

**Interagency Lead Program Issues Study 2004**  
**09/02/04 Meeting notes from presentations and discussion**  
**36 in attendance**

The meeting was held from 1-5 PM in the Mississippi Room of Snelling Office Park. A single large square table was set up in the middle of the room. Both “members” and “technical advisors” sat around the single table. After an introduction by Chairperson Aggie Leitheiser, and remarks by Pat Bloomgren on meeting ground rules, speakers presented background information on each of the 5 designated topic areas. The following bullets represent the main topics presented during the talks and subsequent group discussion.

**Topic #1: How to promote and encourage primary prevention;**

Presented by Megan Curran, Sustainable Resources Center

- Key to prevention is changing the behavior of the family for the long term = difficult
- Increase managed care – incentives to the clinic to provide primary prevention/education
- Docs don’t see it as a concern – at what level should it be a concern; new research supports “no lower threshold” for exposure.
- Cost structure and minimal contact time for clinic visits do not promote primary prevention – becomes “factory work” – [Docs need to be educated on the need to screen targeted areas, but that reimbursement may not cover the cost]
- Pockets of improvement in screening with Docs through use of non-monetary incentives [the Gold Star approach]
- Push for more testing of adults in potentially high exposure industries [contractors] = educational opportunity
- Low incident rate makes universal screening inefficient; must check for risk factors before testing
- Pockets of uninsured are at highest risk
- How to evaluate effectiveness of targeted education/screening?
- Intervention needs to be grass roots to be effective/credible – get into their community and go door-to-door.
- Uncertainty remains in educational message for lead results < 10 ug/dL. The problem with standards – below the standard and everything is fine.
- Push the envelope on the use of cap tests = simple, easy to administer, quick.
- No effective intervention strategy below 10 ug/dL other than removal of the lead.

**Topic #2: How to ensure that all children at risk are tested;**

Presented by Sandy Lien, Medica and Cheryl Lanigan, Minnesota Visiting Nurses Association (MVNA)

- Child & Teen Checkup (CTC)/Women Infant Child (WIC) programs ensure that all have access and are key to reaching target at-risk populations
- Target families are transient in all of the following: housing; medical care; school; and they tend to be non-English and have very limited resources (e.g. financial, transportation, time). They are street smart but not system smart.

- Fear by families of possible eviction or fear of government by immigrant/refugees.
- Link lead screening to school admittance; however, is Kindergarten early enough??
- Withhold (5% on Prepaid Medical Assistance Program contracts) and incentives to raise awareness with Docs
- Medica has a strong collaborative relationship with MVNA
- Need to keep lead within the framework of healthy homes and not establish separate silos. No need to make multiple trips to a location – deal with all issues at once.

**Topic #3: Whether or not to reduce the state mandatory intervention from 20 to ten micrograms of lead per deciliter of whole blood and if a reduction is not recommended whether to develop guidelines on intervention for children with blood levels between ten and 20 micrograms of lead per deciliter of whole blood;**

Presented by Jim Yanarely, St. Paul/Ramsey County Lead Program

- Presentation of information from preliminary meetings with Minneapolis, Hennepin, Ramsey and St Paul [attached]
- Big resource issue. The values presented in the background paper were not disputed [187 to 814 cases by going 20 to 10 ug/dL, cost to state alone \$300k, local cost was not identified].
- All parties stressed that it is important to do it well.
- Operating by multi-funding intervention to do work on houses currently. Lowering the mandatory intervention would create a bigger need with no resources. Biggest burden then falls on the family.
- Recommendation: within current funding sources: dropping the intervention to 15 - most jurisdictions trying to intervene at this level currently. Lower than that without additional resources and the quality of work will suffer. STATUTE CHANGE
- Recommendation: within current funding sources: establish primary prevention intervention at 9 based on MDH Case Management Guidelines.
- Recommendation: establish a sustainable funding source to assist families in conducting lead hazard control work.
- Avoid condemnation of housing
- Issue recommendations instead of orders at lower levels.
- Establish primary prevention through: worker/contractor training through commerce; clearance testing after renovation.
- Training courses for lead safe work practices have to teach practical hands-on. Commerce is an avenue for educating contractors.

