

Strategic Plan for the Elimination of Childhood Lead Poisoning in Georgia by 2010



Georgia Childhood Lead Poisoning Prevention Program November 2004

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Executive Summary

The Georgia Department of Human Resources, Division of Public Health (GDPH), Childhood Lead Poisoning Prevention Program (GCLPPP) has prepared this Strategic Plan to Eliminate Childhood Lead Poisoning in Georgia by 2010 (the Plan) at the direction of the Centers for Disease Control and Prevention (CDC).

Childhood lead poisoning is a serious health problem for the Nation and for the State of Georgia. Lead is a neurotoxin. It is harmful to all individuals and is particularly harmful to the nervous systems of developing fetuses and young children. It can harm a child's brain, kidneys, bone marrow, and other body systems. It can cause a reduction in IQ, impaired learning ability, reading and learning disabilities, and behavior problems.

Over 50,000 blood lead tests were reported to GCLPPP in 2003, approximately 7% of the population less than age 6, and a similar number are expected in 2004. A total of 1264 children, approximately 2.5% of those tested in 2003, had blood lead levels equal to or greater than 10 micrograms per deciliter ($\mu\text{g}/\text{dL}$), the level of concern established by CDC. GCLPPP's targeted screening guidelines give priority to testing children that are identified as high-risk for lead poisoning, primarily children eligible for Medicaid, PeachCare for Kids, and WIC. GCLPPP has also identified 12 high-risk counties that include the state's largest urban areas.

A key element of preparing the Plan was the expansion of GCLPPP's current Lead Advisory Committee (LAC). The membership of the LAC now includes a broad cross section of Federal, state, and local government agencies, professional and private organizations, academic institutions, businesses and individuals. The LAC was organized into the following six subcommittees to focus on high priority topics.

- Primary prevention;
- Surveillance and screening;
- Case management;
- Housing and lead hazard reduction;
- Statutes, codes and enforcement; and
- Education and outreach.

The first activity of the LAC and other interested stakeholders was a Lead Advisory Committee and Stakeholders Summit held in Atlanta on September 1, 2004. Seventy-four people attended this meeting. This effectively launched the work of the LAC. Each of the subcommittees met again in September, and the full committee met in October and November. The goals, objectives, and activities of this Plan are the product of the LAC.

The LAC established the following goal for the elimination of childhood lead poisoning in Georgia: **The percentage of all children under the age of 6 screened annually with blood lead levels $\geq 10 \mu\text{g}/\text{dL}$ will not exceed the following:**

2006—2.0%

2008—1.5%

2010—1.0%.

During the preparation of the Plan, the concept of primary prevention became an overarching goal and the major focus of information and services available to pregnant women and families with young children. Primary prevention means preventing children from becoming lead poisoned by improving the housing stock, creating and enforcing stronger housing-related statutes and codes, increasing awareness of childhood lead poisoning through better outreach and education, and continuous surveillance of screening data so that blood lead testing can be better targeted to high-risk populations and areas.

The most significant objectives and activities included in the Plan are highlighted below:

- Make primary prevention a priority in areas with large numbers and high proportions of children at high risk for lead poisoning. GCLPPP will continue to define and refine targeted areas as more and better data is obtained.
- Promote early interventions by targeting pregnant women and mothers of young children to increase awareness and prevent high-risk children from becoming lead poisoned.
- Increase targeted screening of high-risk populations. Specific annual goals are established for screening in the 12 priority counties and for children on Medicaid.
- Develop comprehensive case management guidelines for use by both private and public health providers.
- Develop a system for tracking the care and management of all children with blood lead levels ≥ 10 $\mu\text{g}/\text{dL}$.
- Initiate a proactive campaign to establish partnerships with local community development and housing agencies to share information and cooperate in the delivery of housing programs to eliminate lead hazards in the housing stock occupied by low-income households.
- Expand the scope of Georgia's Childhood Lead Exposure Control Act to include all housing (not just properties with more than 12 units), add enforcement powers to ensure that lead hazards are controlled, and otherwise strengthen the statute.
- Promulgate regulations that provide legal protection for owners of rental property that meet certain maintenance standards and can demonstrate that there are no lead-based hazards in their housing units.
- Partner with and educate local housing code agencies so they are aware of the dangers of deteriorated paint and promote the maintenance of lead-safe housing.
- Focus education and outreach activities on primary prevention and new initiatives within GCLPPP.
- Include rural areas and smaller communities in all new initiatives and activities.

The costs of implementing this Plan will go beyond the capacity of GCLPPP's current staff and resources. The finances of eliminating lead hazards in housing will be significant. Activities to redirect existing housing resources and obtain new financial resources are included in the Plan.

GCLPPP and the LAC will continue to work diligently to build partnerships to leverage resources. Both will also work to evaluate the costs of administering the Elimination Plan

to determine if existing staff and budgets are appropriate. No less than current staffing would be acceptable.

Ongoing evaluation is a critical part of the Plan and an important function of the LAC, which will meet at least annually to assess the progress being made and recommend mid-course corrections when necessary.

Mission Statement

The mission of our Plan is to eliminate childhood lead poisoning as a public health concern in Georgia by the year 2010.

Statement of Purpose

The purpose of our Plan is to create the methods, procedures and policies that will be used to reduce childhood lead poisoning as a public health concern so Georgia's children are happy, healthy, and lead-free.

Preparation of the Plan

As part of its grant requirements from the CDC, GCLPPP was directed by CDC to prepare a Strategic Plan to Eliminate Childhood Lead Poisoning in Georgia by the year 2010. The Plan was developed during a period of intense activity from July through November 2004. The GDPH contracted with Healthy Housing Solutions, Inc. of Columbia, Maryland to assist in the preparation and development of this Plan.

Georgia Lead Advisory Committee

A key element of the Plan preparation process was the expansion of GCLPPP's LAC. The GDPH determined that a comprehensive and practical plan to eliminate childhood lead poisoning could only be developed if there was widespread participation by all the key stakeholders in the State. Furthermore, the Plan could only be implemented if the responsible parties involved in the preparation of the Plan had a stake in its success. To assure this ongoing stakeholder commitment, the LAC will continue to oversee the implementation of the Plan.

The role of the LAC was to bring together key stakeholders in Georgia to understand current childhood lead poisoning incidence rates and patterns, identify critical opportunities and barriers to preventing such poisoning, inventory current and needed resources to address the problem, and develop appropriate recommendations and implementation steps for GDPH.

The LAC was appointed by the GDPH beginning in July. The membership of the LAC includes a broad cross section of Federal, state, and local government agencies, professional and private organizations, academic institutions, businesses and individuals. (See Attachment A for the membership of the LAC.)

The LAC was organized into six subcommittees to focus on high priority topics and to diversify the work and responsibilities of the LAC. Those subcommittees are as follows:

- Primary prevention;
- Surveillance and screening;
- Case management;
- Housing and lead hazard reduction;
- Statutes, codes and enforcement; and
- Education and outreach.

The work of each subcommittee is discussed in more detail throughout this Plan.

Needs Assessment

Concurrent with the establishment of the LAC, GCLPPP's consultant, Healthy Housing Solutions, conducted a Needs Assessment of the current childhood lead poisoning data and trends in Georgia. The purpose of the Needs Assessment report was to highlight

existing gaps and barriers, and to identify administrative, educational, enforcement, housing and resource needs to administer a comprehensive childhood lead poisoning prevention program that will achieve the 2010 goal. The August 24, 2004 report, which is summarized in the next section of this Plan, was provided to the LAC as a background paper for the Lead Advisory Committee and Stakeholders Summit.

Initial Lead Advisory Committee and Stakeholders Summit

The first activity of the LAC was a Summit held in Atlanta on September 1, 2004. The conference was designed to generate ideas and gather support for the development of the Plan. Seventy-four (74) people attended the all-day session. Dr. Paul A. Blake, Director of the Epidemiology Branch, Division of Public Health, and Marcie Memmer, Summit Coordinator, welcomed the attendees. Dr. Mary Jean Brown, Chief of the Lead Poisoning Prevention Branch of CDC's National Center for Environmental Health, presented the keynote address. She described the scope of the childhood lead poisoning problem in the Nation, the progress that has been made in the last few decades, and the work that remains to eliminate the disease as a national concern. She challenged the participants to be creative in developing a Plan that would meet the needs of Georgia.

The bulk of the day was spent in workshops for the six subcommittees. (Attachment B is a list of participants in each subcommittee.) Each group reviewed strengths, weaknesses, barriers and opportunities to address the issues related to the subcommittee's topic and developed tentative proposals and recommendations.

When the subcommittees concluded their work, the participants convened again in a plenary session. The subcommittee chairs each made an oral presentation to the entire group and answered questions. This closeout session was a highlight of the Summit; it was an opportunity for each person to provide direct feedback on the other committees' ideas. The recommendations of each subcommittee were gathered into a comprehensive report on the Summit. That September 15, 2004 report was distributed to the LAC.

Ongoing Lead Advisory Committee Meetings

The LAC and its subcommittees then held a series of meetings. Each of the subcommittees met during the week of September 20, 2004 to refine the general recommendations initially developed at the Summit. The work of the subcommittees was documented in a report dated September 30, 2004 and distributed to the LAC.

The LAC met on October 6, 2004 to consider and accept the recommendations of the subcommittees. It also adopted a Mission Statement, a Statement of Purpose for the Plan, and an overall goal for eliminating childhood lead poisoning by 2010. The recommendations of the LAC are the core of this Elimination Plan. GCLPPP and its consultant, Healthy Housing Solutions, then proceeded to prepare the Plan. The LAC met one more time on November 9, 2004 to review and approve the draft Plan.



Stic Harris chairs a meeting of the Lead Advisory Committee on October 6, 2004.

Childhood Lead Poisoning in Georgia

The Childhood Lead Poisoning Problem

Childhood lead poisoning is a serious health problem for the Nation and for the State of Georgia. Lead is a neurotoxin. It is harmful to all individuals and no safe threshold has been established. It is particularly harmful to the nervous systems of developing fetuses and young children. It can harm a child's brain, kidneys, bone marrow, and other body systems. It can cause a reduction in IQ, impaired learning ability, reading and learning disabilities, and behavior problems.

The CDC defines an elevated blood lead level (EBLL) as ≥ 10 $\mu\text{g}/\text{dL}$ (micrograms per deciliter). Recent studies indicate that there are harmful effects from lead poisoning at levels less than 10 $\mu\text{g}/\text{dL}$. For instance, Canfield¹ et al reported in a study of 172 children in Cincinnati that an increase in blood lead concentrations from 1 to 10 $\mu\text{g}/\text{dL}$ was associated with an IQ decline of 7.4 points. The impact of this and other recent studies has not yet been measured.

Substantial progress has been made in removing lead from the environment. Most notable was the elimination of lead in gasoline. Lead was also banned from paint in 1978, from use as solder in food and soft drink cans, and as solder in household plumbing. The principal sources of lead exposure for children today, according to the CDC, are house dust contaminated by leaded paint and soil contaminated by both leaded paint and decades of industrial and motor vehicle emissions.

