

Eliminating Childhood Lead Poisoning in New Hampshire



New Hampshire Department of Health and Human Services
Division of Public Health Services
Childhood Lead Poisoning Prevention Program

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Eliminating Childhood Lead Poisoning in New Hampshire



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Mary Ann Cooney
Director

July 21, 2004

Dear New Hampshire Citizens,

I am pleased to provide you with a copy of the *Elimination of Childhood Lead Poisoning in New Hampshire*. The foundation of the strategic plan has been a collaborative effort of New Hampshire leaders and community organizations under the direction of the Childhood Lead Poisoning Prevention Program and its Advisory Committee. This state plan for New Hampshire is part of a national effort that has the same goal.

When reviewing the data presented in this publication you will see that the rate of childhood lead poisoning in New Hampshire is decreasing. However, with the decreasing rates, primary prevention or taking steps to prevent children from exposure to lead-based paint and dust is more important than ever. The priority is to target those communities where the risk for exposure to lead is greatest. Prevention activities in these communities are expected to benefit all children who live in the highest risk areas.

The objectives and strategies outlined in this document will provide a framework to increase awareness in your community of the hazards of exposure to lead and how to eliminate these exposures. The systematic reduction of lead sources, particularly in older, deteriorating housing, combined with proper maintenance and remediation methods, will prevent children from being exposed to lead hazards.

A critical component of this plan is maintaining a strong partnership with organizations in the highest risk communities and throughout the State. Only by working together as individuals, organizations and communities will we be able to achieve the *Elimination of Childhood Lead Poisoning in New Hampshire*. Lead poisoning is preventable. Progress can be continued with sustained efforts. Working together we can eliminate childhood lead poisoning in New Hampshire. I invite you to join the effort in your community.

Sincerely,

Mary Ann Cooney, RN, MS
Director

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Introduction

Childhood lead poisoning continues to be a major, preventable environmental health problem for the children of New Hampshire. Despite significant progress toward the elimination of elevated blood lead levels (EBLL), children, who are most vulnerable continue to be exposed to this toxic metal at an unacceptable rate.

The New Hampshire Childhood Lead Poisoning Prevention Program (CLPPP) and the Childhood Lead Poisoning Prevention Advisory Committee are committed to eliminating childhood lead poisoning in New Hampshire.

Elimination Defined

For New Hampshire, elimination of childhood lead poisoning is defined as follows: “no child less than six years of age will have a blood lead level ≥ 10 $\mu\text{g}/\text{dL}$ by the year 2010”. This goal is more aggressive than the Healthy New Hampshire 2010 objective to reduce by half the number of tested children under age six who have blood lead levels ≥ 10 $\mu\text{g}/\text{dL}$. The NH baseline in 1999 was 820 of 14,610 tested children under six had a blood lead level of ≥ 10 $\mu\text{g}/\text{dL}$.

Mission Statement for Elimination

The Childhood Lead Poisoning Prevention Advisory Committee (Advisory Committee), which represents stakeholders throughout the State of New Hampshire, is dedicated to eliminating elevated blood lead levels ≥ 10 $\mu\text{g}/\text{dL}$ in children under six years of age in New Hampshire through building community capacity to increase lead-safe housing.

This strategic plan describes the scope of the problem, outlines the working history of the CLPPP and critical partners, and sets the course for an increase in the number of healthy homes available to the families with young children living in New Hampshire. This plan was developed with extensive input from the Childhood Lead Poisoning Prevention Advisory Committee and local partners from the highest risk communities in the State. Thank you to all who have helped to develop this plan and who are working toward the elimination of childhood lead poisoning in New Hampshire. It is through *your* commitment to increasing lead-safe housing that childhood lead poisoning will be eliminated in New Hampshire. Addressing the older, deteriorating housing stock that poses a risk

to young children is the key element in eliminating this entirely preventable disease.

An Overview of the New Hampshire Childhood Lead Poisoning Prevention Program

New Hampshire has been working to prevent childhood lead poisoning since 1984. The Childhood Lead Poisoning Prevention Program was originally founded with a grant from the New England Consortium of Childhood Lead Poisoning Programs. Case management of children with elevated blood lead levels and screening projects were the central focus of the small staff dedicated to working on childhood lead poisoning prevention. In 1992, New Hampshire received a grant from the Centers for Disease Control and Prevention to develop a comprehensive lead poisoning prevention program. The CLPPP is a program within the Maternal and Child Health Section (MCH), Division of Public Health Services (DPHS), New Hampshire Department of Health and Human Services.

The CLPPP works to reduce the number of NH children with elevated blood lead levels. The program is a resource for NH residents who need help addressing the hazards of lead in their children's environment. The CLPPP conducts

statewide surveillance, provides medical case management and home inspections for children with elevated blood lead levels, and provides information and referrals for lead hazard reduction. The CLPPP provides free phone consultation and referral to lead screening providers, as well as free lead poisoning prevention information kits.

For those who plan to do renovations in homes built prior to 1978, the CLPPP offers information on using lead safe work practices and a current listing of licensed lead professionals and lead safe renovators. For property owners and contractors, the program provides guidance on federal disclosure regulations and licenses all New Hampshire lead contractors, lead paint inspectors and training providers for lead hazard reduction.

Purpose Statements

The CLPPP and its Advisory Committee see the following as guiding principles:

 To raise community awareness of lead poisoning as a serious, yet preventable, environmental health risk to the children of New Hampshire.

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☒ To educate families, property owners, renovators, and others about lead-safe maintenance and renovation methods in housing built prior to 1978.

☒ To provide technical assistance in maintaining lead-safe housing and increase the availability of lead-safe housing.

☒ To increase and maintain partnerships with agencies, individuals and the local lead action committees to work toward the elimination of childhood lead poisoning in New Hampshire.

☒ To maintain the integrity of surveillance data to effectively direct childhood lead poisoning elimination activities.

☒ To increase blood lead screening in high-risk populations.

☒ To provide medical case management to families with children with elevated blood lead levels to help ensure appropriate care and follow up.

☒ To provide environmental investigations for children with elevated blood lead levels.

☒ To provide oversight and accountability for compliance with New Hampshire Statute for Lead Paint Poisoning Prevention and Control (RSA 130-A). To support

additional legislative initiatives that have proven to be effective.

☒ To increase resources for the elimination of childhood lead poisoning in New Hampshire.

Defining the Problem

Children under the age of six are most vulnerable to the effects of lead exposure. Lead poisoning in young children may result in developmental delays, attention deficits, hyperactivity, slower growth and other serious and persistent health effects.

The results of the latest national health survey by the U.S. Centers for Disease Control and Prevention show the prevalence of lead poisoning in children aged 1 to 5 decreased by half between 1994 and 2000 (CDC, 2004). Although this demonstrates that prevention efforts are effective, childhood lead poisoning continues to be a significant environmental health threat to the children of New Hampshire.

Children most at risk for elevated blood lead levels include:

- children enrolled in Medicaid
- children enrolled in WIC
- children enrolled in Head Start
- children living in housing built prior to 1950

- children living in or spending time in housing built prior to 1978 where recent renovations have occurred (during the past six months)

With almost 30 percent of all the housing units statewide built before 1950 (2000 Census), when the use of lead paint was at its greatest, a significant number of children remain at risk as a result of being exposed to deteriorating lead paint and lead dust. In the highest risk areas of the State, the proportion of housing built before 1950 ranges from 45 to 70 percent. Many of the older housing units in these high-risk areas are deteriorating and pose a threat to young children from lead exposure hazards.

In New Hampshire, more than 90% of all children identified with blood lead levels of 20 µg/dL or greater live in or regularly visit homes built before 1950. Also, almost 1 of every 3 (32%) New Hampshire children with a BLL of 20 µg/dL or greater lived in or regularly visited a home that had undergone recent renovations (within the last 6 months). These homes are both rental properties and privately owned homes.

