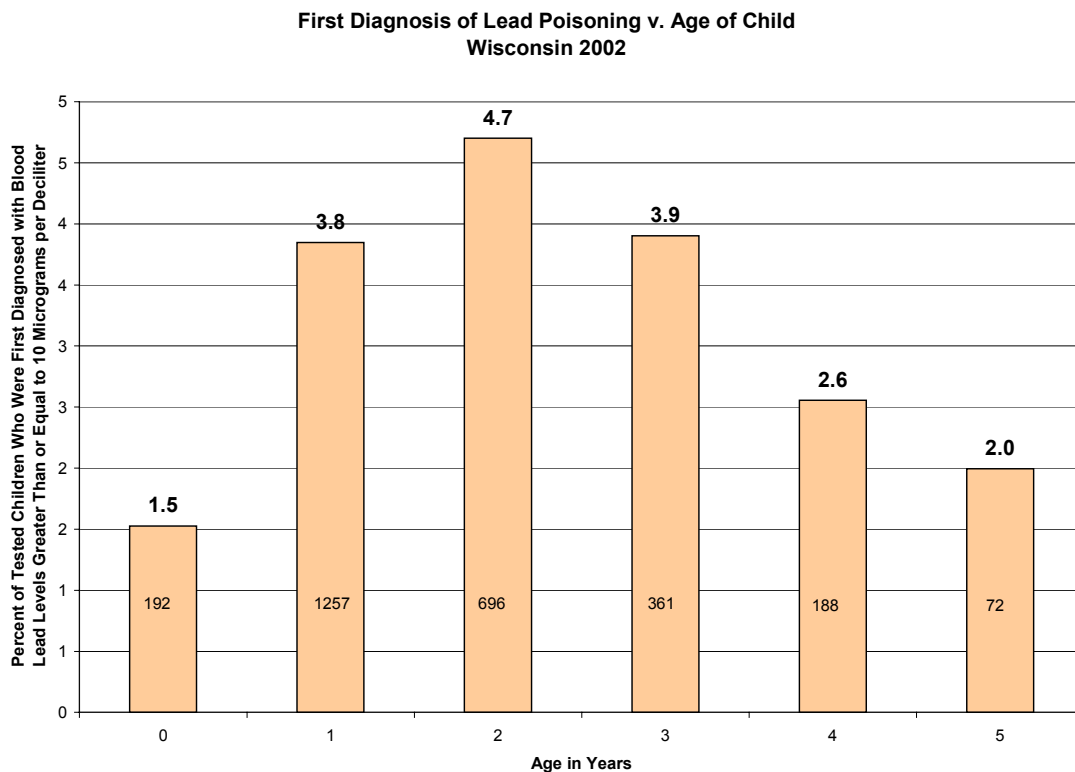
**Race/Ethnicity.** Minority populations in Wisconsin share a greater burden of the lead poisoning problem. Figure 3 (below) presents data on the percent of children tested who were diagnosed with lead poisoning by racial and ethnic group. Lead poisoning rates are highest among African American children, followed by Asian children and Hispanic children. There is a high rate of poverty among minority populations in Wisconsin, especially among African American and Asian populations. Poverty rates are most likely linked to the high rates of lead poisoning that are found in these populations.



**Figure 3. Prevalence of lead poisoning among children ages 0-5 years by race and ethnicity, 1996 – 2002.**

Lead poisoning rates are the lowest among non-Hispanic white children and Native American children.

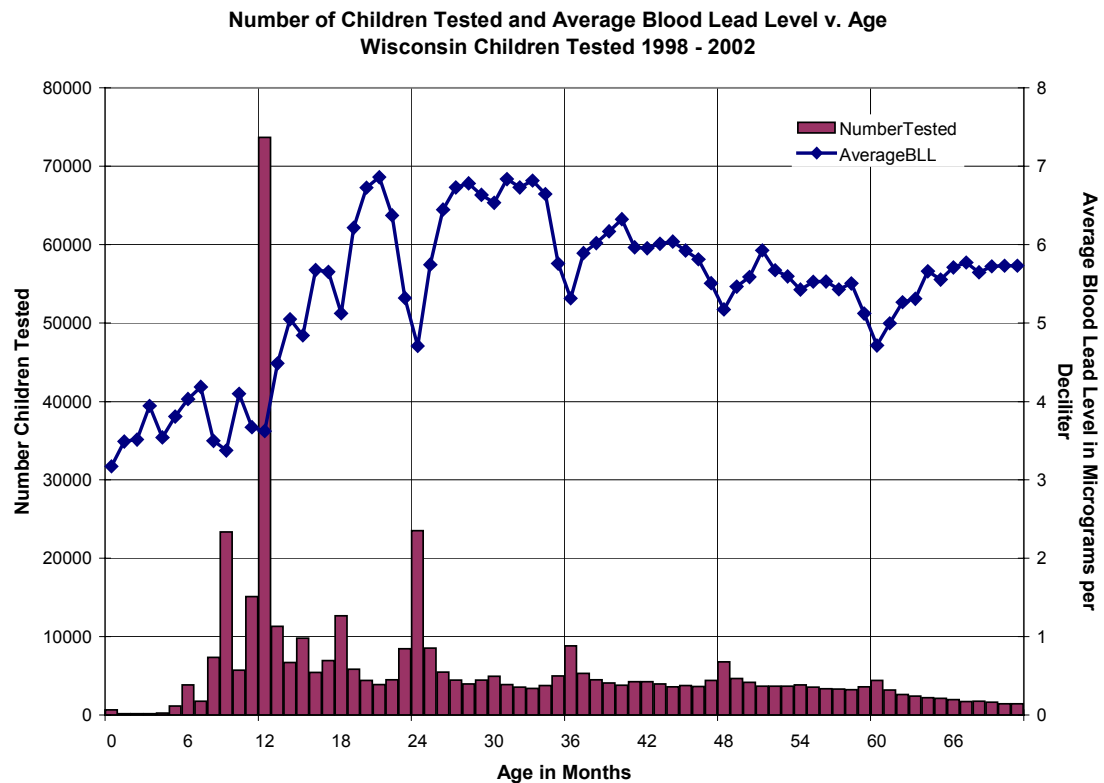
**Age of Child.** Blood lead levels tend to be highest between 18-36 months of age, when children are engaging in frequent hand-to-mouth activity and are becoming more mobile, which provides them greater access to lead hazards that may exist within their environment. Figure 4 (below) presents data on the rate of lead poisoning in Wisconsin by a child's age in years at the time they were tested. The highest rate of lead poisoning has been seen among 2 year olds, with only slightly lower rates among 1-year-olds and 3-year-olds.



**Figure 4. Incidence of lead poisoning by age of child, 2002.**

Current screening policy in Wisconsin includes a recommendation to test high-risk children at 1 year of age so that, if lead exposure has occurred, it can be diagnosed early and interventions can take place to reduce the blood lead level. It is also very important, however, that children be tested again at 2 years of age or later when their risk for lead poisoning may be greater. A normal blood lead test at age 1 does not mean the child is not at risk for lead poisoning later on.

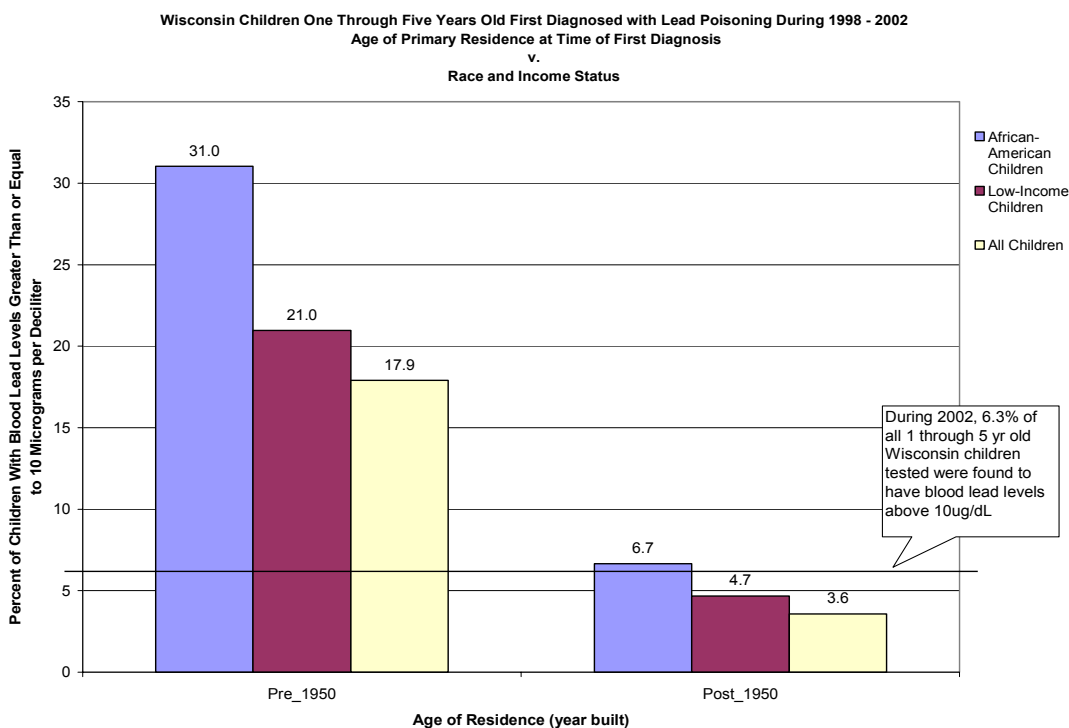
Figure 5 presents data for 1998 through 2002 on the average blood lead level of Wisconsin children by their age in months at the time they were tested and the age at which children were tested. These data demonstrate that many children are tested at 12 months of age, with a dramatic decrease in the number of children tested at later ages. This may result in children's lead poisoning remaining undetected because of the lack of testing at the highest risk ages.



**Figure 5. Number of Wisconsin children tested in 1998-2002 and the average blood lead level at age in months.**

**Age of Housing.** National data have shown that children who live in old housing, where lead paint is more prevalent, are at greater risk for lead poisoning than children who live in newer housing. This same relationship is evident in Wisconsin, where 90% of lead poisoning children have been shown to live in homes that were built before 1950. The maps in Appendix 2 demonstrate this relationship of lead poisoning to old housing in several Wisconsin communities (Milwaukee, Racine and Sheboygan).

By combining several of the risk factors that have been discussed, the impact of housing age on the rate of lead poisoning is further demonstrated. Figure 6 (below) presents data on 3 subgroups of children who were tested during 1998 – 2002. These subgroups are African American children, children enrolled in Medicaid, and all children less than 6 years of age. As the data demonstrate, the risk for children increases significantly if they reside in housing built prior to 1950. For example nearly 32% of African American children who were tested and live in housing built prior to 1950 were found to have lead poisoning as compared to 6.7% of African American children who live in housing built after 1950.