The reduction in childhood lead poisoning has been dramatic because of the above reforms. National reporting regarding children's blood lead levels (BLLs) comes from the National Health and Nutrition Examination Surveys (NHANES). CDC has conducted NHANES surveys since 1976. The 1976-1980 NHANES survey estimated that the percentage of all children aged 1-5 years with BLLs ≥ 10 $\mu\text{g}/\text{dL}$ was 88.2%. Sixteen years later the 1991-1994 NHANES survey reported that the percentage of all children aged 1-5 years with BLLs ≥ 10 $\mu\text{g}/\text{dL}$ was 4.4%. The 1999-2000 NHANES survey estimated that approximately 434,000 children nationally had lead poisoning, 2.2% of the children aged 1-5 years. In 2000 CDC established the goal to eliminate BLLs > 10 $\mu\text{g}/\text{dL}$ among children aged 1-5 years by 2010.

Elevated blood lead levels do not occur equally across all population groups. Children from low-income families are four times as likely to have BLLs ≥ 10 $\mu\text{g}/\text{dL}$ as are children from middle-income families. Children on Medicaid are more than three times as likely to have high levels of lead in their blood as are children not receiving care under Medicaid. Of all children tested in 2001, Black children were more than four times as likely to have elevated BLLs as White children; and Hispanic children were more than 2.5 times as likely to have elevated BLLs as White children.

¹ Canfield RL et al. Intellectual impairment in children with blood lead concentrations below 10 μg per deciliter. *N Engl J Med* 2003 Apr 17; 348: 1517-26.

History of Childhood Lead Poisoning Prevention in Georgia

The history of a program to address the problems of childhood lead poisoning in Georgia is just over a decade old. GDPH received its first grant from CDC to describe the lead poisoning problem in Georgia and to develop a comprehensive childhood lead poisoning prevention program in 1992. The grant was for five years. GDPH initiated the GCLPPP and started gathering data. A strong LAC was created and began to function.

In what turned out to be a mistaken belief that the State would supplant CDC funding, GDPH did not apply to CDC to renew its CDC grant. Unfortunately, State funding did not materialize and the program was discontinued. The staff disbursed to other positions. No data were collected on screening of children. What data that were collected under the initial CDC grant are now corrupted and unavailable to current program administrators.

The State did authorize and provide funding for the seven new positions of Regional Lead Coordinators (RLCs) in 1998. The GCLPPP was reconstituted in 2000 with CDC funding and will continue through June 2006 under a current CDC grant funding cycle. There have been a number of administrative changes during the short history of GCLPPP, and program stability and certainty have been achieved only recently. The CDC mandate to develop a statewide plan to eliminate childhood lead poisoning is timely and requires a careful look at existing structures and plans to improve effective performance of this necessary environmental mission.

Organization for Childhood Lead Poisoning Prevention

GCLPPP consists of five positions: Program Director, Health Educator, Epidemiologist, Data Entry Clerk, and Program Associate. The mission of the GCLPPP is to eliminate lead poisoning as a public health concern in Georgia by 2010.

Operational aspects of childhood lead poisoning prevention are conducted through nineteen Public Health Districts² (PHD) and the hundreds of private physicians' offices throughout the State. Most blood lead testing is typically performed during physical examinations or well-child visits in doctors' offices. A smaller number of tests may be done at the county or District Health Departments. Several laboratories throughout the state analyze these samples and report results back to the physician's office and the District Health Office or to GCLPPP.

Follow up and case management of EBLL cases is the responsibility of the private physician or the County Health Department/District Health Nurse. GCLPPP defines an EBLL as $> 10 \mu\text{g/dL}$, which is a Notifiable Disease in Georgia. If the confirmed BLL is ≥ 20 or from 15 to 19 $\mu\text{g/dL}$ based on two or more venous BLLs at least 3 months apart, the appropriate RLC or their proxy conducts an inspection/risk assessment of the dwelling.

² The terms Public Health District, District Health Office, and County Health Department are used interchangeably and have the same meaning for the purposes of the report.

The complex matrix for management of childhood lead poisoning cases and poisoning prevention activities provides many challenges and weak intersections for effective service delivery. The 159 counties in Georgia are distributed among 19 PHDs. A PHD may contain just one county (Fulton, Clayton, and DeKalb Counties for example) or as many as 16 counties, and may have multiple offices to serve the different counties in the District. The seven RLCs are each responsible for two to five PHDs. One RLC is responsible for lead cases throughout eight counties in the Metro Atlanta area. In more rural areas of the State, the RLC may cover up to 29 counties. This complex organizational structure —159 counties, 19 PHDs, 7 RLCs—presents staffing and implementation challenges for the State’s childhood lead poisoning prevention program. At the very least it is difficult to track and measure the effectiveness of EBL case management or to identify any interventions used to reduce further exposure to lead hazards.

The Georgia Department of Natural Resources (DNR) also plays an important role in preventing childhood lead poisoning. DNR is the designated State agency for generating and enforcing rules and standards for lead training, inspection, and the lead abatement industry in Georgia. DNR administers a lead-based paint abatement certification program for lead abatement inspectors, risk assessors, project designers, supervisors and workers.

Housing Conditions in Georgia

Lead based paint and lead in dust from deteriorated lead-based paint in old housing is now considered the primary cause of childhood lead poisoning. Paint manufacturers began phasing out lead in residential paints in the 1950s and the Consumer Products Safety Commission effectively banned it in 1978. Housing built before 1950 often has large concentrations of lead in paint and poses the highest risk for lead poisoning. Both deteriorated housing conditions and renovation of pre-1950 housing without regard to lead safe work practices increase the potential for lead exposures in young children. The 2000 census reports the following about the age of housing in Georgia:

Table 1: Age of Housing

	Units	Percent		Units	Percent		Units	Percent
Owner	2,029,293	100.0%	Rental	977,076	100.0%	Total	3,006,369	100.0%
1990 - 2000*	643,830	31.7%	1990 - 2000	200,411	20.5%	1990 - 2000	844,241	28.1%
1980 - 1989	443,140	21.8%	1980 - 1989	226,813	23.2%	1980 - 1989	669,953	22.3%
1970 - 1979	351,254	17.3%	1970 - 1979	207,689	21.3%	1970 - 1979	558,943	18.6%
1960 - 1969	240,706	11.9%	1960 - 1969	136,121	13.9%	1960 - 1969	376,827	12.5%
1950 - 1959	163,872	8.1%	1950 - 1959	92,693	9.5%	1950 - 1959	256,565	8.5%
1940 - 1949	77,907	3.8%	1940 - 1949	49,919	5.1%	1940 - 1949	127,826	4.3%
1939 or earlier	108,584	5.4%	1939 or earlier	63,430	6.5%	1939 or earlier	172,014	5.7%

*Data through March 2000.

Approximately 300,000 units in Georgia (10% of all housing) were built before 1950 and 172,014 units (5.7%) were built before 1940. It remains a challenge to rehabilitate all pre-

1950 housing and to abate or control all potential lead hazards. A modest number of old housing units are removed from the housing inventory each year through abandonment or demolition.

New US Department of Housing and Urban Development (HUD) regulations regarding lead-based paint now apply to all federally assisted housing. Housing rehabilitation, homebuyer assistance, and rental assistance programs are all affected by the Federal Lead Safe Housing Rule (LSHR)³. For instance, the Section 8 Housing Choice Voucher program, which is administered by housing authorities throughout the State, provides assistance to low-income families to lease affordable units in the private rental market. All Section 8 units receive a housing quality standards (HQS) inspection at initial occupancy and annually thereafter. The LSHR requirements apply to all units occupied or to be occupied by a family with a child under the age of six. If deteriorated paint is noted during the HQS inspection, an individual trained in lead safe work practices must repair it.

The Georgia Department of Community Affairs (DCA) and the larger cities and counties administer HUD-funded Community Development Block Grant (CDBG) and HOME Investor Partnerships (HOME) programs each year. Most CDBG and HOME programs include homeowner or rental rehabilitation programs. All pre-1978 rehabilitation projects receiving more than \$5,000 per unit in federal assistance must have a risk assessment to identify lead hazards, all lead hazards must be addressed either by abatement or interim controls, and all units must pass clearance at the end of the work. If lead-based paint is disturbed, the work must be done by either State-certified abatement personnel or persons trained in lead safe work practices.

DCA received \$47 million in CDBG money and \$24 million in HOME money in federal fiscal year 2004. Twenty-one cities and counties received an additional \$50 million in CDBG money; 12 cities and counties received an additional \$20 million in HOME money. All together, the State and local governments received approximately \$142 million for CDBG and HOME of which a large portion will be used for housing rehabilitation.

Nevertheless, only a small portion of the privately owned housing in Georgia receives any federal assistance. Most remodeling and renovation is done without any guidance or requirements to test for or control lead-based paint hazards. Since accidental lead exposures during home improvement activities occur in older housing, this situation needs careful consideration as a part of the State's Elimination Plan.

Effective in FY 1995, HUD awarded a \$5.7 million Lead Hazard Control Demonstration Program Grant to DCA. The award was conditioned upon the State implementing the Georgia Childhood Lead Poisoning Prevention Act of 1994. This law established the lead contractor, work risk assessor and training certification program as prescribed by federal EPA regulations. It took over two years for DNR to issue regulations to implement the

³ Formally known as 24 CFR Part 35, Requirements for Notification, Evaluation and Reduction of Lead-Based Paint Hazards in Federally Owned Residential Property and Housing Receiving Federal Assistance.

certification program. During this period, HUD grant conditions prohibited implementation of the Demonstration Program. Project design provided that GCLPPP would provide community education, data analysis (of epidemiological data on housing type, incidence of EBLL children and lead based paint hazards), identification of cases of childhood lead poisoning, and guidelines for medical and case management. As noted above, the GCLPPP lost funding in 1997 and was no longer involved in the project. Over the final two years of the Demonstration Program, the grant completed lead hazard control in 177 units and provided training for over 150 lead industry professionals. After seven years, HUD terminated the grant prior to reaching the 239-unit goal. Nevertheless, both housing and health professionals gained considerable experience. The State of Georgia built capacity to implement lead hazard evaluation and control as part of changes in federally funded programs through Title X.

HUD also awarded a LHC grant for \$3.1 million to the City of Savannah in 1994. The grant was completed in 2000; a total of 250 units were treated.

Prevalence of Childhood Lead Poisoning

Although blood lead data has been collected in Georgia since 1994, it has been of non-uniform quality. 53,824 blood lead screens were reported to GCLPPP in 2003. About 21.5% were manually entered into the program's database while the remaining 78.5% were electronically imported. The bulk of the manual imports were from one laboratory, Quest Diagnostics, which is working out the details currently to electronically transfer all lab results of all tests, including lead tests, to DPH. Four laboratories, Quest Diagnostics, Albany State Laboratory, Chatham County Health Department Laboratory, and Medtox Diagnostics, analyzed almost 90% of all blood lead screens reported to the GCLPPP in 2003.

GCLPPP is now moving to increase the quality of the data collected by:

- Requesting standardized, complete reporting according to CDC guidelines by laboratories as well as providers; and
- Moving toward data sharing and matching with other state child programs, WIC, Medicaid, and Maternal Child Health programs.
- Creating a new, web-based database in conjunction with Maternal & Child Health Epidemiology, Children 1st, the Newborn Screening Program and Birth Defects Monitoring Program with streamlined connectivity to Georgia birth records.