Screening and elevation rates

The CLPPP encourages health care providers to adhere to the recommendations

for screening in the *New Hampshire Childhood Lead Poisoning Screening and Management Guidelines*. The recommendations follow the guidance from the Centers for Disease Control and Prevention that recommend blood lead testing for children at both one year of age and two years of age (Centers for Disease Control and Prevention define the age ranges from 6-17 months and 18-29 months, respectively). In 2002, one-year-olds were screened at a rate of 55.7%. Two-year-olds were screened at a rate of 27.3%. Screening for one-year-olds has declined slightly over the past few years. Meanwhile, screening for two-year-olds has increased slightly.

From 1999 to 2002 the rate of elevated blood lead levels in children younger than six years of age decreased from 4.5% to 3.6%, while there was no significant difference in the number of children tested. See Appendix A. As the rate of elevated blood lead levels in young children continues to decline, targeting those children most at risk for exposure to lead hazards in older housing become even more critical.

State and Federal Medicaid regulations require screening of children enrolled in Medicaid at 12 and 24 months of age. The CLPPP has matched records from

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the childhood lead screening surveillance database with data provided by New Hampshire’s Medicaid program and found that screening rates of children enrolled in Medicaid are low. In 2002, one-year-old children enrolled in Medicaid were screened at a rate of 59.8% (compared to all other one-year-old children at a rate of 51.1%). Two-year-old children enrolled in Medicaid were screened at a rate of 36.4% (compared to all other two-year-old children at a rate of 22.7%). Prior to 2002, a child enrolled in Medicaid was less likely to be screened at 12 months than a child not enrolled in Medicaid (1997-2001).

The NH Division of Public Health Services requires all community agencies funded by the state for primary care and child health services to adhere to the state and federal Medicaid requirements for blood lead testing. Agency performance measures require screening rates be reported to DPHS annually. If an agency is not testing children at an acceptable rate, it must include a plan to improve its blood lead testing during the next year. The CLPPP provides technical assistance to these agencies to improve testing rates, when necessary.

The table below shows that much progress has been made since 1997 in

reducing elevated blood lead levels among children enrolled in Medicaid. However, children enrolled in Medicaid still have elevated blood lead levels at over twice the rate of children not enrolled in Medicaid.

Percent of children aged less than 6 with BLLs ≥ 10 $\mu\text{g}/\text{dL}$ among Medicaid enrollees and non-Medicaid enrollees New Hampshire, 1997-2001

Year	Medicaid enrollees		Non-Medicaid Enrollees	
	Number	Pct	Number	Pct
	Age <6	Age <6	Age <6	Age <6
1997	366	8.30%	330	2.70%
1998	278	7.10%	298	2.70%
1999	333	8.80%	271	2.60%
2000	257	6.70%	237	2.50%
2001	208	5.40%	206	2.20%

The CLPPP has also matched WIC data to lead surveillance data. The chart below details the screening rates for children enrolled in WIC for 2002.

Blood Lead Screening Rates	2002
Among WIC Enrollees - New Hampshire	
1 Year Old	33.5%
2 Year Old	34.0%

In an effort to increase the rates of screening for children enrolled in WIC, the CLPPP and the WIC program have been collaborating to send screening reminder postcards to families of children enrolled in WIC at the time of the child’s first and second birthday.

As a pilot project, the CLPPP is working with Head Start centers to increase screening rates and share blood lead test

results on children enrolled in the programs (with parental permission). If successful in Sullivan and Cheshire Counties, this project will be expanded to other high-risk areas. For more information on high-risk areas, see page 14 of this document.

For additional information on blood lead screening recommendations and protocols, please see the *New Hampshire Childhood Lead Poisoning Prevention Screening and Management Guidelines*. A copy can be obtained by contacting the CLPPP at 800-897-LEAD.

Estimates of Total Elevations

The following estimates of children in New Hampshire with elevated blood lead levels will be used to help measure the change in the number of children at risk for lead poisoning. Using these estimates as an indicator of risk, the CLPPP (with the assistance of Health Statistics and Data Management (HSDM), within the DPHS) will be able to track changes over time.

HSDM used lead testing data from 2002 to estimate the total number of children with elevated blood lead levels ($\geq 10 \mu\text{g/dL}$) by age group. See Appendix B. It was not possible to use a regression analysis for the estimates due to the lack of

universal testing data. For each high-risk town, the percent of children with elevated blood lead levels was applied to the total population of children in each age group for each town. This assumes that the rate of elevation would be the same for the total population in a high-risk town as the elevation rate of those children who were tested. An overestimation of elevation may come into play here because of targeting screening for those most at risk.

The absolute lowest number of children with elevated blood lead levels in each age group is the actual number of children elevated (based on 2002 data). The estimated number is the absolute highest possible number of children with elevated blood lead levels in each age group. It is important to discuss ranges of elevations for each age group because of the selection bias due to targeting testing.

Listed below are the ranges of elevated blood lead levels by age group.

Age	Elevated (2002)	Estimated Number of Children with EBLs
1 Year	223	422
2 Years	167	658
3-5 Years	110	2,167
Total	500	3,248

The selection bias is evident in the 3-5 year age group. The estimate is likely inflated because of the follow up testing that

occurs when a child has a chronic elevation. See Appendix B for more detail on estimated elevations of children living in the high-risk communities.

Working toward the Elimination of Childhood Lead Poisoning in New Hampshire

New Hampshire's Lead Paint Poisoning Prevention and Control Act (RSA 130-A)

In an effort to control childhood lead poisoning in New Hampshire, the state legislature adopted the Lead Paint Poisoning Prevention and Control Act (RSA 130-A) in 1993. It was most recently revised in 2003.

RSA 130-A requires that any laboratory performing blood lead analysis on New Hampshire residents report the test results to the CLPPP. This reporting requirement has been in effect since July 1994.

RSA 130-A requires that the CLPPP investigate all cases of lead poisoning in children under the age of six whose venous blood lead level is ≥ 20 $\mu\text{g/dL}$. The CLPPP also investigates cases in which children under the age of six have two consecutive venous blood lead levels between 15 and 19 $\mu\text{g/dL}$, separated by at least 90 days. A

limitation of RSA 130-A is that environmental inspections are conducted only after a child has been identified with an elevated blood lead level ≥ 20 $\mu\text{g/dL}$ (or a persistent 15 – 19 $\mu\text{g/dL}$).

The investigation includes a risk assessment questionnaire and may include an inspection of the child's home, childcare facility and/or other homes where the child spends a frequent amount of time. The purpose of the inspection is to identify potential sources of the child's lead exposure. When lead exposure hazards are found, the CLPPP may issue an Order of Lead Hazard Reduction (Order) to the owner of a rental property, describing in detail the exact steps the property owner should take to come into compliance with the Order. Privately owned homes are exempt from required intervention. Non-rental properties are issued recommendations and are not required to act on the recommendations.

The CLPPP provides written notification to owners of rental units whenever a resident child, 6 years of age or less, has a confirmed blood lead level between 10 and 19.9 $\mu\text{g/dL}$ of blood. The intent of this is to provide property owners with information and guidance so that lead

hazards in rental units can be safely addressed. They are also informed that it is unlawful to evict tenants based on a child's elevated blood lead level.

RSA 130-A requires that all lead inspectors and abatement professionals be certified or licensed. The CLPPP licenses Lead Risk Assessors, Lead Inspectors, and Lead Abatement Contractors. The CLPPP certifies Lead Training Providers, Lead Dust Clearance Testing Technicians, Lead Workers and Supervisors. The CLPPP also provides identification cards for participants who completed the HUD-approved lead safe renovator training.

Childhood Lead Poisoning Prevention Program Components

The CLPPP is a multidisciplinary professional team that includes a program manager, environmental lead specialists, nurse case managers, health promotion advisors, and surveillance and support staff. The CLPPP team members work both independently and collaboratively to accomplish program goals.