**Figure 6. Prevalence of lead poisoning among children ages 0-5 years by age of housing, race and income status, 1998 – 2002.**

### High-Risk Housing in Wisconsin

Based on national housing survey data, it is estimated that more than 700,000 housing units in Wisconsin have some lead hazards, of which 120,000 units have lead hazards and are occupied by children less than 6 years old. In light of this data, lead hazards will need to be controlled in approximately 20,000 dwellings per year in order to reach the goal of eliminating childhood lead poisoning by 2010 through housing-based interventions. In contrast, in 2003 lead hazards were

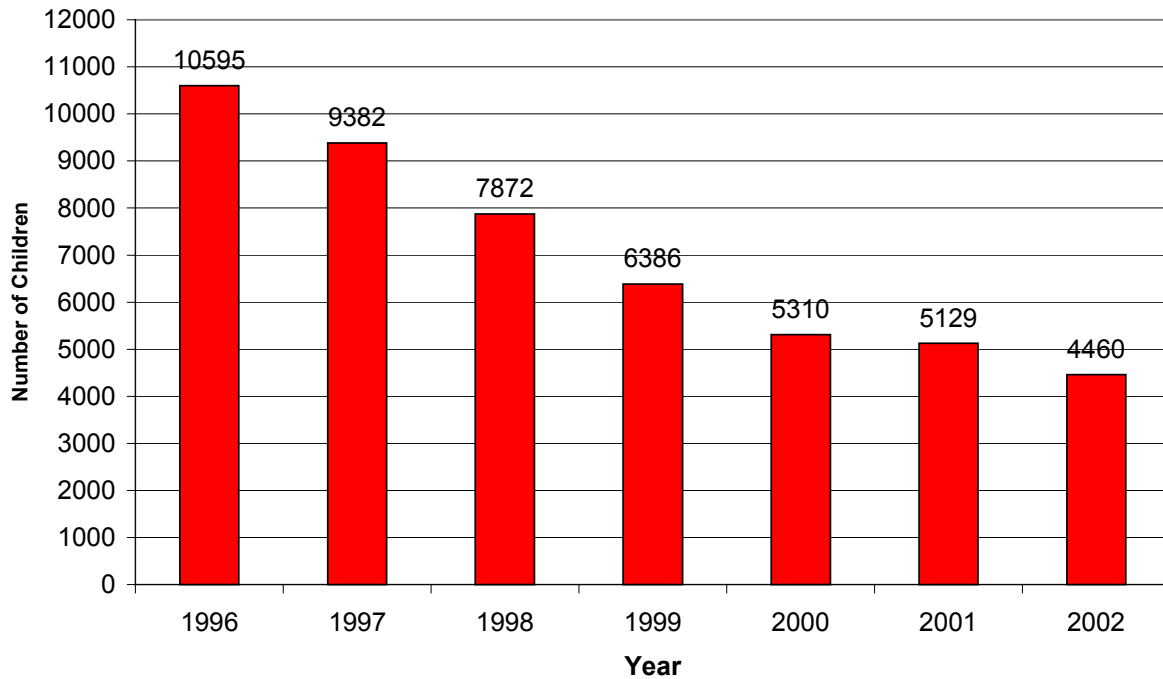
controlled in approximately 3,800 dwellings through a combination of lead hazard controls conducted in response to children with elevated blood lead levels (i.e., secondary prevention) and those performed in high-risk housing in the absence of a lead poisoned child (i.e., primary prevention).

In addition to age of housing, the condition of housing is an important factor that relates to the lead poisoning risk for a young child. There is generally more lead paint found on exterior surfaces of a house than on interior surfaces. For the vast majority of Wisconsin children with elevated blood levels, local health department staff is able to identify lead-based paint hazards in the child's primary residence. Data on housing investigations for lead poisoned children in Wisconsin demonstrate that the most common locations of lead-based paint hazards are windows, porches, and exterior surfaces. The primary cause of the hazards has consistently been found to be due to deterioration of painted surfaces. Twenty percent of children in Wisconsin with elevated blood lead levels live in homes where renovation activity has taken place. In 1997-1998, an EPA-funded survey of 3,654 Wisconsin families found renovation activity was associated with a 30% increased risk of lead poisoning.

### **Progress To Eliminate Childhood Lead Poisoning in Wisconsin**

Tremendous progress has been realized over the last several years in reducing the burden of lead poisoning in Wisconsin. See Figure 7 (below). In 1996, for example, more than 10,000 children were identified with lead poisoning. In 2002, there were 4,460 children identified with lead poisoning, while the number of children tested increased significantly.

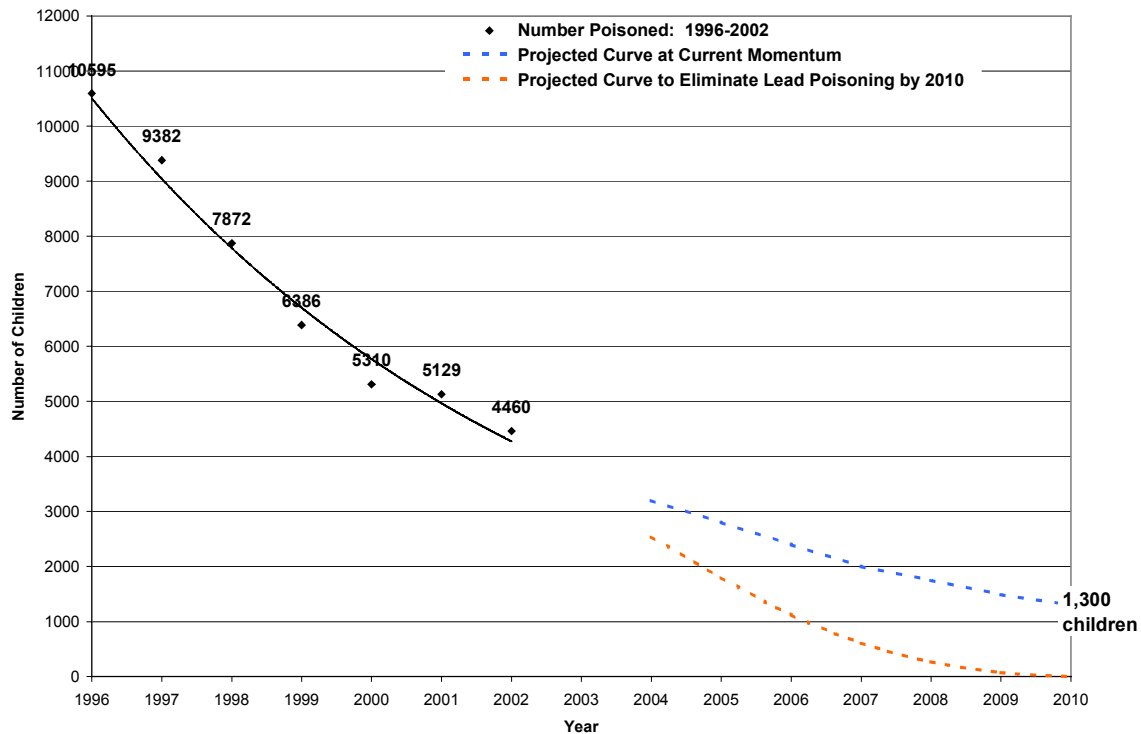
**Number of Wisconsin Children Less than Six Years with Blood Lead Levels of 10 Micrograms per Deciliter or More**



**Figure 7. Number of lead poisoned children ages 0-5 years; 1996 – 2002.**

Based on the level of progress that has been realized since 1996, it's possible to project the number of lead poisoned children that may be identified in 2010, assuming the current blood lead testing rates and level of momentum in reducing the burden of lead poisoning are maintained. According to this projection, there will be 1,300 lead poisoned children identified in 2010. See Figure 8 (below).

**Number of Wisconsin Children Less Than Six Years Who Have Blood Lead Levels of 10 Micrograms per Deciliter or Greater**



**Figure 8. Number of lead poisoned children ages 0-5 years; 1996 – 2010.**

One factor to consider, however, is that the current rate of testing falls far short of reaching all of the high-risk children. For example, children enrolled in Medicaid are at high risk, yet less than 50% of these children are tested at ages one and two. If blood lead testing rates improve, the number of lead poisoned children identified will most likely increase, at least in the short-term, yet this would indicate progress in our efforts to target high risk children. In 2002, the Centers for Disease Control and Prevention estimated there were 12,400 children with lead poisoning in Wisconsin. Since less than 50% of the children enrolled in Medicaid are tested, it is possible that we are identifying less than 50% of the children who are lead poisoned.

#### **IV. Process of the Wisconsin Childhood Lead Poisoning Elimination Plan Committee**

The Wisconsin Department of Health and Family Services (DHFS) appointed members to a Wisconsin Childhood Lead Poisoning Elimination Plan Committee, to develop a plan to eliminate childhood lead poisoning in Wisconsin by 2010. Kenneth Munson, DHFS Deputy Secretary, chaired the committee from January through June 2004. (See Appendix 3 for a complete list of committee members and Appendix 4 for a copy of the appointment letter.)

The Committee included 38 members with broad and diverse membership including public health, housing and policy professionals, elected officials, individuals from the private sector and community-based organizations, the Wisconsin Medicaid Program, U.S. Environmental Protection Agency (EPA) and the U.S. Department of Housing and Urban Development (HUD). Committee members included parents of lead poisoned children, advocates from target communities and minority populations with high prevalence of lead poisoning, rental property owners, real estate groups, the State Department of Insurance Commissioner and the Department of Justice. Included in the list were individuals previously involved in childhood lead poisoning prevention efforts, for example, members of the screening advisory committee. Also included were individuals who have a pivotal role in this arena in their own community. One consideration was the individual's level of responsibility within their own organization, such as those in a position to make decisions or affect policy. Kris Freundlich of the DHFS Office of Strategic Finance provided facilitation and strategic planning support.

During the initial meeting of the committee, staff of the Wisconsin Childhood Lead Poisoning Prevention Program (WCLPPP) provided a broad overview of the status of the lead poisoning problem in the State of Wisconsin and the history of Wisconsin's response to the problem. Amy Murphy of the City of Milwaukee Childhood Lead Poisoning Prevention Program shared their progress from a secondary intervention program to a primary prevention approach. Their strategic plan uses a combination "carrot and stick" enforcement/incentive system for working with rental property owners, relies on community-based organizations to maintain the city council's political will in favor of lead poisoning prevention, and employs research-based

methods of lead hazard reduction. Staff and committee members discussed and developed consensus concerning committee member roles and responsibilities (see Appendix 5).

Following the presentations about the status of the problem in Wisconsin and Milwaukee, the committee members responded in a large group discussion with questions and ideas and strategies for preventing the disease. Between meetings, members provided feedback on the list of strategies compiled at the first meeting. These items became the springboard for the work of the next meeting--ranking the strategies. To reach group consensus on the ranking of strategies, members discussed the strategies and voted for those that they thought would be the most effective and feasible in eliminating lead poisoning.

For the next meeting, WCLPPP staff grouped the strategies into 4 broad categories by subject matter: blood lead testing of high-risk populations; home visitation/ education; funding & resources; and legislation/policy. Committee members were assigned to one of the four groups depending on their expertise. In small group discussions, members sifted through the strategies to determine priority and feasibility and to identify what it will take to accomplish the strategies.

The details of discussion were captured and further refined by WCLPPP staff following the meeting. The strategy categories shifted somewhat, resulting in the final 4 broad areas: blood lead testing of high-risk populations; education; funding/resources; and correcting lead hazards in housing. Again in small group discussions, committee members expanded details of the major strategies to identify critical action steps and performance measures for the first year of the plan. Staff sought members' feedback between meetings, asked for review for any critical missing information or considerations, judgements about feasibility, and other reactions.

At the May meeting, committee members discussed the next phase - implementation of the elimination plan. The discussion centered on three areas:

1. An implementation and evaluation oversight committee and what its function would be, who would serve on it, and how it would operate;
2. Implementation subcommittees with similar points of discussion; and
3. The pursuit of funding--a major issue or barrier to the work at hand.

The discussion at the final committee meeting in June focused on issues surrounding actions to begin immediate implementation of the plan and establishing a Childhood Lead Poisoning Elimination Implementation and Oversight Committee.

## V. Strategic Workplan

### **A. Education**

**5 YEAR GOAL: The general public, parents, policymakers, and property owners will be knowledgeable about lead poisoning risks, prevention, and methods to control lead hazards.**

**Strategy 1: Utilize home-based strategies to educate parents and caregivers about lead poisoning risks, prevention and screening recommendations so they can take the right protective and corrective actions.**

*Why is this important?* Parents are significantly motivated to protect their children's health. If they have adequate information they can take appropriate steps to have their children tested and make changes to their environment to protect their children from lead exposure.

Note: Expansion of home visitation programs will require additional training of local public health staff in environmental assessment skills and a greater commitment of current state and federal childhood lead funding provided to local health departments towards primary prevention and early intervention activities. Another essential component for long term effectiveness of identifying lead hazards in a dwelling is making available the resources for fixing the lead hazards (rental and owner-occupied). The resource/funding strategies to obtain more lead hazard reduction funding are critical for the sustainability of these efforts.

#### **1-5 Year Objectives:**

1. DHFS will partner with other health care or social service programs that conduct home visits with families who live in high-risk housing to assess the home for lead hazards and provide information on lead poisoning prevention.
2. DHFS will partner with other programs that serve high-risk families (e.g., parish nurses, Head Start, day care providers) to enlist their help in educating families, raising awareness and initiating referral to environmental staff to conduct home assessments. (See Housing

Strategy 2, Objective 8 that focuses on strengthening the environmental assessment capacity of these home visitation programs.)

