

***A Brief Guide to Options
for Improving Medicaid Lead
Screening***

**Alliance To End Childhood Lead Poisoning
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Preface

This guide is intended for community members and advocates who want to see blood lead screening become a more useful tool in the fight against childhood lead poisoning. The guide has three parts:

Part 1: Why Focus on Medicaid Lead Screening reviews evidence for focusing attention on lead screening for children enrolled in Medicaid.

Part 2: How to Target Screening to Reach the Children Most at Risk discusses how to use patterns of lead poisoning as a starting point of targeted screening and summarizes important issues.

Part 3: Ensuring Intensive Screening for Children in “Target Populations” discusses strategies for monitoring a targeted screening program.

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The primary author of this guide is Nancy Tips, Project Manager, Alliance To End Childhood Lead Poisoning. The guide is grounded in the 1997 recommendations on lead screening from the Centers for Disease Control and Prevention. It is also based on the findings and contributions of many people in communities and in academic and agency settings.

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Part 1: Why Focus on Medicaid Lead Screening?

Lead screening is an important health service for children in the Medicaid program.

Ninety-three percent of children with severe lead poisoning are enrolled in Medicaid.¹ Many children are found to be lead poisoned every year, even though blood lead levels in the U.S. as a whole are declining.^{2,3,4} Lead still poses a serious health threat to many children in the Medicaid program.

Screening using a blood lead test is the surest way to identify children who are exposed to lead in order to stop their exposure.

The Centers for Disease Control and Prevention (CDC), one of the federal agencies that leads efforts to prevent lead poisoning, recognizes that such screening is important. This agency encourages and supports state and local lead screening programs.⁵

The federal Medicaid program requires routine lead screening for all enrolled children when they reach the ages of one and two.

States must ensure that screening is carried out for children in Medicaid and report each year on the number screened.⁶ Even so, in many states children do not receive the screening to which they are entitled. (See Table 1.)

Table 1: Screening rates reported by states to the federal Medicaid agency (CMS), as part of the required annual report (416 form), 1999

In the table at right, states are listed according to the rates they reported for lead screening in Medicaid. “EPSDT” stands for the Early and Periodic Screening, Diagnostic, and Treatment program. This program provides prevention services for people under the age of 21 who are enrolled in Medicaid. EPSDT prevention services include lead screening and other screening tests, as well as vision, dental, and hearing services.

The table shows that many children who went to a clinic or doctor’s office and had a screening test of some type did *not* have a lead test, even though there was an opportunity. Comparing column 2 and column 3 shows this difference. In many states, a relatively high percentage of children had some EPSDT screening (Column 2) but a much lower percent got lead screening (Column 3).

Notes on individual states listed in the table:

*TX used incorrect age groupings, reporting data only for the entire group ages 1 to 5.

**NY, ID, NH, and WA used outdated reporting forms that were not comparable for most items and did not include figures for lead screening.

State	% children aged 1 - 2 who had at least one EPSDT screening test	% children aged 1-2 who had a screening blood lead test
RI	83%	47%
PA	60%	43%
LA	67%	28%
IL	63%	27%
TX*	47%	26%
NC	64%	25%
MA	41%	23%
AL	46%	23%
KS		20%
MI	42%	18%
MN	58%	17%
NJ	38%	14%
MD	53%	14%
MO	47%	13%
WV	42%	13%
MT	44%	11%
FL	55%	11%
WY	52%	11%
OH	52%	10%
SC	54%	10%
CA	35%	10%
CT	74%	9%
AZ	66%	9%
DC	50%	9%
MS	33%	8%
KY		8%
IA		8%
AR	31%	7%
WI	60%	6%
GA	51%	5%
NE	70%	5%
ND	39%	4%
TN	30%	4%
IN	61%	3%
OR	70%	2%
VT	63%	2%
NM	57%	2%
HI	70%	2%
DE	48%	2%
SD	45%	2%
VA	57%	1%
OK	40%	1%
CO	55%	0%
UT	59%	0%
AK	51%	0%
NY**		
ID**		
ME		
NV		
NH**		
WA**		

Why are Medicaid lead screening rates so low in so many states?

The reasons vary. They include indifference, tight budgets, and barriers such as scheduling or distance to a blood-drawing site. Some states have carried out strategies to improve things.⁷ But in other states, especially those where the risk for lead exposure is generally low, there is sometimes strong feeling that it is unnecessary to screen all young children enrolled in Medicaid.