Education - The educational component of the program is to enhance primary and secondary prevention of childhood lead poisoning in New Hampshire. The CLPPP works toward building community capacity

for critical partners to increase awareness and knowledge of childhood lead poisoning in their communities and to facilitate the adoption of preventive behaviors. In addition to providing resources and support, the program also develops and implements public education campaigns targeted to prevent lead-based paint exposure and to increase the availability of lead-safe housing in the State.

The CLPPP provides technical assistance and formal training in the recognition of lead hazards, lead safe renovation methods and maintenance to renovators and remodelers, building officials, property owners, property management and maintenance staff, and real estate professionals. The lead safe renovation course offered by the CLPPP is approved by the U.S. Department of Housing and Urban Development (HUD). Identification cards and certificates of completion are provided to course participants.

Case Management - Providing case management helps to ensure that any child with an elevated blood lead screening or confirmatory test result receives appropriate, comprehensive, and coordinated medical and environmental follow-up, resulting in a decreased blood lead level. Case

management activities begin when the CLPPP receives a report of a child less than 72 months of age with a blood lead level of 10 µg/dL or greater. The nurse case manager contacts the child's health care provider to advise that venous confirmatory testing (diagnostic testing) be done within the recommended time frame. A case file is opened for a child and case management is initiated when that child has a confirmed blood lead level of 10 µg/dL or greater. The case manager ensures that health care providers are aware of the recommended medical protocols and of the availability of the CLPPP's Medical Consultants for consultation on the medical management of cases. Counseling of parents on ways to reduce risk is provided by telephone, and, in the City of Manchester and Nashua, by home visit. Educational materials are also provided to parents of all children identified with a venous blood lead level of 10 µg/dL or greater.

The nurse case manager also ensures that referral for environmental investigation occurs when appropriate and usually accompanies the environmental lead specialist to home visits to further assess family needs. The case manager refers families to appropriate community health

and social service resources based on findings of the assessment.

The Medical Consultants are practicing physicians with experience in treating children with elevated blood lead levels. The Consultants are available for advice to the CLPPP and to health care providers about treatment options for children with elevated blood lead levels. The Consultants were instrumental in the development and subsequent revisions of the *New Hampshire Childhood Lead Poisoning Screening and Management Guidelines*. They are essential to assure timely and evidence-based treatment of the most highly lead poisoned children in New Hampshire.

Environmental Investigations - The CLPPP's environmental lead specialists perform environmental investigations throughout the State. The trigger for an investigation is a child less than 72 months of age with a venous confirmation of a blood lead level of 20 µg/dL or greater (or with a persistent 15 to 19 µg/dL). Investigations are conducted to determine what lead exposure hazards exist in the child's environment and to initiate action to eliminate those sources of exposure.

In cases where a child less than 72 months of age with a venous confirmation of

a blood lead level of 20 µg/dL or greater is living in rental housing and lead exposure hazards are identified in the home, the CLPPP is authorized under New Hampshire RSA 130-A to issue an Order. The Order requires a property owner to take action to make a property lead safe.

While the environmental investigations conducted by the CLPPP are initially in response to a child that has been poisoned, the inspection and subsequent Order of Lead Hazard Reduction in the case of rental property can be considered a primary prevention measure. Making the property lead safe will allow future tenants to live in safer housing.

Licensing and Certification - The CLPPP sets standards for licensure and certification of those professionals who carry out lead abatement and inspection activities in residential dwellings and licensed child care facilities. The CLPPP also sets the procedures and requirements for the accreditation of training providers. These standards are intended to ensure a qualified and properly trained work force to assist in the prevention, detection, and elimination of hazards associated with lead-based paint.

Surveillance - Since July 1, 1994, New Hampshire has had a mandatory reporting requirement for all laboratories to report the results of all blood lead tests (elevated and non-elevated) performed on residents. Since 1995 testing labs used by our in-state providers have been reporting nearly all tests performed on New Hampshire children. Laboratories report nearly all tests electronically. This database enables the program to provide descriptive data about screening practices in the State.

New Hampshire CLPPP contributes data to Center for Disease Control and Prevention's (CDC) national surveillance database. This effort assists the CDC in presenting a national picture on the progress toward the elimination of the childhood lead poisoning problem.

The main purpose of collecting all blood test data, and not just elevated tests, is to allow the calculation of the rate of elevated blood leads, not just the number. When statistically valid, knowing the rate of elevated blood leads (prevalence), allows the CLPPP to better target prevention efforts.

Childhood Lead Poisoning Advisory Committee

The Childhood Lead Poisoning Advisory Committee (Advisory Committee) has been essential in the development of this plan. The Advisory Committee began meeting in 1998 to develop the Screening Guidelines. An invitation to join the Advisory Committee was mailed to more than 80 individuals, groups and organizations of stakeholders statewide. Over 40 members committed to participate in a number of full-group meetings and smaller work-group meetings. The successful development of the Screening Guidelines was due to the commitment of the Advisory Committee to develop practical guidelines for health care providers in New Hampshire.

After working on the development of the Screening Guidelines, the Advisory Committee agreed to continue to meet twice a year to provide guidance on activities to increase screening among children at high risk for elevated blood lead levels and to continue monitoring and evaluating the screening of children at 12 and 24 months of age in New Hampshire.

In February 2003, the CLPPP and the Advisory Committee began shifting their focus from screening to primary prevention

and increasing community capacity for the elimination of childhood lead poisoning. With this shift in focus from the child to the house, additional critical partners were added to the make-up of the Advisory Committee. The membership had been very heavily represented by health care, social service agencies, and community based organizations. Additional members from the housing community were necessary to balance the representation of stakeholders. Advisory Committee members provided input on other potential groups to include in the membership. The CLPPP also used documents and suggestions from other state and national partners for potential representative members.

Potential new partners were personally contacted by the CLPPP to explain how they are critical partners in the process of eliminating childhood lead poisoning. After the partners agreed to work as a member of the Advisory Committee, they were mailed formal invitations that included background information on the CLPPP and program initiatives.

The membership of the Advisory Committee now ranges from health care providers to property owners, from Head Start to housing authorities. The only requirement to hold a seat on the Advisory

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Committee is that the member must be representing an agency (or themselves in the case of a parent) that has the commitment and resources to work toward the elimination of childhood lead poisoning. For a full list of the current members of the Advisory Committee, see Appendix C.

There are still critical partners that have yet to become members. These potential members will be invited to join the Advisory Committee as relationships can be established with them. The personal contact from the CLPPP helps in establishing the links with individuals, agencies or groups who may not typically think of themselves as having a role in the elimination of childhood lead poisoning. Stakeholder groups that have been identified as additional critical partners include lending institutions, home insurance providers, legislators, the Community Action Programs in all high-risk areas and the New England Society of Home Inspectors. The Advisory Committee will continue to assess the make-up of the group as part of monitoring the progress New Hampshire is making toward eliminating childhood lead poisoning. Additional members can be suggested at any Advisory Committee meeting or by contacting the CLPPP directly.

This plan for eliminating childhood lead poisoning in New Hampshire is truly owned by the stakeholders who represent the citizens of New Hampshire. The Advisory Committee worked with the CLPPP to develop the mission statement, the statements of purpose and the overall goals and objectives that guide the strategies used by the CLPPP and the critical partners to eliminate childhood lead poisoning. The Advisory Committee received background information and worked in small groups to provide input on the components of the plan. The CLPPP was then able to take the information provided by the Advisory Committee members and further develop this plan.

The Advisory Committee also determined that subcommittees should be established in the high-risk areas, instead of establishing subcommittees by program component. In New Hampshire, citizens want to have input into what is happening in their communities. Local committees make it possible for community members to directly affect the health of the children in their communities. Local projects have a much better chance of success if community members are part of the development, implementation and evaluation. The benefit that comes from closely-knit communities

(whether as large as the City of Manchester or as small as the City of Berlin) is the commitment to enhance the well-being of the community. See the next section for a more detailed description of the high-risk communities.