3. Increase consumer self-advocacy for health promotion and disease prevention of childhood lead poisoning by instituting a community health worker model in communities with a disproportionate burden of lead poisoned children or lead poisoning hazards.

**Year One Activities:**

1. By June 2005, expand existing public health home visitation programs to reach:
  - ✓ Pregnant women and families of newborns who live in high-risk housing.
  - ✓ Families of lead poisoned children (blood lead level of 10 mcg/dL or more)
  - ✓ Families of children <30 months of age with blood lead levels of 6-9 mcg/dL to prevent their blood lead levels from rising (NOTE: This will be offered as a template objective for the consolidated contract process for local health departments. If a local health department has only a few children with blood lead levels of 10 mcg/dL or greater, but has young children with levels of 6-9 mcg/dL it could be pursued as a pilot project. If successful and feasible, it could be promoted the following year to other communities).
- 2a. By January 2005, DHFS and partners will identify opportunities to collaborate with regulatory staff who license day care providers to find ways to provide information and education to day care providers who can then share lead hazard information with parents if they think the family may be living in high-risk housing. (See Housing Strategy 2, Objectives 1-3, for details on offering training to day care facility staff to evaluate facilities for lead hazards.)
- 2b. By January 2005, DHFS and partners will provide standardized training on lead poisoning prevention education and environmental assessment to public health and other agencies who identified that they will work with rural nursing or other paraprofessional home visit programs to include lead poisoning prevention within their scope of education.

- 2c. By June 2005, DHFS and partners will provide information and education to parents through the preschool (pre-kindergarten) system (e.g., Head Start) including educating preschool teachers and other educators about: the scope of the lead poisoning problem; risks in their neighborhood; how to identify potential lead hazards in housing; and the learning disabilities that lead exposure can cause.
- 3a. By October 2004, the Childhood Lead Poisoning Elimination Planning Committee will enter a Memorandum of Understanding with the UW-Madison Center for Cultural Diversity in Healthcare (CDH) and selected community partners to assist in the development of a community-driven childhood lead poisoning prevention initiative with a focus on strengthening resilient and asset-based factors of families and neighborhoods to promote healthy living environments and quality healthcare and reduce childhood lead poisoning disparities.
- 3b. By January 2005, WCLPPP will assist the CDH in the development of a community health worker curriculum for the prevention and management of childhood lead poisoning. Consideration will be given to teaching parents to advocate for the long term needs of their children who have been lead poisoned (e.g., assistance in school for learning disabilities or behavior problems).
- 3c. By June 2005, DHFS and partners will work with community health workers to educate parents that blood lead testing is an integral part of any Health Check exam to which their children are entitled as a health test benefit.
- 3d. By December 2006, WCLPPP will assist the CDH in an evaluation of the community health worker model as an intervention to reduce disparities in childhood lead poisoning.

**Leaders:**

1. WCLPPP; managed care organization outreach workers; local PHNs working with hospital staff
2. WCLPPP, PHNs, and other professionals working with families with young children.

3. UW- Madison Center for Cultural Diversity in Health Care; Wisconsin Minority Health Program; Community-based organizations; Medical College of Wisconsin

**Performance Measures:**

1. Increased numbers of home visit programs conducting lead testing and increased number of staff trained as lead dust wipe sampling technician or risk assessors; increased environmental assessments referrals from other home visit programs; increased number of families receiving in-home assessment and education; increased number of home assessment requests from parents/caregivers; percent increase in annual home screenings.
- 2a. Number of day care centers evaluated for lead hazards; number of day care centers where lead hazards have been successfully removed.
- 2b. Number of new organizations that include lead education in outreach to parents.
- 2c. Number of teachers receiving in-service hours of training on lead poisoning risks, effects and prevention; percent of schools with lead poisoning prevention agenda in their school curriculum or parent outreach.
- 3a. The community health worker curriculum including lead poisoning prevention education and developing parent self-advocacy for blood lead testing.
- 3b. Number of community health workers educating parents about lead hazards; number of families receiving lead education by community health workers.
- 3c. Increase in rate of blood lead tests in communities targeted for community health worker efforts.

**Strategy 2: Educate the general public about lead poisoning risks and prevention, screening and treatment.**

*Why is this important?* Hearing the same critical messages about lead poisoning risks and prevention a number of times and through different channels (e.g., in print, on air, from respected individuals such as a physician or nurse, on a public health website) lends credibility to the message, reinforces its “truth,” and facilitates action needed to implement the lead elimination plan.

**1-5 Year Objectives:**

1. Increase awareness of status of childhood lead poisoning in Wisconsin and the need for prevention within the current administration: Governor, DHFS Secretary and her staff, DPH Administrator and his staff, to create opportunities for media coverage.
2. Increase awareness of the public and the public health community of the disparity of childhood lead poisoning, which impacts children of low income families, predominantly African American children, through a partnership with the Wisconsin Minority Health Program and community-based organizations.
3. Increase awareness of the legislative opportunities to promote childhood lead poisoning prevention as part of the Governor’s KidFirst Agenda with the release of the report on WI Act 113 (see Education Strategy 3, Objective 1, Year One Activity 1c) and its impact on the citizens of Wisconsin.

**Year One Activities:**

- 1a. By October 2004, develop a promotional packet with materials including critical messages about lead poisoning that align with the Governor’s Healthy Kids Initiative, arrange promotional opportunities, for example, a WIC project conducting blood lead screening and nutrition counseling, or a project site where lead hazard reduction is taking

place, where the Governor or Secretary Nelson can be covered by media (print, web) as part of National Lead Poisoning Prevention Week.

- 1b. During 2004-5, in conjunction with the Healthy Kids committee, provide information and data on childhood lead poisoning on the DHFS Healthy Kids webpage. Highlight childhood lead poisoning prevention information on the DHFS main webpage in June and October 2004.
2. Develop messages on the health disparities issue in childhood lead poisoning prevalence in Wisconsin to raise awareness of the public and the public health community.
3. With the release of a Department report required by WI Act 113 (see Education Strategy 3, Objective 1, Year One Activity 1c) to the legislature in March 2005, arrange for press coverage with legislators and the Governor to promote lead poisoning prevention.

**Leaders:** Elimination Planning Committee, WCLPPP & Secretary Nelson's DHFS & DPH operations staff

**Performance Measures:**

- 1a, 2, 3. Increase in media coverage of promotional opportunities (e.g. special media events, electronic media coverage, newspaper articles).
- 1b. Increased number of web hits on DHFS lead poisoning prevention website.

**Strategy 3: Educate policy makers/legislators about lead poisoning risks and prevention.**

*Why is this important?* Increasing the visibility of childhood lead poisoning and its impact on the health, wellbeing and prosperity of Wisconsin citizens is necessary in order to garner support for needed policies and resources. Legislators and local community leaders have control of fiscal resources and can influence how children's health is given priority within the framework of the

budget and policies supported. They value being responsive to the citizens in their jurisdiction and the safety and wellbeing of our children should be a priority for all.

**1-5 Year Objectives:**

1. Increase the knowledge base of legislators and community leaders on the childhood lead poisoning prevention problem in Wisconsin, including its economic impact on the future of Wisconsin.
2. Revitalize citizen advocacy in high-risk communities to meet with state legislators and policy makers about the impact of childhood lead poisoning on families.

**Year One Activities:**

- 1a. By October 1, 2004, prepare a report outlining the economic impact of childhood lead poisoning on the citizens of Wisconsin, including the costs of both intervention and prevention, to be a part of the required report described below.
- 1b. Required by Wisconsin Act 113, Section 32.9c.(b), “By March 1, 2005, the Department of Health and Family Services shall prepare and submit to the governor and to the legislature in the manner provided under section 13.172(3) of the statutes a report evaluating the success or failures of this act and rules promulgated under this act in reducing the incidence of lead poisoning or lead exposure in children. The report shall include any statutory changes that the department feels are needed to further the goal of reducing the incidence of lead poisoning or lead exposure in children.” (See Housing Strategy 2, Objective 6, Housing Strategy 3, Objective 5 and Funding/Resources Strategy 2, Objective 14 for details on what will be included in the report.)
- 1c. During 2004-5, prepare key data products like GIS maps, using local housing data and lead poisoning prevalence, and other reports (e.g., Healthy Kids Initiative) which demonstrate the need for increased locally controlled CDBG funds and state budget funds for preventing lead poisoning. These reports will be shared with community leaders and legislators in targeted high-risk communities.

- 2a. By October 2004, planning committee members meet with community-based organizations that are active in advocacy efforts at the local level to develop strategic plans to persuade legislators that prevention is cost effective and to inform and advance legislative interest generally at the state level.
- 2b. During 2004 - 2005, elimination plan committee members will advocate for increased financial support of state dollars for lead poisoning prevention education during home visits as part of the Governor's Healthy Kids Initiative.
- 2c. During 2004-5, create advocacy efforts within organizations that serve and are comprised of public health professionals, e.g., WI Nurses Association, WI Medical Society, and Physicians for Social Responsibility.

**Leader(s):**

- 1. Childhood Lead Poisoning Elimination Planning Committee, Rep. Hubler, Sens. Coggs and Jauch, and authors of the WHEDA lead program bill 993; WALDAB & DHFS Strategic Plan staff (Healthy People 2010), Wisconsin League of Municipalities
- 2. Tom Barrett, Mayor of Milwaukee, CBO leaders from Milwaukee, state-wide advocacy organizations, Childhood Lead Poisoning Elimination Plan Committee

**Performance Measures:**

- 1a-b. Report prepared and submitted to legislature, including recommendations as needed.
- 1c. Data products produced and distributed to local community leaders.
- 2a. Productive meetings with advocacy groups to develop a plan of action to communicate with influential legislators.
- 2b. Increased funding for lead poisoning prevention education and assessment.

2c. Adoption of lead poisoning prevention as a priority by groups engaged in active advocacy.

**Strategy 4: Educate contractors and property owners about lead poisoning risks and prevention.**

**1-5 Year Objectives:**

**Objective:** Increase the awareness of property owners and contractors through training seminars and other informational meetings regarding lead hazard reduction techniques, essential property maintenance practices, lead-safe work practices, and HUD/EPA disclosure and PRE-renovation rules.

**Year One Activities:**

- 1a. During 2004-5, DHFS develop model training seminars that include partnerships with local public health and housing agencies.
- 1b. DHFS and LHDs will provide increased opportunities for local risk assessors to meet with property owners at their properties and to identify locations of potential lead hazards and to discuss appropriate methods of control.
- 1c. During 2004-5, DHFS will provide opportunities for property owners, maintenance personnel and contractors to become trained in lead-safe work practices or to become certified professionals.
- 1d. During 2004-5, DHFS and LHDs will conduct outreach to local landlord associations in appropriate training seminars and meetings regarding lead hazard reduction.
- 1e. By March 31, 2005, DHFS, local health departments, a certified training provider, and the National Paint and Coatings Association will co-sponsor 3 lead-safe work practices trainings in 3 locations in the state.

- 1f. By June 30, 2005, DHFS and LHDs will conduct seminars on the Disclosure Rule for rental property transactions, the PRE-renovation Rule for contractors, lead-safe practices for property maintenance, lead hazard reduction funding, and voluntary enrollment of properties in the Lead-Free/Lead-Safe Property Registry in 5 high-risk communities.

**Leader(s):** DHFS - Asbestos & Lead Certification Section and Wisconsin Childhood Lead Poisoning Prevention Program WCLPPP; Southern WI Landlord Association; local health departments in host locations and high-risk communities

**Performance Measures:**

1a & 1c - 1f Number of property owners/contractors trained following meeting attendance.

1b. Number of training sessions in the field in which experienced risk assessors can provide property owners with information about potential lead hazards and methods of control.

1f. Reduction of violations of lead-safe work practices at inspected sites; reduction of violations of Disclosure or PRE-renovation rules.

## **B. Correct Lead Hazards in Housing**

**5-Year Goal: Identify and control lead hazards in high-risk housing.**

**Strategy 1: Identify and evaluate risk factors in housing, in addition to building age, that are associated with lead poisoning.**

*Why is this important?* Current data demonstrate that residence in older dwellings and rental properties is associated with increased probability of lead poisoning. As Wisconsin identifies other risk factors in housing, Wisconsin communities can more effectively target the limited available resources for prevention activities.