What can be done to improve things?

People who provide health care (such as doctors and nurse-practitioners) are especially resistant to screening if they have screened a lot of children and rarely found a child with lead poisoning. To convince them to take lead poisoning seriously, one strategy is to focus screening on groups of children who are more likely to be at risk.

How is it possible to predict whether or not a child is at risk for lead exposure?

Most states have some communities where lead exposure is common and others where it is rare. For example, a study of several big cities showed that lead poisoned children lived mostly in certain ZIP codes in each city. There was very little lead poisoning outside those neighborhoods.⁸ In such situations, it is possible to predict the likelihood that a child will be exposed to lead on the basis of where the child lives. Other factors, described in Part 2 of this guide, make it possible to make further predictions about which children are at high risk and which are at lower risk.

What about future Medicaid policy?

Future Medicaid policy may reflect the big differences that exist from place to place in the risk for childhood lead exposure. In fact, the Advisory Committee on Childhood Lead Poisoning Prevention (a group of experts in lead poisoning that advises CDC) has recently made recommendations about changes in Medicaid policy to allow states to target screening to children likely to be at risk.⁹

Planning for future targeting.

Screening that is based on predictable patterns of lead exposure is usually called “targeted” screening. Part 2 of this guide has information about targeted lead screening, especially as it relates to decisions that may apply to future Medicaid screening. Advocates can play an important role in helping to think through these issues. Starting the planning process now can help set the stage for and shape stronger policies in the future.

A word about primary prevention.

Screening is a tool for detecting exposures that have already taken place. From the standpoint of parents, doctors, and public health in general, it is far better to eliminate the sources of lead exposure before children are exposed. This is the goal of *primary prevention*. There is a wealth of information available on primary prevention.¹⁰ Additionally, updated recommendations will be coming soon from CDC’s Advisory Committee on Childhood Lead Poisoning, a group of public health experts.

Part 2: How to Target Screening to Reach the Children Most at Risk.

Note: At this writing, routine lead screening for all young children in the Medicaid program is still a federal requirement in all states.

The federal agency that oversees the Medicaid program in partnership with states is the Centers for Medicare and Medicaid Services (CMS). This agency is considering how it might give states flexibility in the future to carry out targeted lead screening. Some states will want to begin planning a targeted approach to screening for children in Medicaid.

Even with a requirement to screen all children, targeting can be used to emphasize screening for children most likely to be at risk.

If CMS policy is revised, some states may officially shift their screening policy to targeting. States that continue a policy of screening all children in Medicaid may also use targeting to emphasize screening where risk is greater. Communities can work with agencies and public health professionals to design a targeted screening policy, as well as to evaluate screening efforts.

The ABCs of targeted lead screening* (* based loosely on CDC's 1997 screening guidance)

- **Aalyze.** Analyze the population according to risk factors that are linked to lead poisoning.
- **Blood lead data.** Look at blood lead data for information about where screening is taking place and which screened children are lead poisoned. (Blood lead data is most helpful where there has been a lot of screening or a careful survey of blood lead levels in a representative group of children.)
- **Census data.** Search US Census data files for information about important risk factors for lead exposure, especially old (pre-1950) housing and poverty. Census data are easy to access and available for small geographic areas (ZIP code and smaller).
- **Detect/Divide.** Detect patterns of likely lead exposure, using census and blood lead data. Divide the population according to lead-exposure risk, on the basis of these patterns.
- **Ensure.** Take steps to ensure careful screening among those predicted to be at high risk for lead exposure and appropriate screening where risk is less.

Patterns of lead exposure.

Young children are most likely to be poisoned by lead dust from lead-based paint that was used years ago to paint older homes

Lead can be found in paint, dust, soil, water, air, and food. Most of the lead in our environment comes from products that are no longer sold in the U.S., such as lead-based paint for houses and leaded gasoline. Unfortunately, lead from past uses remains in residential paint and soil. Older housing (built before 1950) that has deteriorated can have a lot of lead hazards. Also, renovation or re-painting activities in older homes can disturb lead paint and scatter hazardous lead dust and chips. Very young children (ages 1 and 2 years) are the most likely to be poisoned because they put so many things in their mouths. They may receive a dose of lead if there is lead dust on their hands and toys.