An analysis of the Georgia birth records will enable GCLPPP to monitor blood lead test results where children are born into areas dominated by older housing and are at risk for elevated BLLs.

The following table summarizes the results of blood lead testing in Georgia for the period of 1998 to 2004:

Table 2: Georgia Childhood Lead Surveillance Data: 1998 – 2004*

Year	Children Screened Less than Age 6 yrs	Children Screened Ages 1 and 2 yrs	Percent Screened Ages 1 and 2 yrs	10 - 19 µg/dL Less than age 6 yrs	>= 20 µg/dL Less than age 6 yrs	Total >= 10 µg/dL Less than age 6 yrs
1998	22,163	10,233	4.2%	1,555	192	1,747
1999	18,475	8,990	3.6%	1,112	189	1,301
2000	26,301	13,226	5.2%	1,057	180	1,237
2001	31,654	15,429	5.7%	941	164	1,105
2002	33,020	17,960	6.5%	842	155	997
2003	50,742	30,410	10.9%	1,052	212	1,264
*2004	26,164	16,761	12.2%**	440	96	536

*Data through 6/30/04

**Prorated to annual basis

Following are some observations regarding this data:

1. The number and percentage of children screened for blood lead levels have increased each year since 1999, but are still low. There are approximately 700,000 children under the age of 6 in Georgia. (The 2000 census count was 714,090.) The largest number of children screened in any one year was 50,742 in 2003. That is just over 7% of the population less than age 6. Since the data for 2004 are for a six-month period, it is likely that a similar number of children will be tested in 2004.
2. The data show an increase in all reported screens of about 54% from 2002 to 2003. The increase in reported screens of children ages 1 and 2 years was approximately 69%. According to the GCLPPP Epidemiologist, this apparent increase in screens is due in part to the migration from manual reporting to electronic reporting, which means the labs report all lead screens, not just EBLs. Currently, Georgia statutes mandate the reporting of only EBLs. Other factors include increased education and outreach, especially workshops held across the State during the summer and fall of 2002 for health professionals, District workers and office managers.
3. A total of 1264 children was reported to have BLLs ≥ 10 µg/dL in 2003 of which 212 were ≥ 20 µg/dL. This is the largest number since 1999. It is not clear, however, whether this increase in children with EBLs is due to better reporting, increased testing or more targeted testing.
4. The 1264 reported cases of EBLs in 2003 are 2.5% of the number tested that year (50,742). CDC estimated in 2002 that 2.2% of the national population of children under the age of 6 had EBLs. Since the 2.5% rate of EBLs in Georgia is derived from the number of children tested and not the total universe of children, and it presumes that there is some priority in testing to high-risk children or high-risk communities, it is reasonable to conclude that the prevalence of EBLs in Georgia is roughly comparable to national averages.

Conclusion

There is a definite childhood lead poisoning problem in Georgia. CDC estimates that approximately 15,000 children under the age of 6 years have BLLs ≥ 10 $\mu\text{g}/\text{dL}$. Only 7% of the children under age 6 years were tested in 2003 with 1264 blood lead screens ≥ 10 $\mu\text{g}/\text{dL}$. If the CDC estimates are accurate, as many as 90% of the projected cases of childhood lead poisoning are not being diagnosed at this time. The Elimination Plan presents a comprehensive approach to addressing the problem, including the following:

- A primary prevention approach to preventing lead poisoning rather than relying on secondary interventions.
- Expanded screening and surveillance of children, particularly children on Medicaid who are entitled to blood lead tests under federal laws.
- Improved case management of children with EBLs.
- Better targeting of funds for housing and lead hazard reduction.
- Stronger statutes, codes and enforcement activities so that the primary causes of lead poisoning can be eliminated.
- Increased education and outreach programs, especially to high-risk families and communities.

Elimination Plan Goals

The goals for eliminating childhood lead poisoning by 2010 were developed by the LAC subcommittees, with the assistance of the GCLPPP staff, and approved by the full LAC.

Overall Goal for the Elimination of Childhood Lead Poisoning

Goal: The percentage of all children under the age of 6 screened annually with blood lead levels ≥ 10 $\mu\text{g}/\text{dL}$ will not exceed the following:

2006	2.0%	2008	1.5%	2010	1.0%
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The percentage of children screened in 2003 with EBLLs was 2.5%. This new goal provides for a gradual decrease in the incidence in lead poisoning until the overall goal of less than 1% is met. It also recognizes that total elimination of lead poisoning is not realistic. A gradually decreasing goal acknowledges that the new activities to be undertaken pursuant to this Plan will make a difference but will also take time.

It is important to note that the percentage of children with EBLLs may rise before it decreases. That is because GCLPPP will be promoting targeted screening to high-risk populations and neighborhoods. (See the goal for screening and surveillance below.) As more high-risk children are tested, it is likely that a higher proportion of those tested will have EBLLs. Notwithstanding the likelihood of a short-term increase in the percentage of EBLLs, it is still anticipated that progress will be made in reducing the incidence of childhood lead poisoning in Georgia.

The fact that the standard will be the percentage of children under the age of six with EBLLs does not diminish the State's priority for testing children at ages one and two. The under-the-age-of-six standard is consistent with historical reporting and recordkeeping practices, and with CDC's reporting protocols.

Primary Prevention

Goal: Ensure that primary prevention is the major focus of information and services available to pregnant women and families with young children.

Primary prevention means preventing children from becoming lead poisoned by improving the housing stock, creating and enforcing stronger statutes and codes, increasing awareness of childhood lead poisoning through better outreach and education, and continuous surveillance of screening data so that blood lead testing can be better targeted to high-risk populations and areas.

Primary prevention recognizes that priority must be given to areas with large numbers and high proportions of children that constitute a high risk for lead poisoning. Successful techniques and expertise will be expanded to rural areas and smaller communities.

GCLPPP will seek ways to intervene at an early date, in part by linking with birth records, in order to identify potential cases of lead poisoning.

This is a major shift in priorities for GCLPPP. Up to this point, the focus has been on secondary interventions—collecting screening data, assessing the scope and effectiveness of testing, evaluating trends, and recommending changes in testing priorities and policies. Establishing primary prevention as an overarching goal requires redirection and focus of strategies and activities by GCLPPP and its partners.

In a major effort to look beyond traditional health concerns, GCLPPP will establish a database linking the incidence of childhood lead poisoning and high-risk characteristics of communities and housing conditions.

Screening⁴ and Surveillance

Goal: Create policies that ensure the appropriate screening, reporting and surveillance of childhood lead poisoning.

The GCLPPP's Screening Guidelines specifically state that "high risk" children should be routinely screened for blood lead levels at 12 months and 24 months of age with either a capillary or venous blood specimen. The following are identified as high-risk children:

1. Medicaid- or PeachCare for Kids-eligible children;
2. WIC eligible children;
3. Children adopted from outside the United States;
4. Children with a "Yes" or "Don't know" on a verbal risk assessment questionnaire;
5. Children with a parent employed in certain occupations or with certain hobbies; and
6. All children residing in the following high-risk counties: Bibb, Chatham, Cobb, DeKalb, Fulton, Glynn, Gwinnett, Hall, Richmond, Sumter, Thomas, and Troup.

According to the Georgia Department of Community Health's annual report for fiscal year 2002, 469,252 children under the age of 6 years received Medicaid services. Of this number, 304,868 were between ages 1 and 5 years, the most likely age where they would be tested for blood lead levels. The annual report also noted that 326,371 children received Health Checks under the Maternal and Child Health Program.

Federal regulations require testing of blood lead levels in all children on Medicaid at approximately 12 months and 24 months. There is no data at the present time that identifies the number of Medicaid children screened for lead toxicity in Georgia. When one compares any of the numbers in the previous paragraph with the number of children screened as shown in Table 2 above, it appears that only a fraction of all Medicaid children are being tested. For instance, if one compares the 469,252 children under age 6 years on Medicaid with the 33,020 tested in 2002, the percentage tested is only 7.0%. If

⁴ For purposes of this Elimination Plan, the words "screening" and "testing" are used interchangeably and have the same meaning.

one uses the 50,742 tested in 2003, the percentage of children on Medicaid that were tested is still only 10.8%. While the precise figures can be contested or refined, the primary point is not in dispute: either only a small percentage of all children on Medicaid are being screened for lead poisoning, or the results of screening are not being reported to GCLPPP.

The screening and surveillance goals focus on increasing targeted screening in high-risk areas and populations, improving the quantity and quality of surveillance data, and increasing compliance with screening and reporting guidelines.

Case Management

Goal: Establish guidelines that ensure the proper case management of lead poisoned children

Management of cases with EBLLs is shared between private physicians and the district/county public health department offices. There are basically two different tracks for both Medicaid children and non-Medicaid children: the private physician track and the public health track.

With the implementation of the Georgia Better Health Care program in the late 1990s the responsibility for the primary care of children on Medicaid was transferred to private physicians. Such activities include the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and all other ongoing care for most of the low-income children in Georgia. Consequently, private physicians are responsible for managing the care of the majority of children with EBLLs.

Steps taken after a physician receives the blood lead test results from the lab are generally not known since there has been no standard protocol for handling EBLL cases. Current recommendations for confirmatory testing and case management can be summarized as follows:

- Confirm capillary blood lead tests ≥ 10 $\mu\text{g}/\text{dL}$ with a venous diagnostic test. All follow-up testing should be venous sampling.
- If the confirmed venous BLL is ≥ 10 $\mu\text{g}/\text{dL}$, conduct follow-up testing pursuant to a schedule and provide necessary clinical case management. This includes a clinical nutritional assessment and family lead education and referrals.
- If the confirmed venous BLL is ≥ 20 $\mu\text{g}/\text{dL}$, additional clinical case management should be provided, which includes an environmental investigation at the child's place of residence.
- Chelation therapy is recommended for any child with a BLL ≥ 45 $\mu\text{g}/\text{dL}$.

It has been GCLPPP's policy that any case with a BLL ≥ 20 $\mu\text{g}/\text{dL}$ should be referred to a RLC to perform an environmental investigation. The RLCs get referrals from private physicians, GCLPPP, and district and county health nurses. It is clear, however, that the

policy has not been consistently followed because the RLCs received referrals for only a fraction of the 212 known cases in 2003 with blood lead levels > 20 µg/dL.

There is a critical need for the development of comprehensive case management guidelines for both private providers and the public health sector. GCLPPP will develop guidelines along with a system for tracking the management, care and disposition of all cases of blood lead levels ≥ 10 µg/dL. The guidelines and tracking system will recognize the different roles of private providers, district/county health offices, hospitals, and RLCs. A part of this process will be a clarification of the role of the RLCs who have an opportunity to plan a more significant role in case management.

Finally, GCLPPP will work with other stakeholders to identify and establish a resource pool of persons available to provide assistance to others that lack experience in managing lead poisoning cases.

Housing and Lead Hazard Reduction

Goal: Identify and properly control lead hazards in target housing.