### **1-5 Year Objectives:**

1. Identify and evaluate risk factors in housing that contribute to lead poisoning.
2. Use data that identifies risk factors as tools to direct limited resources to dwellings most likely to poison children if hazards uncorrected.

### **July 2004 – July 2005 Activities:**

1. DHFS will complete statistical study of existing dwellings to evaluate and quantify risk factors associated with increases in blood lead test values.
2. DHFS will offer the results of this analysis to housing agencies.

### **Performance Measures**

- 1a. Identified and quantified relative contribution of lead poisoning risk factors.
- 1b. Lead poisoning risk factor data is published in a peer reviewed journal.
2. Dwellings most in need of corrective action are targeted.

<b>Strategy 2: Evaluate and control lead hazards in all pre-1950 housing.</b>
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*Why is this important?* The majority of children with lead poisoning live in homes built before 1950. Only when these lead hazards are evaluated and controlled before children are exposed to lead, can the disease be prevented.

**1-5 Year Objectives:**

1. Identify and reach out to partners and resources that can increase the number of high-risk homes where lead hazards are evaluated and controlled before children are lead poisoned.
2. Evaluate and strengthen local inspection programs that can address the need for owners to keep painted surfaces intact in older homes and to use lead safe work practices during home maintenance.
3. Evaluate lead hazards in state regulated child-care facilities and explore the need to issue rules to implement Chapter 254.168.
4. Expand use of local ordinances to require owners to perform preventive maintenance.
5. Evaluate the Wisconsin Weatherization Rental Code program as a statewide model for requiring that owners demonstrate that they have evaluated and controlled potential lead hazards in older multifamily properties before the properties are sold. [Note: Wisconsin Weatherization rental code requires owners of multi-unit dwellings to assure that the property meets state standards for energy efficiency as a condition of sale.]
6. Recommend legislative changes or changes in administrative rules to create a statewide requirement that all owners of high-risk, i.e., 50 year-old, housing ensure that their properties have intact paint.
7. Require that all Weatherization program staff and other contractors who work for the Low Income Weatherization Program and who perform work that disturbs painted surfaces

routinely utilize lead-safe work practices. In addition, properties receiving Weatherization services that are also enrolled in a HUD funded program must continue to meet the applicable HUD lead regulations when weatherization work is completed.

8. Strengthen lead hazard environmental assessment capacity of other programs that provide direct in-home services to families living in high-risk housing.
9. Support legislative rule changes to require lead-safe work practices and training for workers who do paint disturbing activities in buildings constructed before 1978.

**July 2004 – July 2005 Activities:**

- 1a. DHFS and local health departments will seek partnerships with other programs that inspect homes including: (a) local building inspection programs, (b) housing authorities that inspect dwellings enrolled in the Section 8 tenant based rental assistance program, and (c) staff responsible for evaluating child care facilities or homeless shelters.
- 1b. DHFS and partners will advise local health departments regarding opportunities to accompany other home inspectors in walkthrough investigations.
- 2a. DHFS will evaluate and improve available training to improve the capacity of staff who inspect properties for programs such as federal Section 8 or state child care licensing to recognize lead based paint hazards that need corrective action.
- 2b. DHFS and partners will seek out examples of successful local inspection programs or coordinated local efforts that can serve as models for other communities to emulate.
3. DHFS public health staff will seek to develop a pilot field testing program with staff who evaluate child care facilities and child placement services (e.g., foster homes, adoption interviews) to explore the need to issue rules to implement Chapter 254.168

- 4a. DHFS will provide financial support for local communities to evaluate and strengthen local inspection programs that require owners to (a) keep painted surfaces intact in older homes and (b) use lead safe work practices during home maintenance.
- 4b. DHFS will provide financial support to local agencies to strengthen the local housing construction permit process as a vehicle to promote lead safe standards, both for training workers and for improving housing conditions. For example, municipalities could require and provide lead safe worker training for contractors who pull permits to do any work to disturb painted surfaces in pre-1950 dwellings.
5. DHFS will investigate the Wisconsin Weatherization Rental Code program to determine if this could serve as a model for owners of rental property to demonstrate that they have evaluated and controlled potential lead hazards in older multifamily properties before property is sold. From 1979 to 2002, 110,000 Wisconsin rental properties were improved to meet state standards for energy efficiency.
6. By May 2005, DHFS will evaluate and recommend statutory changes to prevent lead poisoning. DHFS staff will evaluate primary prevention legislation in other states such as Massachusetts, New Jersey, Ohio, Maryland. Among the changes DHFS will consider is a requirement that owners of high-risk 50 year-old housing ensure that all paint is intact in 50-year-old dwellings. Another change that would help prevent lead poisoning would be to replace the word “demolition” with the word “renovation” in Chapter 254.179 (3).
7. Provide at least five training programs for weatherization program staff and/or subcontractors who provide services to families in the Weatherization programs on lead-safe work practices by June 2005.
- 8a. By June 2005, DHFS will evaluate training available (including HUD deteriorated paint, the DHFS virtual risk assessment and Lead Dust Wipe Sampling Technician course) to improve the ability of staff from other agencies (such as Head Start agency staff who

routinely visit homes of young children from low-income families) to recognize lead-based paint hazards.

- 8b. On a pilot basis, local health department staff will offer to do educational walkthrough evaluations with staff from programs who have home visiting or inspection responsibilities. [Note: Before local health dept staff invites others to participate in walkthrough investigations, they should contact both occupants and owners in advance to request permission to do so. This may be especially important if LHD arranges to accompany housing authority staff on Section 8 investigations.]

**Leaders:** DHFS, Local Health Department staff, DOA Weatherization program staff, Managers of other programs that inspect properties where children reside (residences or child care facilities)

**Performance Measures:**

1. Increase in number of partners willing to increase their capacity to address lead hazards in high-risk housing.
2. Number of local inspection programs evaluated for effectiveness that adopt recommendations for improvement.
3. Analysis completed regarding the need to issue rules to address lead hazards in state regulated childcare and foster home facilities under Chapter 254.168.
4. Number of local communities that report increased effectiveness of processes that require lead preventive maintenance on high-risk dwellings.
5. Completed evaluation of weatherization program as model for addressing needs for preventive lead hazard control in rental properties.

6. Legislative action to create statewide requirement that all owners of high-risk, i.e., 50 year-old housing, make sure that their properties have intact paint at property turnover.
7. Number of training programs on lead safe practices provided to Weatherization program staff and subcontractors.
8. Evaluation of available training completed. Number of LHD programs that have established cross training opportunities with other local inspection programs and that establish programs to do joint field inspections for training purposes leading to increased local capacity for lead hazard assessment.

**Strategy 3: Strengthen enforcement of lead hazard reduction in dwellings where children have been lead poisoned.**

*Why is this important?* Currently, after a child is identified with an elevated blood lead level, (a venous blood lead level of 20 micrograms per deciliter or more or two venous blood lead levels of 15 micrograms per deciliter or more) it takes about three years for the child's blood lead to return to a level less than 10 micrograms per deciliter. In the cities of Racine and Milwaukee, local ordinances contribute to more rapid compliance than elsewhere; but in the rest of Wisconsin, only half of Wisconsin property owners correct identified lead hazards within 260 days after local health department investigations identify lead hazards in their properties.

**1-5 Year Objectives:**

1. Reduce the time it takes for property owners to repair lead hazards that have been identified in their properties.
2. Make dwellings where multiple children have been lead poisoned a priority for enforcement.
3. State and local agencies increase referrals to federal agencies to focus federal enforcement on the high-risk properties.

4. Strengthen enforcement capacity at state and local level and increase capacity for state and local health departments to enable owners to achieve voluntary compliance without resorting to enforcement.
5. DHFS, with Department of Justice (DOJ), LHD and others will evaluate how well current statutes control lead poisoning and make suggestions for changes in the statutes to address the needs of families of lead poisoned children for more rapid and lead hazard control by March 2005.

**July 2004 – July 2005 Activities:**

- 1a. DHFS will collect and share examples of local lead ordinances that allow more effective local enforcement options.
- 1b. DHFS and DOJ will develop and offer training to local health departments to enable more rapid and effective property owner compliance with lead hazard reduction requirements.
- 1c. DHFS will provide direction for LHDs to refer families of lead poisoned children to dwellings that have met the criteria to enter the lead safe and lead free registry.
2. DHFS will develop lists of properties that have outstanding orders for lead hazard reduction and that have been associated with more than one lead poisoned child. [Note: important not to focus enforcement efforts on properties where children may have moved in with pre-existing lead poisoning.]
3. DHFS will share this list of addresses with the US Department of Housing and Urban Development (HUD) and the US Environmental Protection Agency (EPA) staff that have the responsibility to follow up to investigate if owners have complied with federal disclosure rules. DHFS will also share this list of “frequent flyer” properties with other collaborating partners, such as the DOJ, to ensure that the owners of these properties do not continue to ignore their responsibilities.

- 4a. DHFS and DOJ will collect, evaluate and share examples of local lead ordinances and methods that enable more effective and timely compliance with C. 254.
- 4b. DHFS will encourage municipalities to use C. 254.59. For example, DHFS and DOA could offer HUD Lead Hazard Reduction (LHR) funds to municipalities that use C. 254.59 to pay for part of LHR work on properties whose owners have delayed making ordered repairs in Elevated Blood Lead level (EBL) cases. Locals then can recapture cost of LHR work as local property taxes from that property owner.
- 5a. DHFS and DOJ staff will develop options for language changes to C. 254 that would allow more local municipal control over enforcement of EBL cases. The current language and legal model relies on District Attorneys and as such are generally ineffective.
- 5b. DHFS will evaluate the Lead-Safe/Lead-Free Registry Program with partners including Milwaukee Health Department with the goals to improve program flexibility for local health departments and to strengthen program effectiveness.

**Leaders:** DHFS, organizations of property owners, EPA, HUD, DOJ, Local Health Departments including Milwaukee Health Department.

**Performance Measures:**

- 1. Reduced time between owners learning of lead hazards to correction of identified lead hazards.
- 2. Reductions in numbers of dwellings that are associated with multiple poisonings.
- 3. Number of referrals to federal agencies (HUD and EPA) or state agencies (DOJ) for enforcement.

4. Changes in local enforcement methods; number of local communities reporting progress with enforcement; training for local agency staff to strengthen enforcement and to increase owners voluntary compliance to correct identified lead hazards.
- 5a. Changes in number and proportion of dwellings where children have been identified as poisoned in which lead hazards are controlled.
- 5b. Legislature adopts statutory changes to better enforce lead hazard control in dwellings identified with lead hazards and occupied by children with lead poisoning.

<b>Strategy 4: Increase incentives for property owners to control lead hazards in residential housing.</b>
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*Why is this important?* Many owners need financial incentives to create safer dwelling units. Apparently, the promise of liability protection has not been sufficient to motivate large numbers of owners to control lead hazards in their properties voluntarily.

**1-5 Year Objectives:**

1. Provide tax credits to property owners who conduct lead hazard reduction in a pre-1950 property:
  - (a) Tie tax credits to property owners who use lead certified contractors;
  - (b) Allow tax credits for employers who pay for their employees to take training that leads to certification as lead safe workers.
2. Investigate and consider other incentives for owners to control lead hazards such as a dedicated lead hazard control trust fund.
3. Provide expanded financing options for owners who need help to pay for lead hazard control measures.

**July 2004 – July 2005 Activities:**

1. Property owners such as the Southern Wisconsin Landlords Association will initiate and support legislation to create tax credits for work that uses certified lead hazard abatement contractors.
2. Property owners, financial institutions, and DHFS, DOA and DOC will identify other incentives and financing instruments that could motivate and enable property owners to more easily correct lead hazards in high risk housing. (See Resources Section for other examples of actions that could increase incentives.)
3. Property owners' organizations such as the Southern Wisconsin Landlords Association will initiate and support legislation to direct the direct Wisconsin Housing and Economic Development Authority (WHEDA) to issue bonds to raise funds to finance lead hazard control activities.

**Performance Measures:**

- 1a. Legislation introduced to support tax credits for property owners.
- 1b. Legislation enacted to support tax credits for property owners.
2. New financing or other incentive opportunities identified and promoted for owners to correct lead hazards.
- 3a. Expanded financing options made available to owners for correcting lead hazards.
- 3b. Legislation introduced/enacted to WHEDA to issue bonds to finance lead hazard reduction.