*The importance of place: Lead poisoned children tend to be found in places where there is a lot of older housing in poor condition. *The foremost way children are exposed to lead is through lead paint in their homes, when this paint has become dust and chips because it has deteriorated or been disturbed; so lead exposure is often concentrated in neighborhoods with a lot of housing built before 1950 that is in need of repair.**

The importance of group: Higher rates of childhood lead poisoning have sometimes been linked to groups of people, especially those with low income, or belonging to certain racial or ethnic groups. Lead poisoning in these groups is thought to be mainly the result of living in older homes with lead paint hazards. But cultural factors may also play a role, as when children are poisoned by lead in home remedies, food, cosmetics, or imported pottery.

The importance of activities: Childhood lead poisoning is also associated with activities, such as re-painting or renovation of older homes. Also, parents may use lead in hobbies or occupations such as making stained glass, bullets, or lead sinkers at home. Or they may bring lead home from jobs in renovation or construction.

Table 2: Looking at patterns of childhood lead exposure

Exposure pattern	Where to find information on this pattern of exposure	Implications for targeting
<p><u>Places.</u> Lead poisoned children usually cluster where there is a lot of older housing and poverty. Industrial sources might also be a problem.</p>	<p><u>Blood lead data:</u> Health departments track blood lead test results and can identify ZIP codes with lead poisoned children, as well as patterns of lead screening.</p> <p><u>Census data:</u> Search census data files for combined concentrations of pre-1950 housing and people living in poverty. Look at small areas, such as ZIP code or census tract.</p> <p><u>Environmental databases:</u>, <i>Scorecard</i> (www.scorecard.org/env-releases/lead) supplies information on industrial lead contamination and other community lead hazards.</p>	<p>Some states assign a risk ranking to each ZIP code on the basis of census data, especially proportion of older housing and poverty level. Then, doctors and other health-care providers can screen children on the basis of the ZIP code of their home.</p>
<p><u>Groups.</u> Certain groups of children may have higher than average risk that is linked to poverty, race, or ethnicity.</p>	<p><u>Census data:</u> Census data can show areas according to residents' income and race, both of which may be associated with increased risk for lead exposure.¹¹</p> <p><u>Local public health information:</u> Local communities may have information on lead exposure in ethnic groups,¹² usually due to use of lead-containing home remedies, foods, cosmetics, or cookware. Local knowledge and awareness of population patterns are useful.</p>	<p>Targeting can be based on neighborhoods, if ethnic groups are clustered. Or, a strategy might target clinics or doctors, or enlist support for screening among community leaders.</p>
<p><u>Activities.</u> Certain family activities may result in childhood lead exposure.</p>	<p><u>Blood lead data:</u> Health departments collect information on exposures from family activity. These include "in-home" activities such as older home renovation, and hobbies such as stained glass work and bullet- or sinker-making; also, there are "take-home" exposures from such parental jobs or activities as construction or firing guns.</p>	<p>Where these activities are common, children can be screened on the basis of the family's answers to a routine set of questions at the doctor's office.</p>

Using patterns of lead exposure to target screening.

Once patterns of lead exposure are understood, it becomes possible to select children who need screening. These children can be identified because of certain characteristics. Most commonly, they can be identified as needing screening on the basis of whether or not they live in an area with a lot of older homes in need of repair. Another characteristic might be that they belong to an ethnic group that has had cases of childhood lead poisoning traced to imported products, such as remedies, foods, cosmetics, or cookware. Then, clinics and practices where these children receive their health care could be alerted to the importance of screening these children.

Sources of information.

The internet has some relatively easy-to-use sources of community-level data relating to lead exposure and drawn from the U.S. census. Take a look at: www.scorecard.org/env-releases/lead. The CDC also maintains a website, www2.cdc.gov/nceh/lead/census90/house11/house11.htm. These websites make it possible to determine where there are concentrations of older housing and poverty in your community. Sometimes this information can be confusing or even misleading however, and might best be used as a starting point for discussions with the health department or other agencies involved in lead screening.

Issues that come up in making decisions about targeting screening.

Many people in agencies, advocacy groups, and communities have debated various issues surrounding targeted screening. They have found that the subject can be very complex. Being aware of the following issues may help communities prepare to take an active role in decision-making.