Linking childhood lead poisoning prevention activities to the abatement and control of lead hazards in housing is new to GCLPPP, and a challenge. Representatives of the housing community have been active participants in the development of this Elimination Plan. The objectives of this goal encompass three subjects: The first is establishing partnerships with community development and housing agencies. The second is finding financial resources for controlling lead hazards. The third is playing a proactive role with local housing and community development agencies by providing screening and housing data to assist them in preparing their Consolidated Plans, a prerequisite for receipt of CDBG and HOME funds from HUD.

Controlling lead hazards in housing is critical to both the broad goals of primary prevention and the specific needs of case management for a lead poisoned child. In fact, childhood lead poisoning will not likely be eliminated as a public health concern until lead hazards are removed from housing occupied by young children. This will only occur if partnerships are established at the city and county level to address the problem of hazardous housing.

Identifying additional financial resources to pay for the cost of lead hazard remediation was one of the primary subjects considered by the Housing and Lead Hazard Reduction subcommittee. Unfortunately, there is no silver bullet. One of the objectives of this Plan is to identify and secure additional financing resources. The CDBG and HOME programs are currently the primary sources of public funding. GCLPPP and its partners will review successful practices in other states and seek to identify whether there are comparable opportunities in Georgia. New legislation may be recommended as a result of this review.

GCLPPP will initiate assistance to help cities, counties and DCA in preparation of their annual Consolidated Plans. HUD guidelines for preparation and submission of

Consolidated Plans require the jurisdiction to “consult with state and local health agencies... and examine data on hazards and poisonings, including health department data on the addresses of housing units in which children have been identified as lead poisoned.” The submission must “estimate the number of housing units that contain lead-based paint hazards...and describe the actions that will take place to evaluate and reduce the number of housing units containing lead-based paint hazards and describe how lead based hazard reduction will be integrated into housing policies and programs.” GCLPPP will actively participate in this process.

Statutes, Codes and Enforcement

Goal: Create policies and procedures that ensure effective health and housing enforcement.

In 1994 the Georgia General Assembly passed two important pieces of legislation regarding lead-based paint and childhood lead poisoning.

The Lead Poisoning Prevention Act established standards for professionals in the lead abatement industry and for conducting lead abatement activities in a lead safe manner. Regulations have been promulgated and the Act and regulations are in effect.

The Childhood Lead Exposure Control Act established standards and procedures for controlling lead poisoning hazards in properties occupied by children with EBLs. Although this law became effective in 2000, implementing regulations are not yet written. While there are several useful provisions in this statute, it does not provide the authority needed to enforce orders to abate lead hazards or to enforce recommendations contained in a lead inspection or risk assessment report. Furthermore, the Act applies exclusively to buildings with 12 or more residential units, thus providing an exemption for much of the housing in the State of Georgia.

The State Housing Code is another example of a potential but unrealized opportunity to improve housing conditions in the State. This code specifically governs residential maintenance standards as opposed to the building codes, which apply to new construction and major renovation projects. The obvious merits of such a housing code underscore its potential utility for primary prevention activities in Georgia. However, adoption and enforcement of the State Housing Code is not mandatory (unlike other construction codes in the state). It is up to individual cities and counties to adopt the State Housing Code and then to enforce it.

GCLPPP and the LAC recognize that both statutes and codes need to be strengthened in Georgia. Both will work with state legislators, one of which is currently on the LAC, and other stakeholders to develop amendments to the Childhood Lead Exposure Control Act. The goal is to broaden its scope to include all housing, add enforcement powers, and make other important changes. In the meantime, GCLPPP will promulgate regulations pursuant to the Act, which, if met by property owners, will provide them with some

measure of protection for units constructed prior to 1978 against liability for lead poisoning.

GCLPPP will also work with local housing code compliance agencies to incorporate visual assessments for deteriorated paint in their inspection and enforcement activities.

Education and Outreach

Goal: Develop an effective education and outreach program that targets high-risk children and neighborhoods.

Education and outreach are essential to any effective childhood lead poisoning prevention program. They are shown here as the last of the six goals in the Elimination Plan because education and outreach are among the primary means by which the other five goals can be accomplished.

Primary prevention will be the primary focus of education and outreach activities. GCLPPP will take a proactive position in reaching out to high-risk populations with information about how to prevent children from becoming lead poisoned.

In addition, education and outreach will aggressively promote new initiatives within GCLPPP. For instance, when new case management guidelines are rolled out, there will be training and an education and outreach component. Similarly, if new legislation is adopted, essential education and outreach to the public and the lead stakeholders will be required to ensure understanding and full implementation.

Notwithstanding the above, GCLPPP will maintain current educational materials on childhood lead poisoning and maintain an informative web site. Materials will be available in different languages and be culturally appropriate.

Financial Resources

GCLPPP and the LAC will work to evaluate the costs of administering the Elimination Plan to determine if existing staff and budgets are appropriate. No less than current staffing would be acceptable.

In large part, the goals, objectives and activities represent a redirection of priorities. This is certainly true for the new focus on primary prevention. In other cases, there will be new policies and protocols that will guide providers in the delivery of health services. This is true, for instance, with regard to improved case management for lead poisoned children. Clarification of policies and protocols will bring clarity to health providers, increase both compliance with federal and state requirements, and ensure the efficient use of resources.

There are not sufficient resources to eliminate all lead hazards in housing in Georgia. GCLPPP will work with DCA and local housing and community development agencies

to improve targeting of existing resources to housing occupied or likely to be occupied by low-income families with children. GCLPPP will also work with its housing partners to identify other potential funding sources, including proposing new legislation if necessary.

Strategic Work Plan Narrative

This Strategic Work Plan has two components: a narrative description of the objectives and a set of tables that include all the activities under each goal and objective.

Primary Prevention

Objective 1: Identify and give priority to areas with large numbers and high proportions of children that constitute a high risk for lead poisoning.

The concept of targeting activities to high-risk populations and high-risk areas is at the heart of Georgia's primary prevention strategy. High-risk populations are largely defined now as those on Medicaid or PeachCare for Kids. High-risk areas are those with concentrations of pre-1950 housing that is generally of low value and poorly maintained. GCLPPP has currently identified 12 of the most populous counties in the State as target areas. These areas will be defined and refined to focus on neighborhoods, zip codes or census tracts.

Targeted areas will then become priorities for screening, education and outreach, and development of partnerships with city/county housing agencies and code compliance agencies. Lessons learned will be transferred to rural areas and smaller communities.

Objective 2: Identify resources to assist rural areas and smaller communities.

Much less is known about childhood lead poisoning in rural areas and smaller communities than is known about urban areas. GCLPPP will conduct surveillance activities for rural areas to determine the extent of the problem. It will also conduct an assessment to determine any deficiencies in education, screening, and case management practices and to identify resources that may be available for rural areas and smaller communities. All GCLPPP initiatives will include rural areas and smaller communities.

Objective 3: Promote early interventions to prevent high-risk children from becoming lead poisoned.

A new emphasis will be placed on intervening at an early date to prevent children from becoming lead poisoned. GCLPPP will target pregnant women to raise awareness and knowledge of lead poisoning and will use birth rate data to target parents of young children. GCLPPP will also promote the EPA Pre-Renovation Education Rule and the Disclosure Rule.

Objective 4: Establish a clearinghouse of data regarding housing conditions throughout the state.

GCLPPP will begin the process of collecting housing data for the purpose of establishing a clearinghouse of housing information in Georgia. The purpose of such an effort is to better target lead screening of children and focus education and outreach activities based

on characteristics of housing within specific areas. Appropriate stakeholders will identify what information should be collected, what form it will take, and what its use will be. Once that first step is completed, additional steps will be identified.

Screening and Surveillance

Objective 1: Increase targeted screening in high-risk areas and populations.

Continued surveillance of lead screening data is at the core of GCLPPP’s strategic work plan. GCLPPP has identified priorities for screening, the most important of which is children eligible for Medicaid and PeachCare for Kids. This objective includes activities to increase private provider, hospital, and public health staff knowledge and awareness of GCLPPP’s screening priorities so that screening of priority populations does in fact take place.

Of equal importance is identifying geographic areas that represent a high risk for lead poisoning. Such areas generally represent neighborhoods with pre-1950 housing, especially housing that is deteriorated and poorly maintained. Children in such areas may not be low income (and therefore eligible for Medicaid), or they may be low income but not on Medicaid. Children occupying old housing being rehabilitated, renovated or restored are especially vulnerable to lead poisoning and should be screened for EBLs.

Specific goals have been established for screening children on Medicaid and living in high-risk target areas. The goals are as follows:

Table 3: Percentage of Children Screened

Year	Children ages 1 & 2 in 12 priority counties	Children ages 1 & 2 on Medicaid
2004	13.9	9.8
2005	15.2	10.8
2006	16.8	11.8
2007	18.4	13.0
2008	20.3	14.3
2009	22.3	15.8
2010	24.6	17.3

As noted above, these goals will be evaluated annually and adjusted as needed.

Objective 2: Continue to increase the quantity and quality of surveillance data.

Major strides have been made in the past year to obtain more complete and better quality data. Reporting by laboratories has substantially improved. GCLPPP is working with the labs to obtain all lead screening reports, not just those $\geq 10 \mu\text{g/dL}$. Most labs now report electronically rather than manually which significantly increases accuracy, saves time for incorporation in GCLPPP’s database, and enhances the capacity for analysis. Continued

work is needed on the completeness of data. Examples of gaps include inaccurate or blank addresses, absence of race or ethnicity information, and failure to indicate whether the child is on Medicaid.

Concurrent with work to improve the quality and quantity of data will be efforts to link GCLPPP's database with WIC and Medicaid databases. Linking with WIC may occur in by the end of 2004 while linking with Medicaid will take longer. Comparing WIC, Medicaid and GCLPPP data will yield much better information on the extent to which priority populations are being screened and on the incidence of childhood lead poisoning.

GCLPPP will also continue to work with state, county and city agencies to identify high-risk properties that are being or should be programmed for removal or rehabilitation.

Objective 3: Increase compliance with screening and reporting guidelines.

The extent to which private providers comply with current federal requirements and state guidelines for screening priority populations, especially children on Medicaid, is largely unknown. Therefore, a survey of private providers known to be noncompliant with the Health Check screening guidelines will identify barriers to blood lead testing. This will be done in conjunction with the Georgia chapter of the Academy of American Pediatricians and the Georgia Academy of Family Practitioners. Based on the results of the survey, activities will be initiated to increase compliance with screening and reporting guidelines.

In order to improve the quality of reporting by laboratories, GCLPPP will develop and publish a semiannual report on the quality and completeness of lab reporting practices. GCLPPP, in conjunction with DCH, will also develop and publish an annual list of those health care providers demonstrating a high compliance rate for screening. Both of these activities are designed to build on the concept that comparison with peers is an important motivation for achievement.

GCLPPP will also work with private insurance plans to raise awareness and compliance with screening guidelines among children covered by private insurance plans.

Case Management

Objective 1: Develop case management guidelines for managing lead poisoning cases.