## **C. Target High-Risk Populations for Blood Lead Testing**

**5 YEAR GOAL: Target high-risk populations for blood lead testing, including:**

- **Assure age-appropriate testing of children enrolled in Medicaid**
- **Provide blood lead testing for all children who are uninsured or under-insured**

### **Strategy 1: Establish New Policies to Improve Age-Appropriate Blood Lead Testing.**

*Why is this important?* Many children who are at risk for lead poisoning are not receiving the age-appropriate blood lead testing they are entitled to. State and federal requirements include blood lead testing at 12 and 24 months of age for children who are enrolled in Medicaid. While 85% of the lead poisoned children in Wisconsin are enrolled in Medicaid, only 50% of Medicaid enrolled children are ever tested. It is important to identify children who are already lead poisoned so the source of their lead exposure can be corrected, thereby preventing further increases in blood lead levels. Early intervention for children with lead poisoning is critical to improving their long-term cognitive and developmental outcomes.

#### **1-5 Year Objectives:**

1. Maximize opportunities for testing children enrolled in Medicaid by allowing all HealthCheck providers who test a child to seek reimbursement for the test.
2. Improve blood lead testing of children enrolled in Medicaid through utilization of data from HealthCheck performance reviews and the Medicaid blood lead testing registry.
3. Evaluate current state and federal blood lead screening policies to determine whether these policies are adequate for targeting children at risk for lead exposure and make recommendations for policy revisions as appropriate.
4. Explore the feasibility of requiring that institutions or programs serving children under 6 years of age obtain written evidence that each child has obtained a blood lead test or is exempt from obtaining one.

### **Year One Activities:**

1. By October 2004, staff of the Medicaid Program and the WCLPPP will determine the feasibility of converting blood lead testing to a fee-for-service test, when not done as part of a comprehensive HealthCheck exam. This will eliminate the need for local public health agencies, WIC projects and other providers to negotiate contracts with managed care organizations in order to seek reimbursement for testing children enrolled in a Medicaid managed care organization.
  
- 2a. By June 2005, the Medicaid Program will utilize HealthCheck performance audit data and the Medicaid blood lead testing registry to develop individual physician blood lead screening profiles. Physicians with low screening rates will be contacted to discuss the need to improve their testing rates and methods to accomplish this. This data will also be distributed to the Chief Medical Officers of the HMOs and the HMO quality improvement staff. (See Strategy 3 for further discussion on the use of this data.)
  
- 2b. The Medicaid Program will continue to examine HealthCheck audit data and reimburse the HMOs a lesser amount for HealthCheck exams that did not include an age-appropriate blood lead test. HMOs will be encouraged to share the HealthCheck performance data for their organization with individual physicians within the HMO and to monitor the testing rates of physicians who are not adequately testing.
  
- 2c. By June 2005, the Medicaid Program will incorporate individual physician blood lead screening profiles into the quarterly lead screening reports that are currently distributed to the HMOs so the HMOs and individual physicians can evaluate their screening rates in relation to their peers. (It is thought that physicians may not have an accurate understanding of the extent to which they are complying with the Medicaid blood lead screening policy and that having this data will motivate physicians with low screening rates to increase their testing, especially if they are testing to a lesser extent than their peers. See strategy 3.)

- 3a. By December 2004, the DHFS will examine Wisconsin blood lead test data in combination with Medicaid eligibility data to determine the incidence of lead poisoning among children who are not currently required to be tested according to federal and state Medicaid policy, e. g. 3, 4, and 5 year olds who have had a previous test.
- 3b. By December 2004, the DHFS will examine Wisconsin blood lead test data in combination with WIC enrollment data to determine the incidence of lead poisoning among children who are not currently recommended to be tested according to Wisconsin blood lead screening policy, i.e., 3, 4, and 5 year olds enrolled in WIC who have had a previous test.
- 3c. By January 2005, the DHFS will develop recommendations for revisions to federal Medicaid and/or Wisconsin Blood Lead Screening Recommendations, as appropriate.
- 3d. By June 2005, the DHFS will convene a committee of health care providers and others to review the blood lead evaluation data, current screening policies and make recommendations for policy revisions, if needed.
- 3e. By June 2005, the DHFS will submit a manuscript to a peer-reviewed journal with the blood lead evaluation results, conclusion and recommendations. This paper will also be submitted to the American Academy of Pediatrics (AAP), with a recommendation to revise federal Medicaid screening policy, if appropriate.
- 4a. By December, 2004, the DHFS will examine the effectiveness of blood lead testing policies in other states that require testing prior to entry into day care, early childhood programs, or other institutions or programs serving children under 6 years of age.
- 4b. By March 2005, committee members will meet with community advocates and state and local decision-makers to seek support for establishing a similar requirement in Wisconsin (see activity 10).

- 4c. By June 2005, if there is support for establishing new blood lead testing requirements in Wisconsin, the DHFS will revise the WI Blood Lead Screening Recommendations and will draft administrative rules to support a policy as mentioned in activity 10.

**Leaders:** The Department of Health and Family Services (State Medicaid Program, WCLPPP, Dr. Murray Katcher), Medicaid Managed Care Organizations

**Performance Measures:**

1. Medicaid billing policy will be revised to allow blood lead testing as a fee-for-service test when not done as part of a comprehensive HealthCheck exam.

2a. The Medicaid Program will have individual physician screening profiles and the profiles distributed to physicians and HMOs with their quarterly blood lead test reports.

2b. HealthCheck performance reviews determine financial penalties to HMOs with inadequate blood lead testing practices.

2c. Quarterly HMO blood lead testing reports contain blood lead testing profiles for the individual physicians within the HMO.

3a. Evaluation completed with results and conclusions of Medicaid screening policy.

3b. Evaluation completed with results and conclusions of WI blood lead screening recommendations.

3c. Recommendations implemented for blood lead screening policy revisions.

3d. A committee will review data on screening policies and make recommendations for needed policy revisions.

3e. A manuscript will be submitted to a peer-reviewed journal and to the AAP if appropriate.

4a. A summary report will be developed of screening policies in other states related to institutions and programs serving children under 6 years of age, including a summary of their implementation and effectiveness.

4b. Committee members and community lead poisoning prevention advocates will have garnered support from state and local decision makers for additional blood lead screening requirements.

4c. The DHFS will submit draft administrative rules requiring institutions and programs serving children under 6 years of age obtain written evidence that each child has obtained a blood lead test or is exempt from obtaining one.

**Strategy 2: Determine physicians screening practices and identify barriers to screening.**

*Why is this important?* It is important to identify current blood lead screening practices and barriers to screening in order to develop effective educational strategies to assure children are appropriately screened and to develop strategies to address the barriers to screening.

**1-5 Year Objectives:**

1. Blood lead screening practices of Wisconsin physicians will be determined by surveying physicians who provide health care to young children and through the use of HMO chart audits.

**Year One Activities:**

1. By June 2004, a survey will be piloted with Milwaukee physicians to determine their blood lead screening practices. The Milwaukee Childhood Lead Poisoning Prevention Program will distribute this survey in the Lead Report, a quarterly publication for physicians in the Milwaukee area.
2. In August 2004, the physician survey will be revised, as needed, based on the Milwaukee pilot and included as a tear-out in the August issue of the Wisconsin State Medical Journal.

3. By December 2004, data from the physician survey will be compiled by the DHFS, and a summary report developed to include survey results, conclusions, and recommendations.
4. By July 2005, the DHFS and committee members will convene a meeting of representatives from HMOs, the state Medicaid Program, physicians, and other health care providers to discuss barriers to blood lead testing and to identify methods to address these barriers.
5. By September 2004, the DHFS and other committee members will meet with the Medicaid Program's Quality Technical Advisory Group to discuss integration of blood lead testing evaluation measures into the current HMO chart audits. The HMOs will be encouraged to provide resultant lead testing evaluation data to individual HMO physicians. (See Strategy 3)
6. By June 2005, the State Medicaid Program will include evaluation of blood lead testing practices in their chart audit process that is conducted with Medicaid managed care organizations that do not meet critical HealthCheck benchmarks (See Strategy 1).
7. By December 2004, committee members will meet with representatives of the Medicaid managed care organizations to determine the feasibility of integrating evaluation of blood lead testing practices into their routine physician chart audits.

**Leaders:** The Milwaukee Health Department, Dr. Slota-Varma, State Medical Society, the Department of Health and Family Services - State Medicaid Program, WCLPPP; Medicaid Managed Care Organizations

**Performance Measures:**

1. A physician blood lead screening survey will be distributed via the Milwaukee Health Department Lead Report.

2. The Milwaukee physician survey responses will be compiled and revisions made to the survey as appropriate and distributed statewide via the Wisconsin State Medical Journal.
3. A summary report will be developed with survey results, conclusions and recommendations.
4. Relevant partners will discuss barriers to blood lead testing and propose recommendations to address barriers.
5. The Medicaid Quality Technical Advisory Group will consider inclusion of lead testing measures in the HMO chart audits.
6. Medicaid managed care chart audits will include lead testing measures.
7. Committee members will meet with the Medicaid managed care organizations to discuss inclusion of lead testing measures in their routine physician chart audits.

<p><b>Strategy 3: Educate physicians on the need for screening and current screening recommendations.</b></p>
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*Why is this important?* Physicians must be knowledgeable of the risks of childhood lead poisoning and current screening recommendations and requirements in order to incorporate blood lead screening into their routine practice in an appropriate manner.

**1-5 Year Objectives:**

1. Wisconsin physicians who provide services to young children will be aware of current Wisconsin blood lead screening recommendations and treatment protocols for children who are identified with lead poisoning.

**Year One Activities:**

1. By August 2004, the DHFS will have published an article in the Wisconsin State Medical Journal regarding the extent of childhood lead poisoning in WI, current screening

requirements and recommendations, and the extent of age-appropriate testing among high-risk children in Wisconsin.

2. The DHFS and other committee members will conduct presentations at grand rounds and other meetings attended by physicians, nurses and other health care personnel, such as the annual meeting of the Wisconsin Chapter of the American Academy of Pediatrics.
3. The DHFS will explore the effectiveness of the Ohio Physician Lead Assessment Network and Education Training (PLANET) program, which is a peer education program for physicians and nurses, and the feasibility of implementing this program in WI.
4. By June 2005, the Wisconsin Medicaid Program will develop physician blood lead screening profiles that contain data for individual physicians on the extent of Medicaid-enrolled children in their practice who have received an age-appropriate test. Wisconsin Medicaid will distribute these profiles to the Chief Medical Officers (CMOs) and quality improvement staff of the HMOs. These profiles will be described as health care provider performance measures. Physicians will also be able to compare their screening rates to that of their peers. (See Strategy 1.)

**Leaders:** The Department of Health and Family Services (Wisconsin Medicaid Program, WCLPPP), Medicaid Managed Care Organizations

**Performance Measures:**

1. Article on WI childhood lead poisoning published in the Wisconsin State Medical Journal.
2. Number of presentations attended by physicians, nurses and other health care personnel on lead hazards and screening.
3. Evaluation of the effectiveness of the OH PLANET Program to educate physicians and improve screening of high-risk children and the feasibility of implementing this program in Wisconsin.

4. Distribution of individual physician blood lead screening profiles and the ranges of values for comparison of the relevant M.D. peer groups to the HMO CMOs and quality improvement staff.

**Strategy 4: Enhance data sharing capabilities between critical partners regarding blood lead testing of children.**

*Why is this important?* If physicians have easy access to their patients' blood lead test histories they can determine whether the child needs to have a test while the family is in their office, thereby maximizing opportunities to obtain age-appropriate tests.

**1-5 Year Objectives:**

1. Provide physicians with easy access to their patients' blood lead test results through the Wisconsin Immunization Registry (WIR), which is a secure HIPAA-compliant environment.

**Year One Activities:**

1. The DHFS Bureau of Environmental and Occupational Health (BEOH) and the Bureau of Communicable Disease (BCD) will sign a Memorandum of Understanding (MOU) that allows for the exchange of confidential patient information, i.e. blood lead test results.
2. The WCLPPP and the Wisconsin Immunization Program will collaborate to determine the most cost-effective method of sharing blood lead test data on the WIR. (For example, on a monthly basis blood lead test results are uploaded onto the Statewide WIC Look-up System. This process was accomplished with a very low commitment of financial resources.)
3. The DHFS will finalize the process and secure the resources to integrate blood lead data on the WIR.