- *Often, it is relatively easy to tell that children who live in certain places or who belong to certain groups have more risk than other children. But are these children at “high” risk? And are the other children at “low” risk? One way to have confidence in predicting risk is to take a close look at a limited population of children. For example, a health department might decide to carry out extensive screening of young children in a certain neighborhood where there are a lot of older homes and poverty. The health department *predicts* that these children will have a high rate of lead poisoning. After a lot of screening has been done, the health department can look at the results to see whether they *confirm* their prediction. Some states have tried this.¹³ The results can be used as the basis of decisions about further screening. Even with additional information from a study such as this, it will still not be possible to guarantee that *every* exposed child will be screened. But communities may find that focusing intensified screening on groups of children who have been shown to be at highest risk is a big help.*
- *What can be done about children who may be exposed to lead in hidden “pockets of risk” that are missed when risk is analyzed? In looking at information that will help make exposure patterns clear, the size of the area you analyze is extremely important. In a smaller area it is possible to identify places, groups, or activities that might be linked to risk for lead poisoning and that would be camouflaged if you were looking at a whole state or even a big county. Many people look to data from the U.S. Census to develop a picture of likely exposure patterns. This information is available for small geographic areas, such as census tract or census block. Using census data, it may be possible to see, for example, small areas or neighborhoods where there is a lot of older housing or poverty. If these areas or “pockets of risk” are identified, then doctors and other health care providers can make it a point to screen children who live in these pockets. Sometimes, this has been successfully done using a neighborhood map showing the location of risk pockets.*

Then when families are at the clinic or doctor's office, they can look at a map and tell the doctor whether they live in a high-risk area.

- *What about screening for children who are not included in an identified "high-risk" group? Should their families answer questions about risk as part of a medical check-up? Are there other ways to spot individual children who might need screening?* Two common aspects of dealing with this issue are:
 - Questionnaires: In addition to screening all children in certain areas or groups, doctors and other health care providers can use a questionnaire. They can ask parents of children who will *not* be routinely screened to answer questions to help spot possible sources of lead exposure. For example, these questions might refer to local sources, such as remodeling an older home. In the past, some questionnaires have proven to be useful, while others have not. The health department may have experience that will help a community decide how well a proposed questionnaire would work for them.
 - Surveillance: Regular reports from the health department on screening and cases, called surveillance reports, might highlight unusual exposures in a community. These reports can be used to warn doctors and other health care providers to be on the lookout for children who, in addition to those in identified high risk groups, might be exposed to lead from unusual or recently identified sources.
- *How do you know when you have enough information to serve as the basis of a decision about targeting?* This issue generally comes up in decisions about which children can safely be excluded from routine screening. It is hard to know if the information that you have, especially the results of previous screening, is enough to serve as a basis for not screening

some children. Epidemiologists, who are trained in analyzing data, might be asked to decide. They can help determine whether existing information gives a good picture of lead exposure in a certain group of children. If not, the health department might consider doing a survey, in which a sample of children, carefully chosen to represent the population under discussion, are screened. Sometimes, survey results will help build a case for changing or keeping current policy.¹⁴

- *How can we balance the potential drawbacks of too much screening (waste of resources, unnecessary discomfort to young children) against the drawback of too little screening (failure to identify many lead poisoned children)?* This is a crucial issue and part of why making decisions about targeted screening is so hard. Communities, parents, and advocates should discuss this issue and take part in agency decision-making. In some places, people may be comfortable using cost-benefit analysis, which takes into consideration the costs and benefits of various screening strategies to society as a whole. Some feel that such an approach can be helpful in establishing a foundation for difficult decisions.¹⁵ Others believe that existing cost-benefit analyses do not do a good job counting the benefits side, that is to say, the value of finding and helping children with elevated levels of lead in their blood.
- *How can we enforce a screening policy if the experience of doctors and other health care providers has been that they have done a lot of screening without finding any cases?* If health care providers have been screening consistently without identifying any cases, it's very difficult to justify continuing routine screening. In fact, it is just such a situation that targeting strategies are designed to address. Remember that health care providers are influenced by evidence that lead poisoning is still a threat among children in their care. If more cases of lead poisoning are found because of intensive screening of

children who are at risk, providers will place more value on screening.