GCLPPP, with the help of the LAC and other stakeholders, will develop comprehensive case management guidelines in calendar year 2005. Among other things, the guidelines will lower the threshold for case management from 20 µg/dL to 10 µg/dL. They will also establish new patterns of communication between the private providers and the public health sector so that no child with an EBLL is neglected.

The guidelines will be widely circulated to stakeholders for review and comment. Case management training of all involved parties will be an essential component of implementation. Experience in the effective use of the guidelines will be tracked and evaluated, and appropriate changes will be made as needed.

Objective 2: Develop a system for tracking the management, care and disposition of all cases of children with elevated blood lead levels (currently ≥ 10 $\mu\text{g}/\text{dL}$).

An essential part of the case management guidelines is a flow chart and a system for tracking an individual case from receipt of a report of an EBLL to closure of the case. Such a system does not currently exist and there is no way of knowing what happens either to individual cases or groups of cases. The tracking system will be designed so that each reported EBLL case is identified as the responsibility of a specific provider whether public or private. Determining what will be reported and by whom will be addressed by GCLPPP and the LAC.

Objective 3: Clarify the role of Regional Lead Coordinators.

The role of RLCs is poorly defined at this time and operations differ widely. Although the RLC's principal role is to perform environmental investigations in support of case management, they can also play a central role in education and outreach, and screening and surveillance. These activities support the work of the medical community and can be expanded to work more directly with local housing and codes agencies.

Objective 4: Establish a resource pool of experts to provide medical assessment, treatment and follow-up services to providers lacking experience in managing lead poisoning cases or to provide consultative services to such persons.

The objective here is to identify and provide professional resources to the health care providers that are not experienced in the management of EBLL cases. GCLPPP, the Georgia Poison Control Center and other stakeholders will identify the range of possible services, which may be provided. Services may be direct assistance, such as assuming temporary responsibility for a case, or consultation on site or by phone. Many providers, especially those in rural areas or smaller communities, are not familiar with lead poisoning treatments. In some cases all they may need to do is call an experienced person who can provide telephonic advice. In other cases, a provider may request an experienced person to temporarily take over the case. (A similar process currently exists for treatment of children with tuberculosis.) The objective is to provide competent support for medical providers without permanently taking over their cases.

Housing and Lead Hazard Reduction

Objective 1: Establish partnerships with community development and housing agencies that participate in lead hazard abatement and control activities.

The most common source of funding for the removal of lead hazards in housing is the Community Development Block Grant (CDBG) program. Twenty-one cities and counties plus the State of Georgia receive an annual allocation of CDBG funds from HUD. Most CDBG grantees use at least a portion of those funds for rehabilitation. This Plan proposes the establishment of partnerships between district/county health offices and local CDBG program agencies.

It also proposes establishing partnerships with housing authorities and other housing agencies that deliver housing programs and services. For instance, housing authorities administer the Section 8 Housing Choice Voucher program and may be a resource for local health agencies.

Objective 2: Identify and secure financial resources for controlling lead hazards.

GCLPPP will assist DCA or any city or county agency in applying for HUD Lead Hazard Control grants. GCLPPP can assist with identifying target areas and problem housing, education and outreach, and other needs to strengthen an application. GCLPPP can also assist with implementation of an approved grant.

GCLPPP will work with other stakeholders to identify funding sources for lead hazard control, review the experience of other states, and propose legislation to create additional funding sources, if appropriate.

Objective 3: Assist local housing, community development and planning agencies in the development of Consolidated Plans.

GCLPPP will play an enhanced role in assisting cities, counties and DCA in preparing their annual Consolidated Plans for submission to HUD. GCLPPP will forward data on the extent of lead poisoning within each jurisdiction and estimates of the number of housing units that contain lead-based paint hazards, if known. GCLPPP will also suggest strategies for reducing lead hazards as part of their housing and community development programs.

Statutes, Codes and Enforcement

Objective 1: Expand the scope of the existing Childhood Lead Exposure Control Act.

During the first year, GCLPPP will define its legislative strategy. GCLPPP will work with the state legislator on the LAC and with other stakeholders to draft language that has a good chance of success and develop a strategy for introducing and lobbying for its enactment. GCLPPP will seek partners such as the Georgia Municipal Association, the Association of County Commissioners of Georgia, and the Georgia Apartment Association to work in support of needed legislation.

Object 2: Develop regulations to implement 31-41-16 of the Childhood Lead Exposure Control Act regarding owner liability for units constructed prior to 1978.

The current statute provides liability protection for owners of rental property in certain defined circumstances who may be sued by occupants seeking damages for injuries allegedly arising from exposure to lead-based paint or lead-contaminated dust. The statute provides that the State will issue an annual certificate of compliance if the owner complies with certain maintenance standards and can demonstrate that there are no lead-based paint hazards. GCLPPP will develop regulations to implement this provision of the statute.

Objective 3: Partner with local housing code agencies to include visual assessments for deteriorated paint in housing code inspections.

Developing partnerships with local code agencies will also be challenging and take time. But enforcement of codes, especially housing codes where they exist, is crucial to the maintenance of a stable and habitable housing stock. Local code enforcement agencies can include visual assessments for deteriorated paint in their inspections. They can also make referrals of egregious cases to the district/county health department. Additionally, they can promote the Pre-Renovation Education and Disclosure Rules, and support and promote the use of lead-safe work practices.

Education and Outreach

Objective 1: Make primary prevention the focus of education and outreach activities.

GCLPPP will shift its focus in education and outreach to primary prevention. It will continue its work to collect and analyze lead screening data, and recommending new priorities for testing. However, educational materials and outreach activities will stress measures to prevent children from becoming lead poisoned, especially high-risk children and pregnant women. GCLPPP will reach out to code enforcement agencies to enlist their support in identifying and addressing potential lead hazards. It will target landlords and property managers, housing program managers and banks to inform them about lead poisoning and deliver the primary prevention message.

Objective 2: Utilize education and outreach activities to promote new initiatives within GCLPPP.

GCLPPP's education and outreach efforts will become much more proactive in delivering new messages advancing new initiatives. These initiatives may include new screening guidelines, new case management protocols, the availability of new professional resources for rural areas, additional financial resources, and new legislation, codes or regulations.

Objective 3: GCLPPP will continue to be a reliable source of childhood lead poisoning prevention.

This important responsibility as a basic resource for information about childhood lead poisoning will not be neglected. GCLPPP's website, publications, slideshows, and other resources will be maintained and available in multiple languages for the general public.

Strategic Work Plan Activities

The following work plan activities are organized by the six basic headings used throughout this Plan. For each subject area there is a goal, several objectives, and a listing of activities to meet the objective. The tables also show the agency that has the lead responsibility for implementing the activity, the years in which the activity will take place, and the intended outcome of each activity.

Goal 1: Ensure that primary prevention is the major focus of information and services available to families with young children and pregnant women

Objective 1: Identify and give priority to areas with large numbers and high proportions of children that constitute a high risk for lead poisoning

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Target strategies and activities to areas with both large numbers and high proportions of children with lead poisoning. GCLPPP currently has identified 12 counties as priority areas for targeting childhood lead poisoning prevention activities	GCLPPP/ LAC	X	X	X	X	X	X	Reduction in incidence of childhood lead poisoning in target areas
2	Continue to adjust priority targets as the data is refined and improved	GCLPPP/ LAC	X	X	X	X	X	X	Reduction in incidence of childhood lead poisoning in target areas
3	Apply lessons learned to lower priority areas, rural areas and smaller communities	GCLPPP/ LAC		X	X	X	X	X	Reduction in incidence of childhood lead poisoning in other areas
4	Target education and outreach activities to priority areas and populations	GCLPPP/ LAC	X	X	X	X	X	X	Increased public awareness about preventing childhood lead poisoning
5	Establish partnerships with other health, housing and community development agencies in target areas to maximize impact of mutually supportive objectives	GCLPPP/ DCH/ DCA/ local CD & housing agencies	X	X	X	X	X	X	Improved cooperation and coordination in delivery of services to target populations

Goal 1: Ensure that primary prevention is the major focus of information and services available to families with young children and pregnant women

Objective 2: Establish a resource pool to assist rural areas and smaller communities

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1a	Conduct an assessment of the need in rural areas and smaller communities for assistance or consultation on medical treatment and case management	GCLPPP/ LAC		X					Needs assessment report
1b	Conduct an assessment of the need in rural areas and smaller communities for assistance or consultation on programs and financial resources available to control lead hazards in housing	GCLPPP/ LAC		X					Needs assessment report
1c	Develop a pool of experts available to provide direct or consultative assistance to rural areas and smaller communities in accordance with identified needs	GCLPPP/ LAC		X					A pool of experts available to provide direct or consultative assistance to rural areas and smaller communities
1d	Pilot resource pool concept in a region or local area that has problems with lead poisoning.	GCLPPP/ LAC		X					Pilot project
2	Continue to be accessible for information that is needed in rural areas and smaller communities	GCLPPP	X	X	X	X	X	X	Rural areas and smaller communities receive accurate and relevant information in a timely manner

3	Ensure that all GCLPPP initiatives include rural areas and smaller communities when high risk children and housing are at stake	GCLPPP	X	X	X	X	X	X	Inclusion of rural areas and smaller communities in all GCLPPP initiatives
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Goal 1: Ensure that primary prevention is the major focus of information and services available to families with young children and pregnant women

Objective 3: Promote early interventions to prevent high-risk children from becoming lead poisoned

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Create an educational curriculum that can be used to raise pregnant women's awareness and knowledge of lead poisoning	GCLPPP/ WIC	X		X	X	X	X	Increased awareness by mothers of young children of ways to prevent childhood lead poisoning
2	Use birth data to target educational mailings to families with small children living in high-risk areas. Use GIS analysis to access birth records of children being born in designated target neighborhoods as a way to communicate lead risks to the parents prior to the child's exposure	GCLPPP		X	X	X	X	X	Targeted mailings
3a	Plan and develop activities that will increase the general public's awareness of and compliance with the Federal Disclosure Rule (1018)	GCLPPP / Region IV EPA/ UGA	X	X	X	X	X	X	Increased public awareness about lead-based paint hazards when buying or renting housing
3b	Refer cases of noncompliance with 1018 to EPA and/or HUD	GCLPPP/ EPA/ HUD	X	X	X	X	X	X	Increased compliance with Federal Disclosure Rule
4	Plan and develop activities that will increase the general public's awareness of and compliance with the Federal Pre-Renovation Education Rule (406b)	GCLPPP / Region IV EPA/ UGA	X	X	X	X	X	X	Increased awareness amongst contractors about the need for using lead-safe work practices during renovation

Goal 1: Ensure that primary prevention is the major focus of information and services available to families with young children and pregnant women

Objective 4: Establish a clearinghouse of data regarding housing conditions throughout the State