The Advisory Committee will collaborate with the CLPPP to implement prevention strategies and monitor the progress toward the goal of eliminating childhood lead poisoning. Members of the Advisory Committee are available to the CLPPP for guidance and input around specific issues year round. Many members work closely with the CLPPP on projects and are in constant communication with the CLPPP. Advisory Members also share information about the CLPPP activities with their respective organizations through newsletters, e-mail and other forms of outreach.

High-Risk Areas and Local Lead Action Committees

In October 2002, the CLPPP determined the highest risk areas of the State. Risk, by town, was determined by the percentage of housing built before 1950, the percentage of children under age six enrolled in Medicaid, the percentage of children under age six enrolled in WIC and

the percentage of one- and two-year-old children. Based on this risk formula, the five highest risk areas (made up of seven towns) are Berlin, Claremont/Newport, Franklin/Laconia, Manchester, and Nashua. See Appendix D for the map *Risk Level for Lead Poisoning By Town – 2001*.

Rates of elevated blood lead levels were not used in determining the highest risk areas in the State. However, the percent of children with elevated blood lead levels, among those screened is higher in high-risk areas than the State rate. See Appendix E for *Blood Lead Testing Among Children Living in High Risk Towns*. In 2002, the statewide rate of elevated blood lead levels was 3.6% among children screened. The rates in the high-risk towns range from 1.9% to 13.1%. The rate of elevated blood lead levels among children screened in Nashua is 1.9%. This is a misleading number. Children living within the core of the city have a higher rate of elevated blood lead levels than the State average due to the higher percent of old housing stock concentrated in that area. Around the older core are many new homes.

To address the unique needs in the high-risk areas of the State, the Advisory Committee worked with the CLPPP to help form Local Lead Action Committees in each

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of these areas. Potential members were identified and then contacted by the CLPPP or Advisory Committee members and asked to join in the process of creating specific plans to eliminate childhood lead poisoning.

Many Advisory Committee members also belong to Local Lead Action Committees. Each committee is as unique as the community it represents. For instance, the Franklin/ Laconia Local Lead Action Committee meets as two separate groups within each city due to differences in stakeholders and resources. In general, the committees are working with the CLPPP to promote educational programs, distribute materials, find additional funding resources for lead-safe housing and implement strategies to eliminate lead poisoning in those communities and throughout the State. The CLPPP provides the Local Lead Action Committees with information on their community, funding opportunities, technical assistance, materials and an opportunity to network with other communities facing similar housing problems. Contact between the CLPPP and each committee is frequent through both formal and informal means. There are critical partners on each committee who are very active in implementing programs that increase lead-

safe housing and that work toward eliminating childhood lead poisoning.

As mentioned earlier, each local committee is unique. Berlin has a strong public health network that has been focusing on safe housing issues. The Berlin Local Lead Action Committee is a subcommittee of a group that has been meeting for some time. The local health officer in the City of Berlin has volunteered to chair this committee. The group is working on safe housing codes and on establishing a certificate of occupancy process for rental properties in the City of Berlin. Like Berlin, many local jurisdictions do not have adequate safe housing codes and the ability to enforce the codes. Fortunately for the City of Berlin, many city officials, community based organizations and private and public partners are interested in addressing housing issues in Berlin. In June 2004, the Berlin Housing Forum was held. The CLPPP is working with the Local Lead Action Committee members to support the activities of the community around safe housing. See Appendix F for a list of members for the Berlin Local Lead Action Committee and additional information on the City of Berlin.

The Claremont/Newport Local Lead Action Committee has been meeting since

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November 2003. The committee has begun working on distributing materials and increasing participation in lead-safety trainings, while doing some longer-range planning for the implementation of other strategies. The group is working on submitting public service announcements and editorials for placement in local newspapers. The local cable access channel has been airing lead poisoning prevention videos and publicizing the lead safe renovator trainings. One committee member, with technical assistance provided by the CLPPP, is pursuing funding for healthy homes projects. See Appendix F for a list of members of the Claremont/Newport Local Lead Action Committee and additional information on the Cities of Claremont and Newport.

A strong community public health network has existed in Franklin for eight years. The Caring Communities Network of the Twin Rivers (CCNTR) actively promotes individual and environmental health as a fundamental requirement of healthy communities, while demonstrating strong leadership and a commitment to service. A staff member of CCNTR chairs the Franklin Local Lead Action Committee. The CLPPP, Health First Family Care Center, CCNTR and The Way Home are the

core members of the group. They are focusing on a healthy homes project to provide education and hazard reduction for lead exposure risks and asthma triggers among Franklin families with children diagnosed with either asthma or an elevated blood lead level. The group is working to secure additional funding to expand this project. See Appendix F for a list of members of the Franklin Local Lead Action Committee and for additional information on the City of Franklin.

The Laconia Local Lead Action Committee is focused on raising community awareness of lead poisoning as a preventable, childhood health issue. The Public Health and Safety Network of the Lakes Region will be the lead agency for this committee. The committee is looking to the CLPPP to provide information that could be widely distributed within Laconia to begin to raise awareness in the community. See Appendix F for a list of members of the Laconia Local Lead Action Committee and more information on the City of Laconia.

The Greater Manchester Partners Against Lead Poisoning has been meeting as a local committee for several years. The committee developed a plan for lead poisoning prevention within the City entitled *Preventing Childhood Lead Poisoning in*

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Manchester, NH (2002). The coalition has education and legislation sub-committees. The committee has developed a public health/ academic partnership between the coalition and Dartmouth Medical School. By working closely with the Center for Environmental Health Sciences at Dartmouth Medical School, the committee is working to increase participation in the City of Manchester's Lead Hazard Control Program funded by the US Department of Housing and Urban Development (HUD), researching effective lead legislation in other states, and seeking additional funding sources to implement more of the strategies in the community action plan. See Appendix F for a list of members of the Greater Manchester Partners Against Lead Poisoning and more information on the City of Manchester.

The Nashua Local Lead Action Committee began meeting in March 2003. The focus of this local group has been on training for property owners, cleaning companies, and community groups and on increasing participation in lead safe renovator training courses held in Nashua. The committee is also working on an outreach plan for contractors, renovators and do-it-yourselfers around incorporating lead safe renovation methods into their work

practices. See Appendix F for a list of members of the Nashua Local Lead Action Committee and additional information on the City of Nashua.

The Local Lead Action Committees in the high-risk areas will continue to be the leaders in bringing about stronger community capacity for eliminating childhood lead poisoning. Each community has set its individual priorities and will continue to work toward the goal of elimination with the technical assistance of the CLPPP and the Childhood Lead Poisoning Advisory Committee. Without involving the critical partners at the local level, the CLPPP would not have been able to increase the visibility of lead poisoning as a problem in these communities. It has been an educational and coalition building process that is beneficial for both the CLPPP and the community partners. Determining strategies that will work best on the local level, by the stakeholders at the local level, has the best chance of success in a state that values local autonomy.

The lessons learned and best practices from these five high-risk areas will be shared with other communities in New Hampshire that have children at increased risk for childhood lead poisoning. There are additional communities, which because of

the percentage of their older, deteriorating housing stock, have the potential for having children exposed to lead hazards in their homes. It will be the job of the CLPPP and the Advisory Committee to provide information to these other communities as New Hampshire progresses toward eliminating childhood lead poisoning. The CLPPP will work closely with the Centers for Disease Control and Prevention and other state CLPPPs to look at other best practice models for elimination of lead poisoning in rural states.

Lead Hazard Control and Healthy Homes Programs

Lead Hazard Control Programs are limited to the City of Manchester, through a HUD Lead Hazard Control Grant and the Community Action Programs using Community Development Block Grant (CDBG) and HOME (rehabilitation funds for homeowners) funding. A limitation to the goal of increasing the availability of lead safe housing is that this funding for lead hazard reduction is not widely available throughout the high-risk communities.