- *Once a targeted screening plan is made, how is it possible to make sure that a promise of intensive screening for all “high-risk” children will be carried out? See below, Part 3: Ensuring Intensive Screening for Children in “Target Populations.”*

Part 3: Ensuring Intensive Screening for Children in “Target Populations.”

A new policy of targeted screening must be backed up by effective monitoring and enforcement, so that no one misinterprets a policy change as “backing away” from lead screening. Communities, parents, and advocates play a key role in keeping attention focused on the promise of smarter screening.

Health care providers are key.

Doctors and other health care providers are the key to how much screening actually gets done. When they agree to provide services for children in Medicaid, often as part of a managed care plan, they are supposed to know about and provide all required services, including lead screening. But the children in their care may not get screened for several reasons:

1. Doctors and other health care providers may believe that lead poisoning is unlikely among the children they see.
2. There may be no blood drawing done in their offices, so that families have to be sent elsewhere. For a lot of reasons, including inconvenience, schedule, and cost, families may not make the extra trip and no one follows up to remind them.
3. Doctors and other health care providers may not know about requirements and policies related to lead screening for children in Medicaid.
4. They may fear that if they identify a lead poisoned child, they won't know how to manage the child's condition. They may also believe that additional activities to help the child get well, such as getting rid of lead hazards in the child's home, won't be carried out by those who are responsible.

Many agencies and groups including health departments, managed care organizations, and the state Medicaid agency need to take steps to improve screening for children in Medicaid.

CDC's Advisory Committee has published recommendations about how to improve,¹⁶ and agencies in various states have used

promising strategies to get more screening done. Communities, parents, and advocates can check to see if these recommendations are followed and if these strategies are in use, as indicators of whether government agencies are doing a good job at Medicaid screening.

- *Agencies need to identify the health care providers and their organizations that provide medical care for most of the children enrolled in Medicaid (managed care organizations, doctors, physician assistants, and nurse practitioners).*

In most places there are managed care plans, certain clinics, or certain practitioners who provide health care for most of the children who are at risk and need lead screening. These organizations and individuals form a “target group” in their own right, and can be identified and reached in various ways. For example, managed care plans with Medicaid contracts can be easily identified by the state agency that oversees these contracts. Individual health care providers can be located through the managed care plans they work for. If there are no managed care plans, the individual providers who need to be reached can be located by canvassing in high-risk geographic areas to determine where most children receive their medical care. They may also be identified from provider enrollment lists maintained by the state Medicaid agency.

- *Agencies need to saturate certain health care providers with information about the need for screening for priority groups of children.*

They should include evidence and how-to information on identifying selected children to be screened within a clinic or practice, as well as information on caring for children who may be identified with elevated blood lead levels. They should explain how homes of affected children will be made safe, so that lead exposure is stopped.

They should provide regular surveillance reports, especially reports with maps showing lead poisoning cases, screening activity, and risk factors highlighted for the local community.¹⁷ One technique used by some agencies¹⁸ is to visit selected clinics and doctors' offices to discuss such maps and to give non-confidential information about risk factors and follow-up care for individual cases. Such a visit is an opportunity for agency personnel to recommend processes in busy clinic settings for efficiently identifying children in need of screening. Many health care providers respond well to information about lead hazards and the results of screening their peers are doing.

These labor-intensive activities will be limited to the providers who care for the majority of at-risk children, thereby trimming the audience to a manageable size in most places. Visiting these clinics and practices will provide an opportunity for agency personnel to discuss follow-up care for lead poisoned children and explain their agencies' responsibilities when lead poisoned children are identified through screening.¹⁹

- *Agencies need to track lead screening among target groups of both children and providers and take action to spur improvement by health care providers who are neglecting to screen at-risk children.*

Systems now exist that make it possible for agencies to identify the individuals in targeted groups of children. For example, state Medicaid enrollment databases, when combined with health department blood lead screening data, can be used to generate lists of individuals living in high-risk ZIP codes, along with their screening records, and where they get their medical care. Lists of children in need of screening can be sent to their doctors.²⁰ The information can also be used by public health agencies and managed care organizations to reward health care providers on the basis of their performance.

Advocates and communities should press agencies to use these systems to their maximum, because without mechanisms to monitor and take action where needed, a targeting strategy may turn out to be meaningless.

Parents and advocates are key.