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Work with appropriate stakeholders to plan and develop a clearinghouse about housing and childhood lead poisoning to better target both housing program activities and screening for childhood lead poisoning	GCLPPP/ LAC/ DCH/ DCA	X						Establishment of data clearinghouse working group
2	Determine what information and what form the information should take (i.e. internet, pdf format, etc.) to go into the clearinghouse	GCLPPP/ LAC/ DCH/ DCA	X						A work plan for the establishment and operation of a data clearinghouse of housing conditions
3	Work with state agencies to gather appropriate housing information	GCLPPP/ LAC/ DCH/ DCA	X	X	X	X	X	X	Housing data related to housing and childhood lead poisoning, such as housing conditions, age of housing, type of construction, etc.
4	Work with private inspectors to gather housing information	GCLPPP/ inspectors & risk assessors	X						Housing data related to housing and childhood lead poisoning, such as housing conditions, age of housing, type of construction, etc.
5	Ensure the clearinghouse is easily accessible for the general public and all other stakeholders.	GCLPPP		X	X	X	X	X	Increased awareness by stakeholders about relationship of housing to childhood lead poisoning

Goal 2: Create policies that ensure the appropriate screening, reporting and surveillance of childhood lead poisoning

Objective 1: Increase targeted screening in high-risk areas and populations

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Continue to identify and assess high-risk areas and populations. GCLPPP has currently identified 12 counties and children receiving public assistance for the poor as high-risk	GCLPPP/ LAC	X	X	X	X	X	X	Annual list of high-risk areas and populations
1b	Work with county and city agencies to access GIS resources including tax assessor and parcel data with property owner, age of construction, and assessed value information in order to identify problem housing and high risk areas	CGLPPP/ county & city agencies	X	X	X	X	X	X	Identified target housing and high-risk areas for lead poisoning
1c	Continue to utilize data from GIS analysis to help locate specific neighborhoods and housing where children are at risk for lead poisoning	GCLPPP	X	X	X	X	X	X	Improved data for targeting.
1d	Narrow high-risk areas to smaller recommended areas for target screening (i.e. zip codes, neighborhoods, etc.)	GCLPPP/ LAC		X		X		X	More accurate targeting to those most at risk for being lead poisoned
2	Increase private provider, hospital, & public health staff knowledge and awareness of GCLPPP's screening priorities	GCLPPP/ FHB/ DCH/ AAP/ AFP/ MAG	X		X		X		Increased compliance with screening guidelines

3	Identify places (i.e. doctors' offices, health clinics, etc.) in high-risk areas where children receive health services to post information encouraging screening	GCLPPP	X		X		X		Increased awareness of those most in need of lead poisoning prevention and screening
4	Increase screening rate of children ages 1 & 2 in targeted areas by 10% per year. The base year is 2003 when 12.6% of children in 12 priority counties were screened.	GCLPPP/ DCH/AAP/ GAFP/ Private Insurance Plans	X	X	X	X	X	X	Screening rates: 2004 - 13.9%; 2005 - 15.2%; 2006 - 16.8%; 2007 - 18.4%; 2008 - 20.3%; 2009 - 22.3%; 2010 - 24.6%
5	Increase screening rate of children ages 1 & 2 on Medicaid by 10% per year. The base year is 2003 in which approximately 8.9% of 1 & 2 year olds on Medicaid were screened	GCLPPP/ DCH/AAP/ GAFP	X	X	X	X	X	X	Screening rates: 2004 - 9.8%; 2005 - 10.8%; 2006 - 11.8%; 2007 - 13.0%; 2008 - 14.3%; 2009 - 15.8%; 2010 - 17.3%

Goal 2: Create policies that ensure the appropriate screening, reporting and surveillance of childhood lead poisoning

Objective 2: Continue to increase the quantity and quality of surveillance data

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Link WIC database to GCLPPP database on a regular basis (probably quarterly)	GCLPPP/ MCH EPI/WIC	X						Increased completeness of GCLPPP data
2	Link Medicaid database to GCLPPP database on a regular basis (probably quarterly)	GCLPPP/ DCH	X						Increased completeness of GCLPPP data
3	Continue to work with state, county, and city agencies to identify high-risk properties	GCLPPP/ DCA/ GA CD & Hsg Auths	X	X	X	X	X	X	High-risk properties identified for community development & housing agencies to make lead safe.
4	Continue to identify and collect data that would be useful to elimination	GCLPPP	X	X	X	X	X	X	Increased wealth of data GCLPPP has available
5	Develop reporting guidelines for labs and providers to increase completeness of data	GCLPPP	X						Improved accuracy and completeness of data
6	Reduce number of incomplete, inaccurate or blank addresses by 10% per year	GCLPPP	X	X	X	X	X	X	Improved accuracy and completeness of data

Goal 2: Create policies that ensure the appropriate screening, reporting and surveillance of childhood lead poisoning

Objective 3: Increase compliance with screening and reporting guidelines

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1a	Survey private providers who do not comply with Health Check (EPSDT) blood lead screening guidelines to identify barriers to screening	GCLPPP/ DCH/ AAP/ GAFP	X						Increased compliance by private providers with screening guidelines
1b	Utilize findings from survey to plan and implement education and outreach campaign to increase compliance with Health Check services	GCLPPP/ DCH/ AAP/ GAFP	X						Increased compliance by private providers with screening guidelines
2	Develop and publish semiannual report on quality of lab reporting. This report will be shared with all appropriate stakeholders	GCLPPP/ LAC	X	X	X	X	X	X	Semiannual report
3	Publicize list of top providers complying with complete Health Check services to recognize providers that have a high compliance rate for screening	DCH	X	X	X	X	X	X	Annual list of top performers
4	Work with private insurance plans to raise awareness and the compliance of screening among children covered by private insurance	GCLPPP	X	X	X	X	X	X	Increase screening among children not covered by Medicaid, but by private insurance that are considered at high-risk for lead poisoning.

5	Create incentives for private providers to send blood lead samples to labs that meet state standards for quality of reporting. The first step is to identify state labs and other labs that are doing high quality reporting of lead screening data. Then providers will be advised that, if they send blood lead specimens to those labs, they will not have to separately report EBLL cases to GCLPPP	GCLPPP/	X	X	X	X	X	X	Improved reporting of all blood lead testing results
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Goal 3: Establish guidelines that ensure the proper case management of lead poisoned children

Objective 1: Develop comprehensive case management guidelines that help public health personnel and private providers properly manage and close out cases of lead poisoning

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Establish a working group of stakeholders to help create and implement guidelines for managing the care of lead poisoned children	GCLPPP/ LAC	X						Advisory group of stakeholders
2	Develop draft comprehensive guidelines for care and management of lead poisoned children	GCLPPP/ LAC	X						Draft case management guidelines
3	Circulate and obtain, obtain comments from stakeholders; revise and publish final guidelines	GCLPPP	X						Final case management guidelines
4	Train private providers and public health staffs, private providers, hospitals, clinics on implementation of new guidelines	GCLPPP/ AAP/ GAFF		X					Trained providers
5	Review experience on use of case management guidelines, update guidelines, and train providers on revisions	GCLPPP/ LAC/ AAP/ GAFF			X				Revised case management guidelines
6	Develop procedures to obtain reimbursement from Medicaid for eligible case management & environmental investigation costs	GCLPPP/ DCH	X						Reimbursement from Medicaid for eligible costs

**Goal 3: Establish guidelines that ensure the proper case management
of lead poisoned children**

Objective 2: Develop a system for tracking the management, care and disposition of all cases of children with elevated blood lead levels (currently $\geq 10 \mu\text{g/dL}$)

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Develop flow chart for tracking the progress of an EBLL case from the lab report to the provider to the environmental investigation (if required) to close out. Separate flow charts shall be developed for management by public health, private providers, hospitals and clinics	GCLPPP/ LAC	X						Flow chart for tracking progress of EBLL cases
2	Incorporate flow chart in case management guidelines; obtain comments, review and revise	GCLPPP/ LAC	X						Revised case management guidelines
3	Train private providers and public health staff on the proper flow and tracking of EBLL cases	GCLPPP/ AAP/ GAFF		X					Trained providers
4	Incorporate tracking reports in surveillance activities to enhance targeting activities to high-risk populations	GCLPPP		X					Improved targeting to high-risk populations
5	Review tracking system and revise as necessary	GCLPPP/ LAC			X				Revised flow chart

**Goal 3: Establish guidelines that ensure the proper case management
of lead poisoned children**

Objective 3: Clarify role of Regional Lead Coordinators

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Identify current functions and activities, needs and gaps in providing comprehensive childhood lead poisoning prevention services in district/county health offices	GCLPPP/ LAC	X						Assessment report
2	Work with RLCs in redefining their job descriptions and responsibilities	GCLPPP/ RLC/ Environ Branch	X	X					Increased scope of RLC responsibilities
2	Prepare revised position descriptions for RLCs	GCLPPP	X						New RLC position descriptions
3	Train RLCs on new responsibilities	GCLPPP	X						Fully trained RLCs

**Goal 3: Establish guidelines that ensure the proper case management
of lead poisoned children**

Objective 4: Establish a resource pool of experts to provide medical assessment, treatment and follow-up services to providers lacking experience in managing lead poisoning cases, or to provide consultative services to such persons

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Identify medical personnel with expertise in lead poisoning that are available to provide medical or consultative services to providers	GCLPPP	X						Resource pool list
2	Establish protocol for obtaining and using such services in case management	GCLPPP	X						Written protocol
3	Inform providers of the availability of expert advice and assistance	GCLPPP	X						Advice to providers
4	Evaluate effectiveness of resource pool	GCLPPP		X					Evaluation report

Goal 4: Identify and properly control lead hazards in housing

Objective 1: Establish partnerships with community development and housing agencies that participate in lead hazard abatement and control activities

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Develop working relationships with CDBG programs that include housing rehabilitation activities	GCLPPP/ local comm development agencies	X	X	X	X	X	X	Increased knowledge of local health & CDBG programs, sharing of information and cases
2	Identify other housing programs and services that may be available to assist with financing lead hazard reduction activities	GCLPPP/ local CD & housing agencies	X	X	X	X	X	X	Increased knowledge of local health & other housing programs, sharing of information and cases
3	Identify roles and secure commitment of resources by health and housing organizations that would contribute to lead abatement and control activities	GCLPPP/ local CD & housing agencies	X	X	X	X	X	X	Increased knowledge of local health, community development & other housing programs, sharing of information and cases
4	Enter into partnerships; execute Memoranda of Understanding to deliver health and housing services and activities in a coordinated manner	GCLPPP/ local CD & housing agencies	X	X	X	X	X	X	Partnership agreements, MOUs

5	Develop and update a directory of health and housing resources available for landlords and tenants when lead hazards are present in housing. Make sure the directory is easily accessible to the general public, public health staff, and housing agencies	GCLPPP	X	X	X	X	X		Directory of health and housing resources
6	Work with housing programs that include housing rehabilitation activities to help target activities in neighborhoods where target housing is located	GCLPPP/ local CD & housing agencies	X	X	X	X	X	X	Increased targeting of housing programs to neighborhoods where target housing is located
7	Work with local housing and community development agencies to plan and deliver lead-safe work practices training.	GCLPPP/ local CD & housing agencies	X	X	X	X	X	X	Increased knowledge by contractors of lead-safe work practices

Goal 4: Identify and properly control lead hazards in housing

Objective 2: Identify and secure financial resources for controlling lead hazards