**Leaders:** The Department of Health and Family Services (WCLPPP, Wisconsin Immunization Program).

**Performance Measures:**

1. A signed Memorandum of Understanding between the BEOH and the BCD.
2. The WCLPPP and the Wisconsin Immunization Program agree on the process by which blood lead data will be accessible through the WIR.
3. The methodology for linking blood lead data with the WIR and providing access to test results to users of the WIR will be documented and financial resources secured to begin implementing the process.

## **D. Funding & Resources**

**5-YEAR GOAL: Develop resources to achieve the goal of eliminating lead poisoning of children in Wisconsin.**

**Strategy 1: Increase the proportion of available HUD funding that local communities devote to lead poisoning prevention.**

*Why is this important?* Wisconsin and 21 larger urban communities annually receive \$78.6 million in Community Development Block Grant funds and \$29 million in HOME funds from the US Department of Housing and Urban Development (HUD). The 21 larger urban communities receive about 58% of this total and the State of Wisconsin receives about 42% or \$33 million in CDBG funds and \$13 million in HOME funds to distribute to the smaller communities in the state. In practice, the State of Wisconsin and the “Entitlement Communities” have fairly wide discretion in how they use these CDBG funds. By federal law a substantial portion of these funds (a minimum of 70%) must benefit low-to-moderate income households. As state and local grantees make decisions about funding priorities, they are required to make opportunities for the public to comment on both the plans and the performance of these programs. The general public and low-income families, in particular, could take more advantage of opportunities to influence grantees’ (the State of Wisconsin and the entitlement communities) decisions about how these HUD funds are used.

### **1-5 Year Objectives:**

1. Examine current funding available to Wisconsin from HUD and maximize future funding for the elimination of lead poisoning.
2. Provide information and support to decision-makers such as mayors, city council members and government agency staff in working toward lead hazard elimination.
3. Increase public participation in the process of setting priorities for the use of available HUD funds.

4. Increase the proportion of the State's Small Cities CDBG funds dedicated to housing renovation and lead hazard reduction.
5. Provide educational information to families with young children that apply for CDBG and HOME funds to encourage the applicant families to focus their requests for funds to address lead hazards. Note: HOME funds require all lead hazards to be addressed.
6. Each entitlement community will develop a Plan to Eliminate Lead Poisoning by 2010. Note: All HOME entitlements are CDBG entitlements but not vice-versa.
7. Entitlement cities and counties will increase funds available to address lead hazards in rental housing.
8. Ensure that there are enough certified contractors and lead safe workers to conduct lead hazard abatement and lead hazard control in all areas of the state.

**Year One Activities:**

1. By September 2004, DHFS, DOA, DOC-Division of Housing and local health and housing agencies will estimate the amount of funding needed to address the estimated 120,000 WI housing units that have deteriorated paint and children under age 6 residing in them. By November 2004, DOC will review the number of dwelling units that have corrected lead hazards in the Small Cities or non-entitlement grantee communities within the last year.
2. By October 2004, the DHFS will develop childhood lead poisoning data packets for the "key" governmental entities and advocacy groups/organizations in Wisconsin's 13 highest risk communities.
3. By May 2005, DHFS staff will have met with the integral governmental agencies and advocacy groups/organizations in the 13 Entitlement Communities identified as high-risk

to explore the potential to target HUD funds and to seek out other funds for lead hazard reduction.

4. By March 2005, DHFS will work with DOC staff to require greater commitments to control lead hazards from communities seeking Small City funds from the DOC.
5. By December 2004, DHFS, DOC and DOA will work with local health departments to ensure that eligible families are informed about CDBG and/or HOME funds and any other funds available for lead hazard reduction within their jurisdiction.
6. By May 2005, DHFS and DOA staff, local governmental groups and key advocacy and special interest groups/organizations will meet with the integral governmental representatives/agencies in the Entitlement Communities identified as high-risk to explore the potential to target available HUD funds and to seek out other funds for lead hazard reduction.
7. By June 2005, DHFS will contact Entitlement Communities to discuss the use of CDBG and other funds to control lead hazards in rental property. Note: Beloit currently targets 25% of its CDBG funds at rental property.
8. By November 2004, committee members will meet with the Insurance Commissioner's Office to discuss insurance issues/options for lead-based paint abatement contractors.

**Leader(s):** The Departments of Health and Family Services, Commerce, and Administration; Office of the Insurance Commissioner; Local health departments. Advocates such as parents, property owners and organizations; Governor and the Secretary of the Department of Commerce would need to support any changes in the distribution of funds to small cities.

**Performance Measures:**

1. A report provides an estimate of the amount of funding needed to address the 120,000 high-risk housing units and the amount of dollars available for lead hazard reduction.

2. Childhood lead poisoning information packets are delivered to governmental and advocacy groups/organizations in the 13 high-risk communities.
3. DHFS and DOA will have met with the 13 high-risk communities resulting in a net increase in the number of entitlement agencies that set numerical goals for the number of dwelling units that are made lead-safe.
4. Data showing a net increase in the number of dwelling units where lead hazards are controlled within communities that receive Small City CDBG funds.
5. There will be a 10% increase in the number of eligible families applying for CDBG funds for lead hazard reduction. Note: DOC will supply a base number of families applying to do lead hazard control with CDBG funds distributed through state agencies in 2003.
6. The number of CDBG Entitlement communities that develop a plan to eliminate childhood lead poisoning by 2010.
7. Following DHFS and DOA staff meetings with all 13 high risk Entitlement Communities, 5 communities will expand the amount of CDBG funds directed towards lead hazard reduction in rental housing.
- 8a. The Insurance Commissioner's Office will identify possible improvements related to insurance coverage for lead risk assessors and contractors.
- 8b. Net increases in the number of contractors performing lead hazard abatement and increases in the number of lead safe workers in areas of the state where the service was nonexistent or minimal will be considered a success.

**Overall Performance Indicator:** An increase in the number of dwellings that have lead hazards reduced each year.

**Strategy 2: Increase the total amount of funds available in Wisconsin for lead poisoning prevention through traditional and new sources.**

*Why is this important?* Currently available funds are insufficient to eliminate lead poisoning by 2010. Even if current resources were targeted more efficiently, more resources will be needed.

**1-5 Year Objectives:**

1. Establish a Childhood Lead Poisoning Prevention Coalition to garner grassroots support for lead hazard abatement activities at the local level. Suggested members include: Wisconsin Apartment Association, State Medical Society, Children's Health Alliance, WI Council on Children and Families, WI Contractor's Association, i.e., groups with local interests, vested in the high-risk communities. There should be government/public and private sector co-chairs.
2. Provide tax credits for lead hazard reduction activities in high-risk older dwellings.
3. Establish a Lead Hazard Reduction Trust fund that could receive both public and private funds and offer both loans and grants. Identify a competent fiscal institution to administer such a fund.
4. DHFS will provide information and guidance to local agencies that choose to apply to HUD for competitive grants for Lead Hazard Reduction funding.
5. Meet with window manufacturers to educate them on the important role their products play in lead hazard reduction and to encourage them to offer reduced rates on windows to weatherization agencies, lead abatement contractors and others involved in lead hazard reduction. DHFS will provide window manufacturers with data to show how window replacement can contribute to reductions in lead dust levels.

6. Expand the Wisconsin Weatherization Rental Code model to include addressing lead hazards and to ensure intact paint as a baseline condition. Under current rules, rental property must receive an energy audit at time of sale. Expand this idea to require lead risk assessments in rental properties at time of sale.
7. Identify institutions such as banks that rental property owners now use for financing and loans and begin working with these institutions to expand their lending programs to address lead hazard reduction. Offer public funds to these lenders if they offer below market interest rate loans that require lead hazard reduction as a condition of the loan.
8. Request that the Wisconsin Bankers Association members provide lead hazard reduction funds in their communities.
9. Encourage private banks to fund lead hazard reduction projects to meet their legal obligations under the Community Reinvestment Act.
10. Encourage local agencies to apply to the University of Wisconsin Medical School and the Medical College of Wisconsin for Blue Cross/Blue Shield funds established for public health programs.
11. Direct WHEDA to issue bonds to support loans for lead hazard reduction.
12. Identify well-funded interests to fund lead hazard reduction in high-risk housing.
13. Broaden the base of lead hazard reduction funds by creating a surcharge on the sale of paint. It is estimated that approximately \$100,000,000/year is needed to correct hazards in homes.
14. The March 2005 report from DHFS to the legislature will describe resources needed to eliminate lead poisoning in Wisconsin by 2010.

### **Year One Activities:**

1. By October 2004, the Wisconsin lead poisoning elimination partners will assess the efficacy of a coalition to prevent childhood lead poisoning that would educate local officials and advocate for lead hazard abatement at the local level.
2. By December 2004, the Coalition or other parties will consult with legislators to determine the feasibility of sponsoring a change in the tax law that would allow deductions for lead hazard reduction activities for properties occupied by low-income families in the 13 high-risk communities.
3. By January 2005, DHFS and other parties will explore the feasibility of establishing a Lead Hazard Reduction Trust Fund. Representatives from DHFS and DOC will meet with the city of Stevens Point to discuss the process they followed to set up a housing trust fund and explore the implications for setting up a similar state or local fund(s) for lead hazard reduction.
4. By September 2004, DHFS will develop and share with the eligible Entitlement Communities (possibly meet directly with the high-risk communities) a template/methodologies of what is required for a community to develop a competitive HUD lead hazard reduction application.
5. By March 2005, the DHFS and members of the Wisconsin Association of Local Health Departments and Boards (WALHDAB) and other appropriate partners will meet with Wisconsin window manufacturers to present facts on childhood lead poisoning and the significance of their support in its' prevention.
6. By November 2004, meet with staff that administer the Wisconsin weatherization code and three community-based organizations to discuss options and incentives available to such agencies that choose to more boldly encompass lead hazard reduction activities into their current activities.

- 7 - 9. By March 2005, the appropriate state agency representatives will meet with officials from the Wisconsin Banker's Association to discuss action that could be taken to increase the availability of low interest loans for lead hazard reduction in low to moderate income housing both owner occupied and rental.
10. By December 2004, the DHFS will develop an informational package with the necessary grant preparation information for the 13 high-risk communities to apply for BC/BS funds.
11. By September 2004, through appropriate and effective channels, contact will be made with WHEDA to explore the potential of issuing bonds for lead hazard reduction.
12. By May 2005, the Coalition (if established) or other interested parties will develop a list of potential benefactors (e.g. PEW, Petit Foundation, Robert Wood Johnson, TIDES, Annie E. Casey, etc.) and begin to solicit funds for childhood lead poisoning prevention.
13. By October 2004, estimate the amount of paint sold annually and the potential revenue that would be gained (using different formulas) for lead hazard reduction if a surcharge on paint were imposed. By January 2005, legislators will introduce a bill recommending a paint surcharge.
14. By May of 2005, DHFS will use the Report to the Legislature to demonstrate the ongoing need to continue childhood lead poisoning prevention activities.

**Leader(s):** The Governor's office; the Coalition to Prevent Childhood Lead Poisoning; the Departments of Health and Family Services, Commerce and Administration; the Wisconsin Association of Local Health Departments and Boards (WALHDAB); The Wisconsin Banker's Association; WHEDA.

**Performance Measures:**

1. A Childhood Lead Poisoning Prevention Coalition exists.

2. Key Legislators sponsor a bill/legislation calling for a tax credit for lead hazard reduction activities.
3. Appropriate agencies file a report with recommendations on the feasibility of establishing a Lead Hazard Reduction Trust Fund.
4. Increase the number of agencies applying to HUD for lead hazard reduction (LHR) funds and the number of agencies receiving HUD funding.
5. Number of window manufacturers who express interest in using information about lead hazards in old painted windows in their marketing.
6. Increase the number of weatherization agencies formally involved in ongoing lead hazard reduction.
- 7 - 9. A meeting held with the WI Banker's and a position statement with recommendations to enhance the role of banks and other lending institutions in lead hazard reduction is developed.
10. The DHFS develops and distributes the grant information package to the 13 high-risk communities - 50% apply for BC/BS funds.
11. WHEDA adopts a stance on providing a bond issue for lead hazard reduction activities.
12. The Coalition is successful in garnering 2 philanthropist partners to provide funds for lead hazard reduction.
13. The legislature is successful in passing a surcharge on the sale of paint. (Note: It is estimated that approximately \$100,000,000/year is needed to correct lead hazards in homes.)
14. The report to the Legislature is successful in persuading the legislature to increase and fund childhood lead poisoning prevention activities until the cause of this affliction is eliminated.