Parents and advocates can powerfully deliver the message about lead poisoning risks in their neighborhoods and communities. They can use the media to focus attention on the problem.²¹ They can use public interest litigation to press their point.²² They can work with agencies to consider the issues, develop strategies, and pay close attention to both screening rates and the rates of lead poisoning. The result will be better services and a brighter future for children who are in danger of lead poisoning.

End notes

¹ Kaufmann, et al. *Elevated Blood Lead Levels and Blood Lead Screening Among US Children Aged One to Five Years: 1988-1994*. Pediatrics Vol.106 No.6 December 2000.

² Centers for Disease Control and Prevention. Update: blood lead levels—United States, 1991-1994. *MMWR* 1997;46:141-6. Erratum: vol.46, no.7. *MMWR* 1997;46:607.

³ Centers for Disease Control and Prevention. Blood Lead Levels in Young Children---United States and Selected States, 1996-1999. *MMWR* 2000;49(50):1133-7.

⁴ The number of children with severe lead poisoning (blood lead levels of 20 µg/dL or greater) remains significant. Among 1,256,907 children screened in 19 states in 1998, 1.2% —more than 15,000 children— were severely lead poisoned. (See Footnote 2.)

⁵ Centers for Disease Control and Prevention. *Screening Young Children for Lead Poisoning: Guidance for State and Local Health Officials*. Atlanta: CDC, 1997.

⁶ US Health Care Financing Administration, *State Medicaid Manual, Part 5 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Section § 5123.2*, September 1998. Department of Health and Human Services.

⁷ See for example, the states showcased in *The Foundations of Better Lead Screening for Children in Medicaid*, The Alliance To End Childhood Lead

Poisoning, April 2001. Available at the Alliance web site (www.aeclp.org)

⁸ Brown MJ, Shenassa E, Tips N. *Small Area Analysis for Childhood Lead Poisoning*. Washington DC: Alliance to End Childhood Lead Poisoning; 2001

⁹ These recommendations can be viewed at the web site of the Alliance To End Childhood Lead Poisoning (www.aeclp.org)

¹⁰ See for example the Alliance website (www.aeclp.org) and the website of the National Center for Healthy Housing (www.centerforhealthyhousing.org) for information and strategies on this topic.

¹¹ According to national estimates from CDC, elevated blood lead levels are 8 times more likely to occur in low-income than high-income children and 5 times more likely in black children than white children.

Information from states that have collected information on income and race along with blood lead data supports this national finding.

¹² National estimates also show that elevated blood lead levels are nearly twice as likely in Mexican American children as white children.

¹³ See Washington and Oregon examples in *Foundations of Better Lead Screening*.

¹⁴ A good source of information on such surveys is the CDC's Lead Poisoning Prevention Branch. More information is available at <http://www.cdc.gov/nceh/lead/lead.htm>.

¹⁵ Cost benefit analysis in relation to childhood lead poisoning prevention strategies has received a fair amount of attention. See, for example: Grosse et al. *Economic Gains Resulting from the Reduction in Children's Exposure to Lead in the United States*. *Environ Health Perspect* 10:563-569 (2002).

¹⁶ Advisory Committee on Childhood Lead Poisoning Prevention, Centers for Disease Control and Prevention: Recommendations for Lead Screening of Young Children Enrolled in Medicaid: Targeting a High-risk Group for Lead Screening. *MMWR Reports and Recommendations*, December 8, 2000.

¹⁷ See Oregon's initiative, reported in *The Foundations of Better Lead Screening for Children in Medicaid*, a report available from The Alliance To End Childhood Lead Poisoning (www.aeclp.org).

¹⁸ See Maine's Primary Care Provider Incentive Program, reported in *Track, Monitor, and Respond*, a report also available from the Alliance.

¹⁹ See: CDC. Guidelines for the management of elevated blood lead levels among young children. Atlanta, Georgia: U.S. Department of Health and Human Services, Public Health Service, CDC, 2002

²⁰ See Rhode Island's initiative, reported in *The Foundations of Better Lead*

Screening for Children in Medicaid.

²¹ See for example *Media Advocacy Guide for Lead Poisoning Prevention Advocates*, for more information on using the media. Available from the Alliance at 202-543-1147.

²² A helpful document in this regard is *An Advocate's Guide to the Medicaid Program* by the National Health Law Program (NHeLP). Available at www.healthlaw.org.