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Assist DCA and/or city and county agencies in applying for HUD Lead Hazard Control grants by identifying target areas and problem housing, offer assistance with education and outreach, providing letters of support, etc.	GCLPPP/ DCA/ local CD agencies	X	X	X	X	X	X	Applications to HUD for Lead Hazard Control grants
2a	Establish a working group of stakeholders that will explore the possibility of developing legislation for new funding sources	GCLPPP/ LAC/ DCA/ GMA/ ACCG/ GCCA*		X					A working group of stakeholders to seek new funding sources
2b	Review funding sources used in other states, identify opportunities in Georgia, develop options for consideration by legislature	GCLPPP/ LAC/ DCA		X					Memorandum of options for new funding sources from state legislature
2c	Prepare specific legislative proposals, including a tax credit for abatement of lead hazards in housing, for Georgia legislature	GCLPPP/ LAC/ DCA			X				Specific legislative proposals

*Georgia Municipal Association, Association of County Commissioners of Georgia, & Georgia Community Action Agencies

Goal 4: Identify and properly control lead hazards in housing

Objective 3: Assist local housing, community development and planning agencies in the development of Consolidated Plans

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Identify cities and counties that must prepare a Consolidated Plan and schedules for public hearings and submission to HUD	GCLPPP/ HUD	X						List of jurisdictions that will submit Consolidated Plans
2	Prepare standard documentation on childhood lead poisoning and housing with lead hazards in each jurisdiction plus strategies for incorporating lead hazard reduction in housing programs	GCLPPP	X	X	X	X	X	X	Documentation for presentation to jurisdictions
3	Make presentations at public hearings where feasible	GCLPPP/ RLCs	X	X	X	X	X	X	Local jurisdictions are informed about lead poisoning and lead hazards in their jurisdictions

Goal 5: Create policies and procedures that ensure effective health and housing enforcement

Objective 1: Expand the scope of the existing Childhood Lead Exposure Control Act

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1a	Seek consultation to determine actions needed to amend existing legislation to make it more comprehensive and relevant to the current trends of childhood lead poisoning in Georgia	GCLPPP/ LAC/ GA General Assembly		X					A working plan to amend existing legislation
1b	Remove current language in O.C.G.A. Section 31-41-18, which limits the Act's application to multifamily, structures over 12 units. Add language which expands the coverage of the Act to any housing constructed before 1978 (to read identical to the Residential Lead-Based Paint Hazard Reduction Act)	GCLPPP/ LAC / GA General Assembly		X	X				Increased coverage of the Act, especially for those units that do the most harm in regards to lead poisoning.
1c	Include language that identifies how the law will be enforced and who will enforce the law.	GCLPPP/ LAC / GA General Assembly		X	X				A law that can be enforced properly.
2	Establish a working group of stakeholders that will be responsible for drafting legislation and providing consultation to GCLPPP on legislative issues	GCLPPP/ LAC/ legislators/ landlords		X	X	X	X	X	An advisory group of stakeholders
3	Identify local advocacy and community-based organizations that will advocate for newer, more comprehensive legislation on behalf of GCLPPP	GCLPPP		X					List of potential advocacy groups

4	Develop an education campaign for those persons that will be affected by new legislation before adopting any new statutory provisions	GCLPPP/ prof orgs representing stakeholders			X				Educational campaign for those affected by new legislation
5	Identify existing state and federal laws regulating lead hazards and their enforcement provisions. Make this information available to stakeholders.	GCLPPP/ LAC	X						Increased awareness of Federal and state laws.

Goal 5: Create policies and procedures that ensure effective health and housing enforcement

Objective 2: Develop regulations to implement 31-41-16 of Childhood Lead Exposure Control Act regarding owner liability for units constructed prior to 1978

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Follow-up with all necessary stakeholders (i.e. GDPH legal, LAC, etc.) to determine best practices for writing regulations specific to this law	GCLPPP		X					A working plan for developing new regulations
2	Establish relationships with all stakeholders that could be affected by regulations to gather feedback and to provide information on the new regulations	GCLPPP/ LAC		X					A network of stakeholders that will be affected by new regulations
3	Develop education campaign to increase landlords awareness of the new regulations and how their participation will be beneficial to providing lead-safe housing for families	GCLPPP/ GA Apt Assn/ prof groups representing landlords		X					Educational campaign for those affected by new legislation
4	Consider developing a list of landlords that have a "certificate of compliance" to make available to the public	GCLPPP		X	X	X	X	X	List of units with a "certificate of compliance"

Goal 5: Create policies and procedures that ensure effective health and housing enforcement

Objective 3: Partner with local housing code agencies to include deteriorated paint in housing code inspections

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Identify localities that have adopted local housing codes	GCLPPP/ DCA		X					List of localities that have adopted housing codes
2	Work with local housing code agencies to include assessments of deteriorated paint as part of their inspection	GCLPPP/ local code enf agencies		X	X				Revised local housing code inspection checklists and procedures
3	Encourage housing code inspectors to provide lead poisoning prevention information to occupants of pre-1978 housing	GCLPPP/ local code enf agencies		X	X	X	X	X	Increased awareness of ways to prevent childhood lead poisoning
4	Encourage housing code inspectors to make referrals of pre-1978 housing with deteriorated paint which is occupied by young children to Public Health for environmental investigations	GCLPPP/ RLCs/ local code enf agencies		X	X	X	X	X	Referrals from housing code inspectors to Public Health
5	Encourage RLCs to make referrals to housing code inspectors when they investigate EBLL cases of families that live in extremely deteriorated housing	RLCs/ local code enf agencies		X	X	X	X	X	Referrals from RLCs to local housing code inspectors

Goal 6: Develop an effective education and outreach program that targets high-risk children and neighborhoods

Objective 1: Make primary prevention the focus of education and outreach activities

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Utilize surveillance data to determine high-risk populations through the use of GIS and risk factor analysis to target for education and outreach activities	GCLPPP	X	X	X	X	X	X	Increased education about lead poisoning prevention amongst those people who can make the biggest difference in preventing it
2a	Create the appropriate media and the most effective message that will increase people's awareness and encourage best practices for preventing childhood lead poisoning	GCLPPP/ LAC		X	X	X	X	X	Increased public awareness about preventing childhood lead poisoning
2b	Identify a spokesperson(s) (i.e. parent of a lead-poisoned child, well-known community activist, legislator, etc.) who can help GCLPPP raise the profile of lead poisoning prevention in the community	GCLPPP/ LAC		X	X	X	X	X	Increased public awareness about preventing childhood lead poisoning
3	Create and develop educational materials and outreach activities for pregnant women, especially for those women living in high-risk areas	GCLPPP	X						Increased awareness by pregnant women about how to prevent childhood lead poisoning
4	Increase providers' compliance with providing anticipatory guidance to families with children at risk for lead poisoning	GCLPPP/ DCH	X	X	X	X	X	X	Reduction in the rate of childhood lead poisoning

5	Meet with and present information on lead poisoning prevention to people and agencies that can directly affect the availability of lead-safe housing in Georgia	GCLPPP/ DCA/ local CD & HAs	X	X	X				Increased awareness by community development and housing agencies about the need for lead-safe housing
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Goal 6: Develop an effective education and outreach program that targets high-risk children and neighborhoods

Objective 2: Utilize education and outreach activities to promote new initiatives within GCLPPP

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Develop appropriate educational activities for stakeholders affected by the new screening guidelines and future updates	GCLPPP/ AAP/ AAFP/ LAC	X						Increased compliance with new screening guidelines
2	Develop appropriate educational activities for stakeholders affected by the new case management guidelines and future updates	GCLPPP/ AAP/ AAFP/ LAC		X					Increased compliance with new case management guidelines
3	Continue to expand the development and utilization of partnerships to reach targeted audiences that are affected by new program initiatives	GCLPPP/ LAC	X	X	X	X	X	X	Increased understanding of new initiatives
4	Increase media coverage of childhood lead poisoning and GCLPPP's activities	GCLPPP/ media	X	X	X	X	X	X	Increased public awareness of childhood lead poisoning activities

Goal 6: Develop an effective education and outreach program that targets high-risk children and neighborhoods

Objective 3: GCLPPP will continue to be a reliable source of childhood lead poisoning prevention information

	Activity Description	Lead Agency	2005	2006	2007	2008	2009	2010	Intended Outcome
1	Update information on childhood lead poisoning, including surveillance data, on the Georgia Division of Public Health website yearly	GCLPPP	X	X	X	X	X	X	Up-to-date, accurate information for the public on Georgia's Childhood Lead Poisoning Prevention Program
2	Update and maintain educational materials so that they are available in different languages, easily readable, and culturally appropriate	GCLPPP	X		X	X	X	X	Up-to-date, accurate information for the public on Georgia's Childhood Lead Poisoning Prevention Program
3	Develop information for the Hispanic/Latino community that provides information on lead poisoning related to imported pottery and folk remedies	GCLPPP		X					Spanish language publications and educational activities that are culturally appropriate
4	Ensure that updated surveillance data is made available to all stakeholders	GCLPPP	X	X	X	X	X	X	Stakeholders that are knowledgeable about the current childhood lead poisoning problem in Georgia

Evaluation Plan

The evaluation of the Elimination Plan's activities is critical to implementation of the Plan. Evaluation will be conducted concurrently with implementation rather than waiting until some future date. Consequently, evaluation will be ongoing with important evaluation milestones to be established by the LAC.

Lead Advisory Committee

Evaluation of the Plan will be performed by the GCLPPP staff, with the support of the LAC. The first step will be to establish a Program Evaluation subcommittee made up of key stakeholders who have an enduring interest in the results and success of the Elimination Plan. The subcommittee will meet quarterly.

Membership will include representatives of both the health and the housing communities from the public and private sectors. Most of the data that is collected and analyzed will relate to the health arena (e.g., screening children, case management, etc.). On the other hand, achieving the Plan's goal of primary prevention means that lead hazards must be eliminated over time from the State's housing stock. The subcommittee will therefore include representatives of the housing arena to establish evaluation indicators and sources of information to make judgments about improvements in housing conditions.

Most screening and case management are the responsibility of private providers operating under guidelines issued or to be issued by the State. Therefore, GCLPPP will work closely with representatives of AAP and GAFP to conduct surveys, education, outreach and training of private providers, and to involve them in the design and implementation of the program evaluation.

What will be evaluated

The GCLPPP will evaluate the implementation of the Elimination Plan. The Plan describes the current state of childhood lead poisoning in Georgia. It establishes the goal that by 2010 no more than 1% of all children less than six years old who receive lead screens will have blood lead levels greater than 10 µg/dL. The Plan lays out a comprehensive set of activities under six broad objectives.

The evaluation will include an assessment of both process and program effectiveness. Process evaluation will include such measures as whether the Plan is being implemented as planned and on time, whether the flow of paper and information meets expectations, whether partnerships are being formed as anticipated, and whether the LAC has included all relevant stakeholders.

Program evaluation will consider both short-term and long-term objectives. For instance, the evaluators will look at such short-term objectives such as whether there is an increase in screening Medicaid children, whether all lab results are being reported to GCLPPP, whether all children in case management are being tracked, and whether there is an

increase in housing code enforcement related to deteriorated paint conditions. Long-term objectives include whether there is a reduction in the incidence of childhood lead poisoning. If so, the evaluation will identify the factors that contributed to this reduction and what activities did not appear to be important.