**Topic #4: How to provide incentives and funding support to property owners for lead hazard prevention and reduction;**

Presented by JoAnne Velde, Minneapolis Housing Inspections and Jim Cegla, Minnesota Housing Finance Agency

The rubber meets the road on this one: primary prevention really means getting the lead out of houses before a child is poisoned. Karen Clark highlighted this as THE issue.

- Tax credit for performing lead abatement [\$1000/house put on the table = \$2 million drop in revenue could be offset by a paint can fee].
- Paint can fee.
- Petroleum storage tank fund [MPCA].
- Current federal grants are helpful, but lead needs a sustainable pot of money.
- Minneapolis is getting aggressive with their rental property owners through an inspection cycle and coordinated efforts with other city programs.
- Money up front is minimal compared to the costs of being reactive.
- How to approach [MFHA matrix - attached] based on type of ownership: Incentive vs funding support, need for incentives vs funding supports
- Housing funds can be targeted. Various funding sources already in place which need to have lead incorporated into: Rental rehab; Community Development Block Grant (CDBG), etc
- Incentives should not be limited to \$\$.

**Topic #5: Ways to provide resources for local jurisdictions to conduct outreach.**

Presented by Elizabeth Auch, Countryside Public Health Department Director

- Primary prevention is cheaper than reactionary activities.
- Primary prevention can and should be incorporated into daily activities of local public health and into other units of local government.
- Lead prevention can provide an incentive for community building and building relationships with different segments of government ie: housing, health and real estate
- Uncertain at what point, financially and administratively, LPH can create and sustain a primary prevention program. Will be different for various LPH offices depending on current capacity.
- Local resources are thin and continue to be strained. Countryside currently has an annual budget of \$10,000 to address all lead issues, and was the location for a large CDC-funded study of lead prevalence. Start up for the Countryside study was \$100k.
- Increasing the # tested increases the # identified or decreasing the threshold increases the # defined.
- Consumer education can become a primary prevention program
- Let the home buyer push the process of driving the market – create buyer incentives to becoming lead informed [however, the market can influence the process. ie: hot market = no pre-sale testing]
- Need to link lead information into the general home inspection process
- Creation of a lead safe housing registry would force sellers to disclose and would influence the market. Concern over maintenance of the registry: safe today does not equal safe tomorrow.
- Be sensitive to non-metro needs – training, resources – bring it into the community
- Need enforcement of existing federal disclosure requirements – it's done during real estate transactions but not done well.

- Promote the use of lead identification techniques that are readily available to the general public [home test kits]; though not definitive, positive results will prompt further investigation by homeowner.

### **Issues for Oct 7 meeting:**

- 1) Because the first meeting ran over schedule, any questions on content of the 5 target areas will be addressed as needed
- 2) Several questions were raised without being able to fully discuss, including how to:
  - a. educate Docs on lead risk factors and screening guidelines
  - b. improve collaboration with WIC, C&TC, and other current family resources
  - c. promote “healthy homes” rather than individual programs
  - d. promote lead awareness and capacity in local agencies to foster relationships between local agencies, housing/health (which are diverse): share working models between agencies
  - e. balance the needs of the Twin Cities (greatest # of cases in smallest area) vs. outstate cases (1/3 of total cases across large area).
  - f. Develop positive incentives (rather than negative regulations) for clinics, contractors, home buyers/owners, home inspectors, other lead partners
- 3) There were two specific areas that were presented but not fully explored:
  - a. Three recommendations presented during Topic #3 discussion: lower intervention to 15 ug/dL, expand primary prevention, find new funding
  - b. Several alternatives for sustainable funding from state sources were presented but not evaluated by the group, including paint fees, tax credits, incentives, and others.