## VI. Oversight and Evaluation

### LEAD POISONING IMPLEMENTATION AND OVERSIGHT COMMITTEE (LPIOC)

Representatives:	<ul style="list-style-type: none"> <li>▪ Predominantly members of the original elimination planning committee</li> <li>▪ Other critical partners</li> </ul>
Purpose:	<ul style="list-style-type: none"> <li>▪ The purpose of the committee is to provide the leadership and action to implement and evaluate progress for ongoing reporting required by the CDC grant.</li> </ul>
Responsibilities	<ul style="list-style-type: none"> <li>▪ Provide leadership in global oversight of efforts to achieve lead poisoning elimination goal</li> <li>▪ Evaluate success of elimination efforts</li> <li>▪ Develop new partners and supports that advance lead elimination efforts</li> <li>▪ Revise and update elimination plan</li> <li>▪ Advise implementation subcommittees</li> <li>▪ Serve on implementation subcommittee(s)</li> <li>▪ Advance lead elimination activities within own organizations</li> </ul>
Chairmanship	Two co-chairs; one public and one private sector
Frequency of meetings	Three times a year
Implementation subcommittees	<p>Subcommittees will be formed to advance activities related to the plan goals surrounding:</p> <ul style="list-style-type: none"> <li>⇒ Education</li> <li>⇒ Funding and resources</li> <li>⇒ Lead hazard control</li> <li>⇒ Targeted screening</li> </ul>
Number of implementation subcommittees and frequency of meetings	Will flex as needed depending on activities underway
Leadership of implementation subcommittees	Each subcommittee will, at a minimum, designate one chair who will take the lead for convening subcommittee meetings, advancing activity, and reporting progress at full committee meetings.
Representatives of goal subcommittee members	<ul style="list-style-type: none"> <li>▪ Subset of the LPIOC</li> <li>▪ Other strategic partners as identified by the oversight committee / subcommittee members</li> <li>▪ Temporary representatives/consultants for special projects/efforts</li> </ul>
Responsibilities of subcommittee members	<ul style="list-style-type: none"> <li>▪ Responsibility for ensuring that their plan goal activities are implemented and achieved</li> <li>▪ Oversight of state activities in their goal area</li> <li>▪ Enhance coordination and expansion of efforts</li> <li>▪ Outreach to new partners</li> <li>▪ Report on activities / results at full oversight committee meetings</li> </ul>

Committee administration tasks for full committee	<ul style="list-style-type: none"> <li>▪ Develop agendas and identify/ gather relevant materials</li> <li>▪ Conduct planning to most efficiently conduct committee business</li> <li>▪ Develop progress tracking approaches</li> <li>▪ Identify and develop ideas to present to full committee to remedy organization problems / roadblocks</li> </ul>
Responsibility for conducting full committee administration tasks	<ul style="list-style-type: none"> <li>▪ DHFS staff</li> <li>▪ Co-chairs</li> <li>▪ Interested committee members</li> <li>▪ Possibly a managing staff person if funding obtained (e.g. grant / other)</li> </ul>

## **APPENDIX 1**

### Cost Savings from Preventing Childhood Lead Poisoning in Wisconsin

**WHAT LEAD POISONING COST WISCONSIN**

Year: 2002

Incidence of children with BLLs **2766**

Distribution	# of kids >10mcg/dL	% of kids >10mcg/dL
10 to 14	1913	69%
15 to 19	503	18%
20 to 44	330	12%
over 45	20	1%
over 70	4	0%
over 25	175	6%

**Incidence:**

The first BLL, venous or capillary  $\geq 10$ ,  
 The child could have had previous non-elevated tests.  
 An elevated capillary followed by a venous test within 90 days:  
**only the venous value was included.**

Note: In 2002:

549 children had elevated capillary tests w/ a  
 normal venous test w/in 90 days  
 21 children had normal capillary tests w/ subsequent  
 elevated venous tests w/in 90 days.

**Special Education**

cost per year:	20% of kids >25mcg/dL	3 yrs special ed	Total cost
\$12,733.00	35	\$38,199.00	\$1,336,965.00

**Medical Costs**

	Cost to Treat	Total Cost
10 to 14	\$56.00	\$107,128.00
15 to 19	\$56.00	\$28,168.00
20 to 45	\$783.00	\$258,390.00
over 45	\$1,018.00	\$20,360.00
over 70	\$2,626.00	\$10,504.00
<b>Total Cost</b>		<b>\$424,550.00</b>

**Juvenile Justice**

# of Juveniles incarcerated	Annual Per Capita Institutionalized Costs	Total Costs	Costs if 10% due to LP
754	\$52,271.00	\$39,412,334.00	\$3,941,233.40

**Lost future income**

Grosse, et al	Average number IQ points lost per BLL >10mcg/dL:	Number of children affected ( $\geq 10$ mcg/dL)	Lost earnings per IQ point	Total lost earnings:	Loss of revenue given 6.75% WI Income Tax
3% discount rate	12	2766	\$3,720.00	\$123,474,240.00	\$8,334,511

**Total Annual Savings (or \$ not spent) \$14,037,259.60**

This information was developed using Wisconsin data for 2002 and the methodology from *Long-term costs of lead poisoning: How much can New York save by stopping lead?*, 2003, Katrina Smith Korfmacher, PhD, Environmental Health Sciences Center, University of Rochester.

Summary of the Savings Accrued by Eliminating Lead Poisoning in Wisconsin

Benefit	Estimate of Annual Benefit	Comments
Increased earning potential	\$8,334,511	Strong correlation between lead poisoning and lowered IQ; lowered IQ results in reduced income over a lifetime. Reflects 6.75% state income tax on lost revenue.
Neonatal mortality	Unquantified	Difficult to quantify for both epidemiological and ethical reasons.
Health care – direct treatment	\$424,550	Does not include lead-related problems such as behavioral difficulties.
Health care – long term effects	Unquantified	Includes hypertension, stroke, and osteoporosis.
Special education	\$1,336,955	Probably vastly underestimates costs because does not include needs of children with BLL under 25 µg/dL.
Juvenile Delinquency	\$3,941,233	Does not include costs other than residential treatment.
Criminal justice	Unquantified	If effects of lead on juvenile delinquency carry through to adult behavior, costs could dwarf the juvenile costs.
State infrastructure	\$1,004,100	Rough estimate of costs of grants to counties for lead prevention work and \$125,000 allocation to 16 <sup>th</sup> Street Community Health Center. This amount does not include the 1.4 FTE with the Wisconsin Childhood Lead Poisoning Prevention Program nor costs of the Asbestos and Lead Section and the Lead-Free/Lead-Safe Registry.
Legal liability of municipalities	Unquantified	Only a small number of cases have been settled to date; however there is a much larger potential for future cases.

**Total Annual Savings to Wisconsin: \$14,037,259.60**

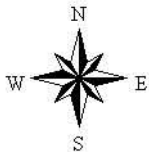
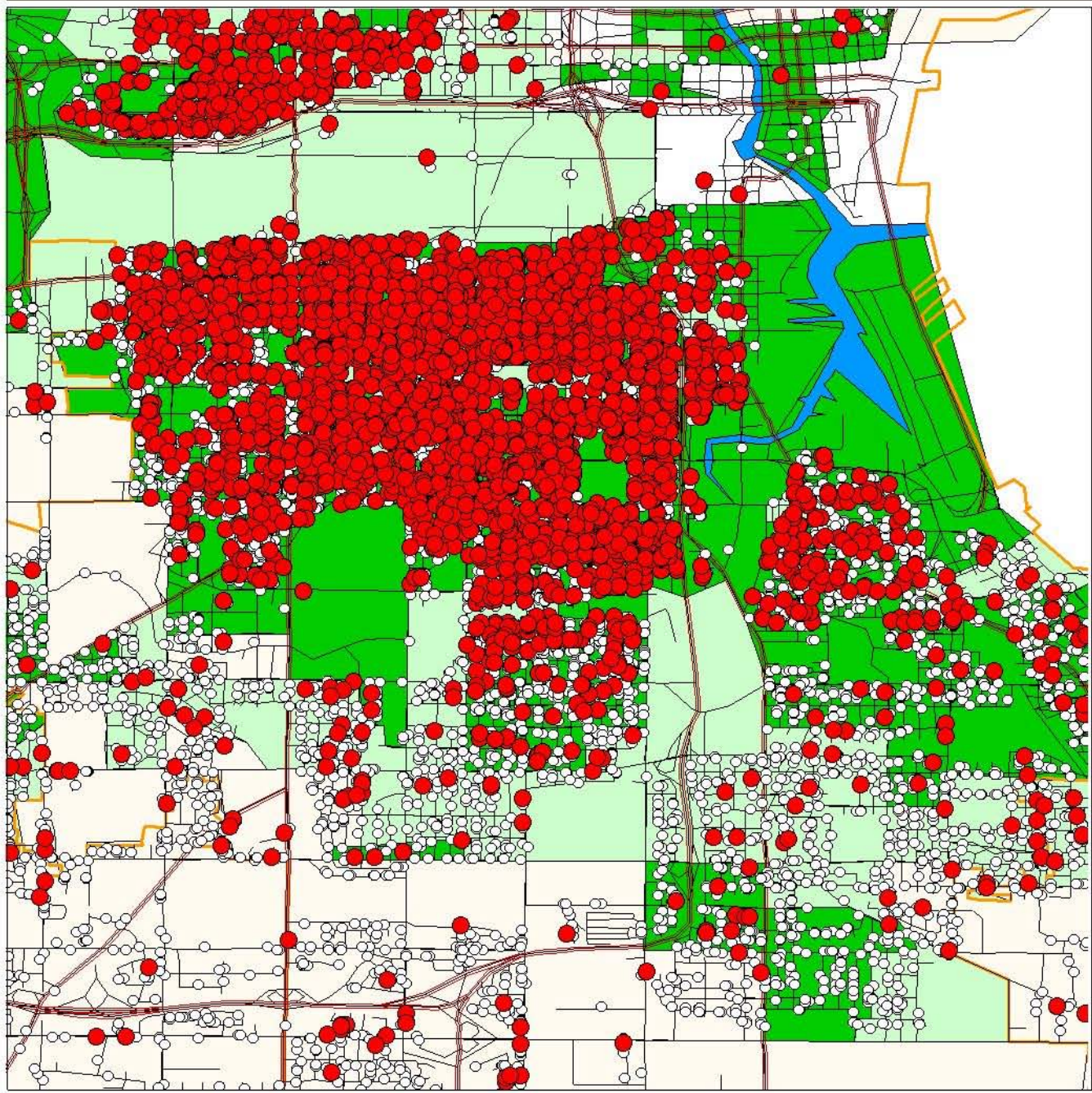
This information was developed using Wisconsin data for 2002 and the methodology from *Long-term costs of lead poisoning: How much can New York save by stopping lead?*, 2003, Katrina Smith Korfmacher, PhD, Environmental Health Sciences Center, University of Rochester.