In response to this limitation, the CLPPP is providing technical assistance to and working with critical partners who are interested in applying for lead hazard control

and healthy homes funding. The CLPPP will continue to investigate federal and foundation funding possibilities for additional lead hazard reduction in high-risk areas. Increasing the amount of funding for lead hazard reduction in older homes is essential in preventing young children from lead poisoning and in eliminating lead poisoning in New Hampshire.

New Hampshire is fortunate to have a community-based organization that incorporates lead hazard reduction into its mission of helping low income households obtain and keep safe, affordable housing. The Way Home, in Manchester, provides a Healthy Home Services program that specializes in childhood lead poisoning prevention. A licensed lead abatement contractor manages the program that includes trained and certified work crews and educators. Healthy Homes Services is very skilled in working with both property owners and tenants to have each side do its part in protecting the health of the child. Families in Manchester are referred to Healthy Home Services when a child has an elevated blood lead level between 10 and 19 $\mu\text{g}/\text{dL}$ to help make the property lead-safe and prevent the blood lead level from increasing.

Healthy Home Services is willing to work in other high-risk areas in the State as funding permits. The other high-risk areas would benefit from satellite offices of this program.

Implementing Strategies

To develop a comprehensive plan for the elimination of childhood lead poisoning, the Advisory Committee developed goals and objectives to address community capacity building, policy, screening, surveillance, enforcement and resources for lead safe housing. Essential to the implementation of the strategies outlined for each goal and objective are the critical partnerships with stakeholders and their commitment to implement key strategies and resources outlined in the following workplan. The critical partners who are listed later in this document in the Goals and Objectives Table are represented on the Advisory Committee and on the Local Lead Action Committees. Letters of commitment from these partners can be found in Appendix G.

The workplan (goals and objectives table) includes specific, measurable and time-phased objectives for primary prevention, secondary prevention and surveillance. All goals and objectives were

developed with input from the Advisory Committee. Directly following the goals and objective table is a logic model to be used to evaluate the success of this plan. For more details, see the annual work plan (July 2004 through June 2005) in Appendix H.

Primary Prevention Goal

Prevent lead exposure in young children.
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The high-risk geographic areas have been determined based on risk data. See Appendix D for additional information. GIS mapping of local surveillance data will be used to continue to more accurately pinpoint the areas of highest risk to young children within the high-risk communities. Statewide, the highest risk populations have been identified as those children enrolled in Medicaid, WIC, Head Start and/or living in older homes. Data from CLPPP surveillance indicate that lead-based paint in older homes is the source of more than 90% of New Hampshire lead poisoning cases. In addition, almost one in three (32%) children with a blood lead level of 20 µg/dL or greater lived in or regularly visited a home that had undergone recent renovations (within the last 6 months).

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Increasing the amount of lead-safe housing in New Hampshire is an integral part of the plan for eliminating childhood lead poisoning. Strategies to build community capacity to create and maintain lead-safe homes include integrating lead-safe work practices into routine building maintenance, addressing lead hazards during renovations, and enhancing local safe housing codes. In addition, the Advisory Committee is committed to sustaining and enhancing healthy home initiatives by increasing funding for and enhancing collaboration with housing agencies. Working with the Local Lead Action Committees on all initiatives enables the community to be involved in planning, implementation and evaluation. The Local Lead Action Committees and/or their individual members are provided with technical assistance from the CLPPP when applying for funding opportunities. The CLPPP will continue to provide this assistance and research additional funding opportunities, such as private foundation funding.

The CLPPP offers a series of HUD-approved lead safe renovation courses annually, as well as courses on lead-safe maintenance methods to property owners and maintenance staff. The CLPPP is

beginning to train building officials in lead-safe maintenance and renovations. By enhancing their knowledge of lead hazards, the building officials will be better able to work with property owners to keep their properties lead safe.

Although the house is the number one contributor to lead exposure to young children in New Hampshire, monitoring other exposure sources that could increase risk to children in high-risk areas will be done in collaboration with critical partners such as the Department of Environmental Services and the New Hampshire Office of the National Environmental Trust.

Providing technical assistance and training for critical partners is an essential part of increasing the awareness and knowledge of lead poisoning prevention efforts. The CLPPP continues to use a train-the-trainer model to educate professional and paraprofessional staff in community agencies regarding prevention strategies. Technical assistance is provided on an ongoing basis to community groups and the Local Lead Action Committees for outreach, education and advocacy efforts. The CLPPP also increases awareness through partnerships the distribution of materials by the Poison Information Center, Medicaid, and WIC.

A comprehensive prevention campaign that utilizes best practices in health promotion, behavior change theory and social marketing has been a goal of the CLPPP and some critical partners for many years. With funding, staff time and student assistance from the Center for Environmental Health Sciences at Dartmouth Medical School, the prevention campaign is beginning to become a reality. The campaign will be developed and piloted in the City of Manchester, with collaboration from the Manchester Health Department and the members of the Greater Manchester Partners Against Lead Poisoning. Successful campaign strategies will then be implemented in the other high-risk areas.

By collaborating with academic partners, curricula for health professional students and education students will include information about lead poisoning prevention and the effects of lead on growth and development. Public health students will also be trained to bring the information to their peers.

The CLPPP, though a partnership with the New Hampshire Department of Environmental Services, will continue to license and certify all lead professionals.

Licensure and certification help ensure an adequately trained workforce.

Orders are issued on properties when a child less than the age of six has an elevated blood lead level $\geq 20 \mu\text{g/dL}$ and the property is a rental property. The Order is designed to describe, in detail, the exact steps the property owner should take to come into compliance with the Order. If the property is privately owned, the CLPPP may investigate with the permission of the owner, but may only issue recommendations for reducing lead exposure hazards.

The CLPPP has dedicated one Environmental Specialist on staff to concentrate on property owners who have not complied with Orders. The status of Orders is tracked using a database dedicated to environmental tracking. The NH Department of Health and Human Services legal advisors work closely with the CLPPP when property owners fail to comply with Orders. The potential consequence of non-compliance is a Notice of Administrative Fine. An increasing number of properties are coming into compliance with comprehensive tracking, issuance of advisory letters, issuance of Notices of Administrative Fines and technical assistance provided to property owners on compliance-related issues.

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New Hampshire has had cases where the required disclosure of an Order on the property was not carried out and the new owner purchased the property without knowledge of the existence of an Order. To prevent a new owner from purchasing a property without being aware of the Order, the CLPPP now attaches a copy of the Order to the property deed. In the event that a property is sold without the appropriate disclosure, the existence of the Order will be discovered through a title search. The CLPPP expects that this action will increase the number of properties coming into compliance, as new owners are less apt to purchase a property without addressing the lead hazards. Therefore, young children occupying the property in the future will be living in a lead-safe environment. This strategy will be included as a Building Block in *Building Blocks for Primary Prevention*, published by the Alliance for Healthy Homes.

The CLPPP continues to provide referrals for enforcement action to federal partners. In addition, each Local Lead Action Committee will develop project proposals in the event that a property owner violates the federal disclosure law and selects funding a project as part of the settlement process. Proposals will be

written for Supplemental Environmental Projects (SEPs) from the U.S. Environmental Protection Agency and for Child Health Improvement Projects (CHIPs) from U.S. Department of Housing and Urban Development. Having the projects defined and in the form of a proposal will increase the chances that a Local Lead Action Committee could get funding from violations that occur in their area.

State policies to address childhood lead poisoning are applicable after a child is poisoned. In an effort to look at improving prevention policies, research is being conducted on initiatives that have been proven effective in other states. The research is being conducted through the Center for Environmental Health Sciences at Dartmouth Medical School, in collaboration with the Vermont College of Law.