Evaluation Design

The current rate of childhood lead poisoning in Georgia is 2.5% of all children under the age of six who were screened in 2003. The goal is to reduce that to no more than 1.0% by 2010. That goal alone is easy to measure. However, there are additional goals that must also be evaluated as GCLPPP evolves over the next several years. Among the most important are the following:

Increase targeted screening in high-risk areas and populations.

Lead screening is the only way to detect whether a child is lead poisoned and the only way to know whether the goal of eliminating childhood lead poisoning is being achieved. GCLPPP has identified high-risk areas (currently defined as 12 counties) where priority needs to be given to screening as well as to education and outreach, code enforcement and controlling lead hazards in housing. The Plan establishes specific annual goals for increasing screening rates by 10% per year in high priority target areas. The Plan also establishes annual goals for increasing screening rates by 10% per year for children on Medicaid, a high priority population according to the CDC and GCLPPP guidelines.

The current 2.5% rate of childhood lead poisoning is based on all screens reported by the labs, not on the total number of lead screens analyzed. Therefore, an important part of the Plan is to increase both the quantity and quality of reporting. All of the major labs report all blood lead test results now, but other labs and hospitals do not report any results at all. GCLPPP may seek legislative authority to require the reporting of all blood lead test results, not just those that exceed 10 µg/dL as is the case now.

The LAC will evaluate whether the screening goals are being met, whether the reported results are based on complete and accurate data, and whether the goals need to be revised as 2010 approaches.

Improve case management of lead-poisoned children.

Little is actually known about the nature and extent of case management. There currently is no sufficient tracking or reporting system. One of the major goals of the Plan is to develop case management guidelines for both public and private providers and to establish a system for tracking and reporting on the progress of a child from the time the lab reports an EBLL to case close out.

The GCLPPP will evaluate the implementation of the guidelines and the tracking/reporting system. The evaluation will include whether all involved stakeholders participate in the drafting of the guidelines, whether the tracking/reporting system will

likely be useful to program managers and/or burdensome to providers, and whether there actually is medical follow-up to reported EBLL cases. In short, GCLPPP will review whether case management is effective in reducing or eliminating the effects of lead poisoning.

Control lead hazards in housing.

The evaluation design for this component of the Elimination Plan will be refined by the GCLPPP during 2005. GCLPPP is currently unaware of consistent, accurate reports or information about actions taken to eliminate lead hazards in housing. Although individual cities and counties collect and report data on housing conditions and housing program accomplishments, there is no statewide data collection and reporting system.

GCLPPP will establish a system for tracking and reporting the establishment and accomplishments of partnerships, Memoranda of Understanding, interagency agreements or contracts between district/county health agencies and city/county housing and community development agencies.

The GCLPPP will evaluate the Elimination Plan activities designed to increase the cooperation between health and housing agencies so that housing programs aggressively address lead hazards in housing.

Increase statutory authority to comprehensively address lead hazards in housing.

The Elimination Plan includes activities to expand the scope of the current Childhood Lead Exposure Control Act to include all housing (rather than housing with just more than 12 units), and provide authority for enforcement of orders to eliminate lead hazards in housing.

Overarching goals and objectives.

There are two other goals and objectives that govern all activities that are undertaken but are not necessarily subject to accurate measurement or reporting.

1. Primary prevention. GCLPPP and the LAC have adopted the overall objective of making primary prevention the major focus of education and outreach and program services. This constitutes a major shift in priorities.
2. Services to rural areas. While GCLPPP has established priorities for high-risk areas and populations, it will nevertheless assure that new initiatives include rural areas and smaller communities when high-risk children are at stake.

Evaluation of these overarching goals and objectives will include review of relevant reports and data, consideration of anecdotal evidence from stakeholders, and possibly interviews from stakeholders and users of GCLPPP's services.

Collection and Analysis of Data

All GCLPPP staff will be responsible for determining a plan for collecting and analyzing data. Depending on the activity, the Program Director, Health Educator, and Epidemiologist will determine the following for all evaluation activities:

- Who will collect what data;
- When and where will the data be collected; and
- How the data will be collected.

The Epidemiologist will be responsible for continuing to improve the quantity and quality of data, maintaining data sources that are valuable to evaluation activities, and the analysis of data.

The GCLPPP Director will be responsible for gathering and presenting information to the LAC and its Program Evaluation subcommittee for evaluating the success of the Elimination Plan.

Evaluation Conclusions and Recommendations

The quarterly meetings of the Program Evaluation subcommittee are primarily for the purpose of sharing information on progress in carrying out the many activities in the Plan. The annual meeting of the full LAC will include a report by this subcommittee on the interim results of the evaluation and the subcommittee's conclusions and recommendations for revisions, if necessary, in the goals, objectives, or activities of the Elimination Plan.

Attachment A

Lead Advisory Committee Members

Person	Organization/Agency
Leticia Mayfield	American Academy of Pediatrics (Georgia Chapter)
Sylvia Caley	Atlanta Legal Aid
Dr. Seema Csukas	Children's Healthcare of Atlanta
Dr. Lynn Platt	Backus Children's Hospital, Savannah, Georgia
Errol Newark	City of Atlanta
LeRon Mitchum	City of Savannah
Glenn Misner	DCA
Adriane Saunders-Small	DCH/Medicaid
Rheyshene King	DHR/DPH/Georgia Public Health Laboratory, Albany
Dr. Rama Chandran	DHR/DPH/Georgia Public Health Laboratory, Atlanta DHR/DPH/Environmental Health and Injury Prevention Branch
Mike Smith	
Dr. Ken Powell	DHR/DPH/ Epidemiology Branch
Brenda Jordan	DHR/DPH/Family Health Branch
Stic Harris	DHR/DPH/Epidemiology Branch
Valeria Johnson	DHR/DPH/WIC
Angela Gardner (District 7)	DHR/Nursing Section
Annette Harkins (District 2)	DHR/Nursing Section
Marcus Mincey	DNR
Bill Hover	DNR/Historic Preservation Division
Malisa Thompson	DCA/Housing Finance Division
Bill Burns	Environmental Awareness Foundation
Alex Winston	EPA - Lead-Based Paint Program/US EPA Region 4
Bradley Hix	GA Apartment Association
Melvin James Moore	GA Assn of Housing & Redevelopment Authorities
Dr. Robert Gellar	GA Poison Center
Bob Hamilton	Georgia Association of Realtors
Susan Reif	Georgia Legal Services
Vicki Hanrahan Ainslie	Georgia Tech. Research Institute
Emily Williams	HUD/Healthy Homes Division
Hak Keun Chang	HUD/Community Planning and Development Division

Bonnie Maurras	Leadnology Today
Karla Lee Drenner	Member/House of Representatives
Randy Haney	Life Environmental Services
Scott Johnson	Marcor Remediations
Dr. Roland Pattilla	Moreouse/School of Medicine
Dr. William Miller	Quest Labs
Judy Hartley	RLC – Chatham County Health Dept.
Ryan Cira	RLC - Metro Region
George Horkan	RLC - Southern Region
Luke Gardiner	Savannah Housing Dept, Construction Services
Gina Peek	UGA/Cooperative Extension Services

Attachment B

Subcommittee Members

Primary Prevention	
Vicki Ainslee, Chair	Georgia Tech Research Institute
Sharon Pendleton, Facilitator	Healthy Housing Solutions
Randy Haney	Life Environmental Services
Ed Saidla	WCHD, Public Health
Dean Crist	WCHD, Lead Coordinator, District 4 & 7
Don Loggins	Newton County Environmental Health
Tarolyn Moore	DCA
Errol Newark	City of Atlanta, Bureau of Housing
Dr. Roland Pattilla	Morehouse School of Medicine
Rachel Flury	DHR, Regional Lead Coordinator

Screening and Surveillance	
Adriane Saunders-Small, Chair	DCH, Division of Medical Assistance
Forrest Staley, Facilitator	GCLPPP
Debbie Hall	Clayton County Board of Health
Seema Csukas	Children's Healthcare of Atlanta
Dr. William M. Miller	Quest Diagnostic Laboratory
Rheyshene King	Albany Regional Laboratory
Candace Clay	DHR, WIC
Roy L. Weldon	Joel Army Health Clinic, Fort McPherson
Any Fenn	District 4 Health Services
Dominique Godfrey	South Health District 8-1
Ken Powell	DHR, DPH, EB, CDIEE Section
George A. Horkan III	DHR, HD 8, Lead & Disaster Resources
Gerrianna Williams	DHR, Division of Public Health

Case Management	
Annette Harkins, Chair	District 2, Gainesville
Stic Harris, Facilitator	GCLPPP
Barbie Bushey	District
Brenda T. Jordan	DHR, Infant & Child Health
Dr. Robert J Geller	GA Poison Center
Judy Hartley	Cobb County Health District
Debbie Liby	District 5-2
Susan Malone	District 9-1
Diane Watson	District 9-2
Valeria Johnson	WIC
Lavonne Painter	Fulton County

Statutes, Codes and Enforcement	
Susan Reif, Chair	Georgia Legal Services
Jack Anderson, Facilitator	Healthy Housing Solutions
Bob Blake	DeKalb Co Board of Health
Malcolm Saunders	Fulton Co Dept of Health
Scott Johnson	Marcor Environmental, Inc.
Marcus Mincey	DNR Lead-Based Paint & Asbestos Program
Gene Godfrey	South Health District 8-1
Carla Coley	North Central Health District
Mike Smith	DHR Div of Public Health
Luke Gardiner	City of Savannah
Carl Newsome	City of Savannah
Sylvia Caley	Health Law Partnership
Tracy Patterson	GCLPPP

Housing and Lead Hazard Reduction	
Ryan Cira, Chair	DeKalb County Board of Health
Gordon McKay, Facilitator	Healthy Housing Solutions
Charles R. Everett, Jr.	Coastal Plain Economic Opportunity Authority
Barry Troutman	HUD, Office of Public Housing
Glenn Misner	Dept of Community Affairs
Jeffery Fountain	Coffee County Health Dept/ District 9
Pam Holland	CDC
Jason Osgatharp	North Georgia Health District
Winston A Turner	Troup Co Environmental Health/ Dist 4
LeRon Mitchum	City of Savannah
Bradley A. Hix	Atlanta/Georgia Apartment Association
Alex Winston	US EPA, Region 4
Hak-Keon Chang	HUD, Office of Community Planning & Dev
Bill Hover	DNR, Historic Preservation Division
Melvin James Moore	GA Assn of Housing & Redevelopment Auths
Casey Betsch	Cobb County Environmental Health
Cherry Ivey	GA Environmental Facilities Authority

Education and Outreach	
Gina Peek, Chair	Univ of GA, Cooperative Ext Services
Marcie Memmer, Facilitator	GCLPPP
Leticia Mayfield	GA – American Academy of Pediatrics
Marti Mastbrook	Cobb County Board of Health
Angie Gardner	Children’s Medical Services, District 7
Maurice Redmond	DPH, Environmental Health Section
Caron Lee	Clayton County Board of Health
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