## **APPENDIX 2**

GIS Maps of 3 of Wisconsin's High-Risk Communities:

Milwaukee, Racine and Sheboygan

# Addresses of Children Tested for Lead Poisoning (1995 - 2001)



Maximum Blood Lead Level ( $\mu\text{g}/\text{dL}$ ) at Address  
○ 0 - 9  
● 10 - 760

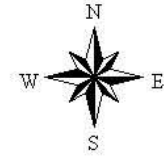
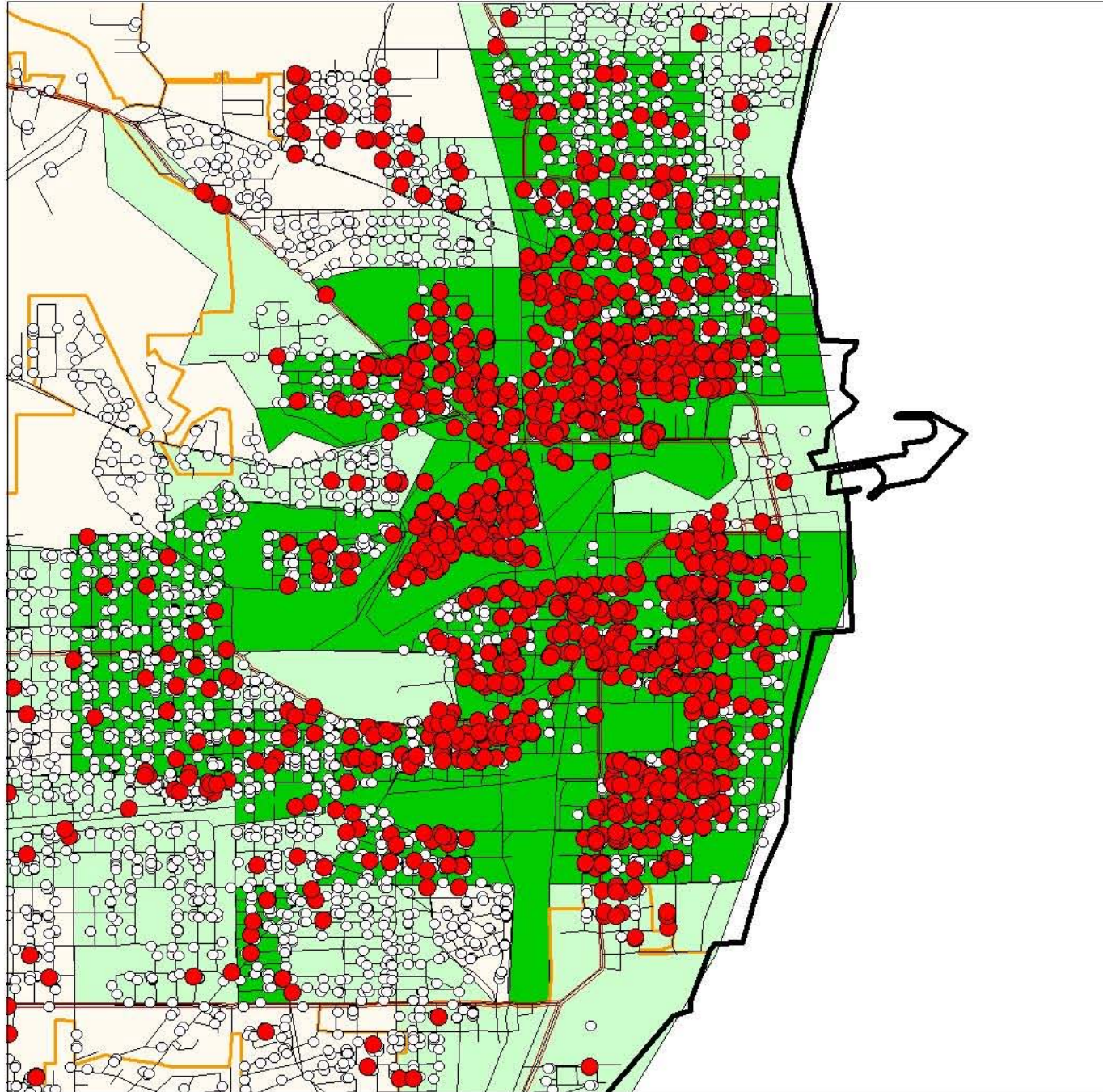
Percent of Houses Built Before 1950  
□ 0 - 33  
□ 34 - 66  
□ 67 - 100

▬ County Highways  
▬ County Roads  
▭ City Boundary  
▭ County Boundary  
■ Water

Dec 6, 2002

City of Milwaukee [South]

# Addresses of Children Tested for Lead Poisoning (1995 - 2001)



Maximum Blood Lead Level ( $\mu\text{g}/\text{dL}$ ) at Address

- 0 - 9
- 10 - 95

Percent of Houses Built Before 1950

- 0 - 33
- 34 - 66
- 67 - 100

County Highways

County Roads

City Boundary

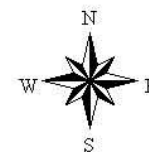
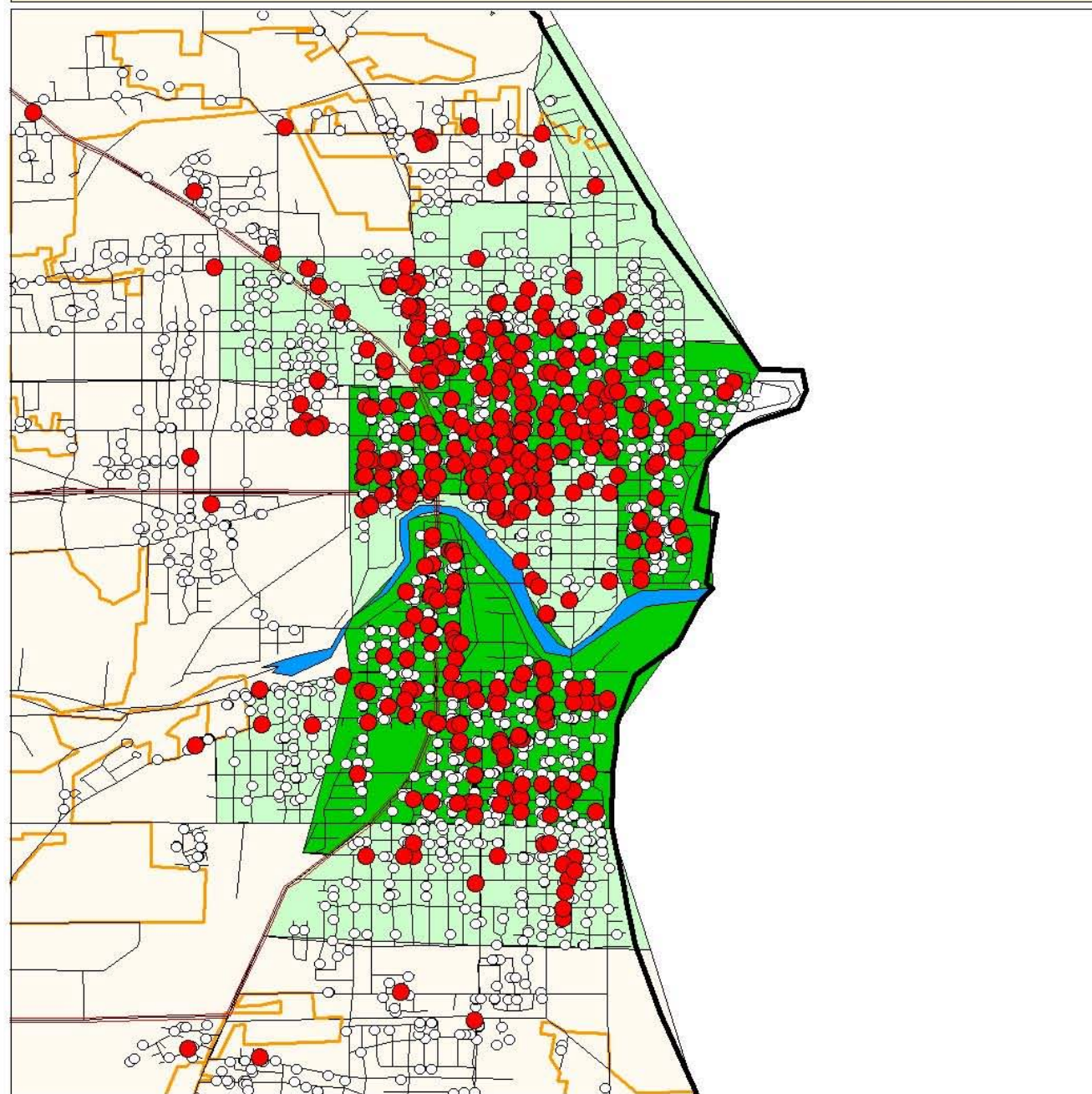
County Boundary

Water

Dec 6, 2002

City of Racine

# Addresses of Children Tested for Lead Poisoning (1995 - 2001)



Maximum Blood Lead Level ( $\mu\text{g}/\text{dL}$ ) at Address

- 0 - 9
- 10 - 159

Percent of Houses Built Before 1950

- 0 - 33
- 34 - 66
- 67 - 100

County Highways

County Roads

City Boundary

County Boundary

Water

Dec 6, 2002

City of Sheboygan

**APPENDIX 3**

Wisconsin Childhood Lead Poisoning Elimination Plan Committee

Member Contact Information List

### Wisconsin Childhood Lead Poisoning Elimination Plan Committee

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## **APPENDIX 4**

Letter of Invitation to Committee Members

December 19, 2003

A. Henry Anderson, M.D.  
Wisconsin Division of Public Health  
Bureau of Environmental Health  
1 West Wilson Street, Room 150  
Madison, WI 53702

Dear Dr. Anderson:

The Department of Health and Family Services is pleased to invite you to participate in eliminating childhood lead poisoning by the year 2010. We need your assistance to achieve this goal for Wisconsin.

The Centers for Disease Control and Prevention (CDC) has charged each state with developing a plan that will address this formidable environmental health issue. To meet this goal, we are assembling a diverse group of stakeholders representing health care, business, government, public health, advocacy and rental property. This group will comprise the Wisconsin Childhood Lead Poisoning Elimination Committee.

This task is especially important for Wisconsin. The rate of lead poisoning in Wisconsin far exceeds the national average. In 2002, 6.3% of children ages one to five who were tested had elevated blood lead levels of 10 micrograms per deciliter or more. This rate is nearly three times the national average of 2.2% reported in the 1999/2000 National Health and Nutrition Examination Survey (NHANES). Wisconsin data indicate that children from low-income families and those living in older housing with deferred maintenance are disproportionately affected by lead poisoning.

Your participation in this committee will involve attending 5 to 6 meetings over a 5-month period beginning January 7, 2004. You will be asked to review documents, participate in discussions and provide your expertise in developing strategies for lead poisoning prevention. From this work, a childhood lead poisoning elimination plan for Wisconsin will be developed and submitted to CDC by June 30, 2004.

Of even greater importance, beyond committee meeting participation, is your voice to advance this plan in your communities and among your peers. It will take a partnership of many—both government and private—to eliminate lead poisoning in children and the associated lifelong complications.

We look forward to your participation on the Wisconsin Childhood Lead Poisoning Elimination Committee. Staff from the Wisconsin Childhood Lead Poisoning Prevention Program will contact you to verify your commitment to this process and to review details of the meetings.

Thank you for your support. We look forward to working with you.

Sincerely,

Kenneth Munson  
Deputy Secretary

## **APPENDIX 5**

### Wisconsin Childhood Lead Poisoning Elimination Plan Committee Member Role and Responsibilities

## **Wisconsin Childhood Lead Poisoning Elimination Plan 2010 Committee** **Mission, Purpose and Responsibilities**

January 7, 2004

### **Mission;**

The mission is the elimination of childhood lead poisoning in the State of Wisconsin by 2010.

### **Purpose:**

The purpose is to serve as a decision-making body to develop a strategic plan to eliminate childhood lead poisoning in the State of Wisconsin by 2010.

### **Responsibilities:**

Based on direction from the federal tri-agencies, U. S. Centers for Disease Control and Prevention, Environmental Protection Agency and Housing and Urban Development, members of this committee will:

1. Develop a long-term childhood lead poisoning elimination plan for Wisconsin to be accomplished by 2010.
2. Adopt short-term, intermediate and long-term outcomes that need to be achieved. Identify baseline measures and means to gather data to determine progress.
3. Agree on assignments to member organizations(s) to take lead responsibility to implement activities to achieve outcomes.
4. Develop an evaluation plan for the overall elimination plan:
  - ✓ Identify measures of attitude and behavior change,
  - ✓ Coordinate implementation activities,
  - ✓ Get updates on progress/barriers, and
  - ✓ Develop strategies to address barriers.
5. Identify external partners essential to effective implementation and how they will be involved (now or later) to advance progress toward desired outcomes.
6. Identify resources and resource needs that will achieve desired outcomes.
7. Identify the process to conduct an annual evaluation of progress and prepare an annual progress report including outcomes measures, process measures, accomplishments and lessons learned.
8. Re-evaluate/modify overall plan directions; assign further activities to advance progress toward outcomes for the next year.