The CLPPP will continue to provide technical support to leaders in high-risk areas to support their efforts in sustaining CDBG funds earmarked to increase the number of lead-safe housing units. The CLPPP will continue to provide assistance, feedback and information at forums and community meetings to promote safe housing as an issue for children's health.

The New Hampshire Child Advocacy Network sets a Children's

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Agenda each year for priority topics in the areas of education, economic security, health, and safety and protection. Over 200 network members, who are child advocates and primary prevention proponents, work on achieving Priority Action Steps in the Children's Agenda each year. The CLPPP will work with network partners to submit a proposal to include *Eliminating Childhood Lead Poisoning in New Hampshire* on the Children's Agenda for 2006. This would bring statewide attention to this strategic plan.

Secondary Prevention Goal

Increase screening for children at highest risk for lead exposure.
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Outreach, technical assistance and consultation are provided to health care providers to increase their compliance with the recommendations made in the *New Hampshire Childhood Lead Poisoning Screening and Management Guidelines*. Efforts to increase screening are focused on those children most at risk for being exposed to lead paint and dust in older homes. These groups include:

- children enrolled in Medicaid
- children enrolled in WIC
- children enrolled in Head Start

- children living in housing built prior to 1950
- children living in or spending time in housing built prior to 1978 where recent renovations have occurred (during the past six months)

Both national and New Hampshire data demonstrate that as a group, children enrolled in Medicaid, WIC and Head Start are more likely to be exposed to lead hazards because of the linkage between income, housing conditions and increased risk. Health care providers are reminded of the state and federal mandates that requires all children enrolled in Medicaid (Healthy Kids Gold) to be tested at 12- and 24-months of age. Children between 36- and 72-months of age with no record of prior testing must also receive a blood lead test. The American Academy of Pediatrics endorses these requirements (APA, 1998).

Continuing to work with health care providers to increase screening rates among the highest risk populations will enable the CLPPP and critical partners to assess the progress toward elimination of childhood lead poisoning in New Hampshire.

Case management of children with elevated blood lead levels is a core function of the CLPPP. Providing timely follow-up and care coordination for children with

elevated blood lead levels are achieved through consultation with health care providers at the state and local level. In Manchester and Nashua, contracts with local agencies enable their case managers to provide services for children with elevated blood lead levels.

Case managers provide referrals to the CLPPP environmental lead specialists to help ensure timely environmental investigations in the homes of children with elevated blood lead levels. The investigations help determine the source of exposure.

The environmental investigations in a rental property, and subsequent Order of Lead Hazard Reduction, are important prevention strategies because they require the property owner to make the property lead safe and maintain it in a lead safe condition.

The New Hampshire Medicaid Program reimburses the CLPPP for nursing case management and environmental investigations provided to children enrolled in Medicaid. This reimbursement is required for the CLPPP as part the *Preventive Health Amendments of 1992*.

The Screening Guidelines were originally published in 1998 to establish screening recommendations and protocols

for New Hampshire health care providers. The Centers for Disease Control and Prevention provided guidance for developing statewide screening plans and protocols in *Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials*, November 1997. The latest revisions to the Screening Guidelines will be published and distributed in the summer of 2004.

Surveillance Goal

Maintain the integrity of surveillance data.
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Since 1994 New Hampshire RSA 130-A has mandated reporting of blood lead testing data for all New Hampshire citizens. Data analysis drives decisions made for activities focused on the elimination of childhood lead poisoning. Data management is essential to maintaining the integrity of the data. The CLPPP uses data for decision-making and shares data with critical partners. Accurate and complete laboratory reporting of blood lead test results and demographics allows the CLPPP surveillance staff to ensure data integrity. Past audits of data demonstrated a high rate of accuracy and completeness.

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Currently child data and housing data are maintained on separate databases. Using the National Electronic Disease Surveillance System (NEDSS) Lead Program Area Module (PAM) will enable the CLPPP to have all child and environmental (housing) data in one database. The web-based system will make the data available in real-time to the CLPPP and to the contracted case managers.

Goals and Objectives Table

Primary Prevention Goal: Prevent lead exposure in young children.		
Objective 1: Set priorities and develop targeting strategies for high-risk areas and populations.		
Strategies	Critical Partners	Timeline
1. Designate five high-risk geographic areas. Continue to refine the designation of high-risk areas by using GIS to pinpoint the areas of greatest risk.	CDC, Medicaid, WIC, Bureau of Health Statistics and Data Management	Initial selection of five high-risk areas completed
2. Collaborate with local health and housing officials to identify and target high-risk housing in the high-risk areas.	Local Lead Action Committees, Regional Public Health Networks, NH Building Officials Association	July 2006
3. Identify high-risk populations statewide.	Medicaid, WIC, Head Start	Completed
Evaluation Plan: High-risk community designations completed. GIS maps developed and accessible to the communities. High-risk populations and housing units identified.		
Objective 2: Build community capacity to increase lead-safe housing.		
Strategies	Critical Partners	Timeline
1. Create and maintain Local Lead Action Committees in high-risk areas.	Stakeholders in high-risk areas, Regional Public Health Networks	March 2004
2. Integrate lead-safe practices into routine building maintenance and renovation by implementing property owner trainings in each high-risk area.	NH Property Owners Association, Granite State Managers Association, Local Lead Action Committees	Five trainings annually, April to June
3. Address lead hazards during maintenance, renovations, and disposal. <ul style="list-style-type: none"> a. Offer HUD-approved lead safe renovator trainings in each high-risk area. Integrate lead safety into existing programs targeted to do-it-yourselfers and professionals. b. Develop lead-safe training for building officials & private home inspectors. c. Monitor other environmental lead exposure sources that could increase risk to children in high-risk areas. 	<p>NH Housing Finance Authority, Local Lead Action Committees, Home Builders & Remodelers of NH, building trades schools, NH Division of Historical Resources, Community Action Programs, weatherization programs, public housing authorities</p> <p>NH Building Officials Association, NE Society of Home Inspectors</p> <p>NH Department of Environmental Services, National Environmental Trust, NH Fish and Game Department</p>	<p>Five trainings annually, January to March</p> <p>July 2004</p> <p>On-going</p>

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4. Enhance local safe housing standards by providing model codes for adoption by local jurisdictions.	Local Health Officers, NH Building Officials Association, Local Lead Action Committees, Regional Public Health Networks	February 2006, on-going distribution
5. Sustain and enhance healthy home initiatives by integrating healthy homes models, increasing funding resources, and enhancing collaboration with housing and other partners. Utilize <i>Building Blocks for Primary Prevention</i> .	HUD, EPA, The Way Home, Local Lead Action Committees, private foundations, lending institutions, state agencies, Center for Environmental Health Sciences at Dartmouth Medical School, NH Housing Finance Authority, Alliance for Healthy Homes	On-going
Evaluation Plan: Local Lead Action Committee member lists, meeting minutes and reports. Number of property owners trained. Number of renovator and remodelers trained. Number of home inspectors and building officials trained. Housing code developed and distributed. Number of local jurisdictions adopting more protective housing codes. Expanded healthy homes programs.		

Objective 3: Increase the number of community members with skills to prevent lead poisoning.		
Strategies	Critical Partners	Timeline
1. Train critical partners from the community to educate others in prevention strategies. Use train-the-trainer model.	The Way Home, Home Visiting NH, WIC, Head Start, Healthy Child Care NH, Minority Health Coalition, health care providers, Local Lead Action Committees	Six trainings annually
2. Provide technical assistance for community-based outreach, education and advocacy efforts (incorporating easy to read and culturally appropriate materials).	hardware stores, Medicaid, Regional Public Health Networks, NH Division of Historical Resources, Center for Environmental Health Sciences at Dartmouth Medical School	On-going
3. Establish comprehensive prevention campaigns in high-risk areas utilizing best practices in health promotion, behavior change methodology and social marketing.	Center for Environmental Health Sciences at Dartmouth Medical School, Local Lead Action Committees, CDC, NELCC	Manchester - 2005 Other high-risk areas- 2007
4. Integrate lead poisoning prevention and effects of lead on growth and development into curricula for health professions, child care providers and education students. Use train-the-trainer model.	Center for Environmental Health Sciences at Dartmouth Medical School, NH Department of Education, child care providers	2006
Evaluation Plan: Training, technical assistance, outreach and advocacy tracked by phone log, reports, and education logs. Prevention campaigns developed, implemented, evaluated and shared with other high-risk areas. Number of curricula including lead information. Number of trainings in prevention and implications of lead poisoning.		

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Objective 4: Enforce RSA 130-A and He-P 1600 and assist with federal law compliance.		
Strategies	Critical Partners	Timeline
1. Increase the number of properties in compliance with an Order of Lead Hazard Reduction (Order).	The Way Home, HUD, EPA, NH Property Owners Association, NH Housing Finance Authority, NH Attorney General, lending institutions	On-going
2. License and certify lead professionals.	Lead training providers, NH Department of Environmental Services	On-going
3. Assure compliance with state regulations during lead hazard reduction work.	Licensed lead professionals, Local Health Officers, NH Building Officials Association	On-going
4. Provide compliance assistance to individuals and organizations regarding the Disclosure Rule and Pre-Renovation Education Rule. Make referrals to EPA and HUD.	HUD, EPA, NH Property Owners Association, Granite State Managers Association, NH Housing Finance Authority, Local Lead Action Committees	On-going
5. Develop project proposals for Supplemental Environmental Projects (SEPs) and Child Health Improvement Projects (CHIPs) in each high-risk area.	Local Lead Action Committees	July 2005
Evaluation Plan: Percentage of properties in compliance with Orders. Number of lead professionals licensed and certified. Number of individuals provided with compliance assistance materials. Number of on-site compliance visits. Project proposals developed.		

Objective 5: Strengthen state policies addressing childhood lead poisoning.		
Strategies	Critical Partners	Timeline
1. Research policy initiatives that have proven effective in other states.	CDC, HUD, EPA, Center for Environmental Sciences at Dartmouth Medical School	June 2005
2. Provide findings of research to stakeholders for their consideration for potential policy action.	Local Lead Action Committees	On-going
3. Provide technical assistance to local officials in the high-risk areas to support the use of Community Development Block Grant (CDBG) funds to increase the number of lead-safe housing units.	Local Lead Action Committees, NH Housing Finance Authority, public housing authorities	On-going
4. Develop proposal to include lead poisoning prevention in the NH Child Advocacy Network's Children's Action Agenda.	NH Children's Alliance	Summer 2005
Evaluation Plan: Report of effective policy initiatives. Number of presentations to local officials. Childhood lead poisoning prevention on the Children's Action Agenda.		

Secondary Prevention Goal: Increase screening of children at highest risk for lead exposure.		
Objective 1: Increase adherence to the <i>NH Childhood Lead Poisoning Screening and Management Guidelines</i> .		
Strategies	Critical Partners	Timeline
1. Increase screening of children enrolled in Medicaid, WIC, and/or Head Start at 12- and 24-months of age (or < 72 months if not previously tested).	Medicaid, WIC, Head Start, Maternal and Child Health contract agencies, health care providers, Nashua Health Department, Manchester Health Department, Child Health Services, health professional associations	On-going
2. Increase screening of children: a. living in pre-1950 housing b. living in or spending time in pre-1978 housing with recent renovations.	see critical partners above	On-going
3. Increase health care provider awareness of federal and state mandates for screening of children enrolled in Medicaid at 12- and 24-months of age.	Maternal and Child Health, health care providers, Medicaid, health professional associations, Local Lead Action Committees	On-going
Evaluation Plan: Percentage of screening increased in high-risk populations. Documentation of provider outreach and change in statewide and Medicaid screening rates.		

Objective 2: Ensure best practices of case management are implemented.		
Strategies	Critical Partners	Timeline
1. Revise <i>NH Childhood Lead Poisoning Screening and Management Guidelines</i> by adopting CDC case management guidelines. Endorsement by professional associations in NH.	CDC, Maternal and Child Health contract agencies, Manchester Health Department, Nashua Health Department, Child Health Services, health care provider associations	Summer 2004
2. Provide timely testing, clinical follow-up and care coordination for children with elevated blood lead levels.	Manchester Health Department, Nashua Health Department, Child Health Services, health care providers	On-going
3. Provide timely environmental investigations to identify lead exposure hazards within dwellings where children with elevated blood lead levels reside.	Manchester Health Department, Nashua Health Department, Child Health Services, health care providers, The Way Home	On-going
4. Continue to receive reimbursement for case management services for Medicaid-enrolled children.	Medicaid	Quarterly
Evaluation Plan: NH Screening Guidelines revised and distributed. Percentage of timely confirmatory and follow-up testing. Timeliness of environmental investigations and identification of source of lead exposure. Amount of quarterly reimbursement from Medicaid for case management services.		

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Surveillance Goal: Maintain the integrity of surveillance data.		
Objective 1: Improve blood lead surveillance data management to more effectively direct childhood lead poisoning elimination activities.		
Strategies	Critical Partners	Timeline
1. Improve data management by incorporating surveillance and case management software.	CDC	On-going
2. Improve laboratory reporting of blood lead test results and demographic data.	Laboratories, health care providers	On-going
3. Share surveillance data with agencies serving high-risk children.	WIC, Medicaid, Head Start, Maternal and Child Health contract agencies, Manchester Health Department, Nashua Health Department, Child Health Services	At least annually for all critical partner groups, ad hoc reporting as requested
4. Continue to include lead surveillance data in Annual NH Kids Count Report.	state agencies	Annually
Evaluation Plan: Monitor data for accuracy and completeness. Increased completeness of data initially reported by laboratories. Surveillance reports distributed.		

Evaluation Plan for Eliminating Childhood Lead Poisoning in New Hampshire

Resources	Activities	Outputs Short	Outcomes	Impact
In order to accomplish the activities, the following are needed:	To address the problem, the following will be accomplished:	The activities will produce the following evidence:	The activities will lead to the following changes in 1-3 years:	The activities will lead to the following changes in 4-6 years:
<ul style="list-style-type: none"> • Qualified staff • Funding • Childhood Lead Poisoning Advisory Committee • Local Lead Action Committees (LLAC) • NH State agencies' support • Public housing authorities' support • Legislative support • Federal partners • Contracts with local agencies 	<ul style="list-style-type: none"> • Designate high-risk populations, geographic areas and housing • Maintain LLACs • Provide training & technical assistance • Develop housing codes • Increase healthy homes initiatives • Increase compliance activities • License & certify lead professionals • Research effective public policies • Develop proposal for Children's Agenda • Promote adherence to NH Screening Guidelines • Match WIC & Medicaid data • Monitor & evaluate data 	<ul style="list-style-type: none"> • High-risk populations, geographic areas and housing identified • LLAC activities • Number of trainings and participants • Safer housing codes • Increased healthy homes programs • Prevention campaign • Increased percentage of properties in compliance with Orders • Number of licensed & certified lead professionals • Report legislative initiatives • Increased screening • Timely confirmatory and follow-up testing and timely environmental investigations • Medicaid reimbursement • Complete data 	<ul style="list-style-type: none"> • Increased number of lead-safe homes • Lead safe renovation & maintenance methods are standard practice • Decreased incidence & prevalence of EBLLs • Local jurisdictions adopt protective housing codes • Effective & empowered critical partners • Protective legislation • Increase in knowledge, attitudes & behaviors • Accurate data focusing prevention activities 	<ul style="list-style-type: none"> • Childhood lead poisoning (>10 ug/dL) eliminated in children under six years of age in New Hampshire

Evaluation Narrative

The program logic model is defined as a picture of how your organization does its work – the theory and assumptions underlying the program. A program logic model links outcomes (both short- and long-term) with program activities/ processes and the theoretical assumptions/principles of the program. In general, logic modeling can greatly enhance the participatory role and usefulness of evaluation as a management and learning tool. Developing and using logic models is an important step in building community capacity and strengthening community voice. The ability to identify outcomes and anticipate ways to measure them provides all program participants with a clear map of the road ahead. (W.K. Kellogg Foundation, 2001)

Building community capacity plays an important role in this strategic plan. The CLPPP and the Advisory Community wish to continue to strengthen the community voice of all involved in eliminating childhood lead poisoning. For these

reasons, using the logic model to guide all critical partners on the road to elimination of childhood lead poisoning makes the most sense.

The CLPPP will monitor all activities and progress in the strategies identified in the goals and objectives section. Monitoring short- and long-term outcomes will be done by the CLPPP staff working in that program content area and/or with critical partners involved in the program content area. Each CLPPP staff member will report progress to the program manager on a quarterly basis. Data to track progress for the indicators will be available through blood lead surveillance databases, housing databases, reports from critical partners, licensing and certification databases, training logs, phone consultation logs, screening matching data reports and various other sources.

As this plan is implemented, the CLPPP expects that some strategies will need modification. New goals and objectives may be added, while others are discarded. The purpose of continually evaluating progress is to effectively and efficiently address the goal of eliminating childhood lead poisoning.

A semi-annual review will be conducted by the Advisory Committee to

determine if appropriate progress is being made. The Advisory Committee will assist the CLPPP in redirecting resource appropriately toward more effective strategies. Any effective strategies used by Local Lead Action Committees will be shared in other high-risk areas. Sharing information on successes and barriers with other stakeholder groups (e.g., health care providers, CAP agencies, property owners) will foster collaboration and facilitate the use of best practices.

An annual report on the progress toward elimination of childhood lead poisoning in New Hampshire will be provided to the Centers for Disease Control and Prevention and the Advisory Committee by September 30th of each year. The report will contain revisions to this strategic plan based on evaluation of progress and detail any necessary changes in moving forward with the plan.

Vision for the Future

To be recognized as a model of excellence in promoting healthy home environments for children.

The New Hampshire Childhood Lead Poisoning Prevention Program wishes to expand its mission in the future. The

CLPPP will continue to collaborate with federal, state and local agencies working on healthy home initiatives to efficiently address multiple hazards within homes of families with young children. Every child deserves a safe and healthy home.

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Appendix A

Children Screened for Lead Poisoning 1999-2002

Eliminating Childhood Lead Poisoning in New Hampshire

**Childhood Lead Poisoning Prevention Program
Statewide Lead Screenings by Year By Age by Lead Level Range**

YEAR	Age	Blood Lead Range				Grand Total	Pct Elevated (<10 ug/dl)	Screen Rates
		<10	10-14	15-19	20+			
1999	1 Yr	7,733	188	40	40	8,001	3.3%	55.4% 24.4%
	2 Yrs	3,262	153	39	22	3,476	6.2%	
	3-5 Yrs	2,646	125	26	15	2,812	5.9%	
	Over 5 Yrs	607	18	2	1	628	3.3%	
1999 Total		14,248	484	107	78	14,917	4.5%	
2000	1 Yr	7,364	146	29	25	7,564	2.6%	53.8% 23.6%
	2 Yrs	3,222	138	38	14	3,412	5.6%	
	3-5 Yrs	2,595	111	18	16	2,740	5.3%	
	Over 5 Yrs	639	14	2	4	659	3.0%	
2000 Total		13,820	409	87	59	14,375	3.9%	
2001	1 Yr	7,443	147	40	17	7,647	2.7%	52.4% 23.4%
	2 Yrs	3,090	148	25	23	3,286	6.0%	
	3-5 Yrs	2,509	141	26	16	2,692	6.8%	
	Over 5 Yrs	602	30	13	2	647	7.0%	
2001 Total		13,644	466	104	58	14,272	4.4%	
2002	1 Yr	7,589	176	38	23	7,826	3.0%	53.6%* 27.2%
	2 Yrs	3,645	132	29	11	3,817	4.5%	
	3-5 Yrs	2,439	83	14	15	2,551	4.4%	
	Over 5 Yrs	600	7	5		612	2.0%	
2002 Total		14,273	398	86	49	14,806	3.6%	

* Uses the number of births in 2000 as denominator - 2001 births were not available.

Appendix B

Estimated Number of Children with Elevated Blood Lead Levels

Estimated Number of Children with Elevated Blood Lead Levels

2002 Lead Testing Results for New Hampshire

Category	Age Group	2002 Pop	Elevated	Not Elevated	Total Tested	Percent Elevated	Percent Tested	Estimated Number of Children with Elevated Blood Lead Levels
Berlin	1 Yr	102	4	112	116	3.4%	113.5%	4
Claremont	1 Yr	153	11	117	128	8.6%	83.7%	13
Franklin	1 Yr	123	6	66	72	8.3%	58.3%	10
Laconia	1 Yr	180	2	84	86	2.3%	47.8%	4
Manchester	1 Yr	1,464	54	949	1,003	5.4%	68.5%	79
Nashua	1 Yr	1,140	8	558	566	1.4%	49.6%	16
Other Towns	1 Yr	11,989	138	5,453	5,591	2.5%	46.6%	296
Total	1 Yr	15,151	223	7,339	7,562	2.9%	49.9%	422
Berlin	2 Yrs	102	5	76	81	6.2%	79.3%	6
Claremont	2 Yrs	153	5	76	81	6.2%	52.9%	9
Franklin	2 Yrs	123	7	22	29	24.1%	23.5%	30
Laconia	2 Yrs	180	5	27	32	15.6%	17.8%	28
Manchester	2 Yrs	1,464	40	582	622	6.4%	42.5%	94
Nashua	2 Yrs	1,140	3	266	269	1.1%	23.6%	13
Other Towns	2 Yrs	11,989	102	2,458	2,560	4.0%	21.4%	478
Total	2 Yrs	15,151	167	3,507	3,674	4.5%	24.2%	658
Berlin	3-5 Yrs	371	6	65	71	8.5%	19.2%	31
Claremont	3-5 Yrs	541	7	25	32	21.9%	5.9%	118
Franklin	3-5 Yrs	414	4	18	22	18.2%	5.3%	75
Laconia	3-5 Yrs	661	2	14	16	12.5%	2.4%	83
Manchester	3-5 Yrs	5,094	33	345	378	8.7%	7.4%	445
Nashua	3-5 Yrs	4,100	10	312	322	3.1%	7.9%	127
Other Towns	3-5 Yrs	44,054	48	1,594	1,642	2.9%	3.7%	1,288
Total	3-5 Yrs	55,235	110	2,373	2,483	4.4%	4.5%	2,167
Grand Total	All Ages	85,536	500	13,219	13,719	3.6%	16.0%	3,248

1. population estimates taken from 2002 population projections for "0 to 4" and "5 to 9" age groups based on 0.2*0 to 4" for both 1 Yr and 2 Yrs age groups, and 0.5 * "0 to 4" + 0.2 * "5 to 9" for 3-5 Yrs age group.

2. Projecting rates of positive lead tests on the population of children not tested causes bias in overestimating the expected number of positive tests. Children at higher risk are more often selected for testing, such as children known to live in older housing or children with previously elevated test results. This is also the likely reason why children in the 3-5 year age groups, in the higher risk towns, have higher rates than the two younger age groups.

3. Town grouping received with data. Towns listed by name are targeted as having a higher percentage of homes constructed before 1950 and a higher risk to children of lead exposure due to lead-based paint chips and dust.

4. Note that the Total and Grand Total "**Estimated Number of Children with Elevated Blood Levels**" are based on summing age-specific estimates and are not based on generating estimates using Total and Grand Total numbers and percentages.

5. Note that the Percent tested in Berlin is greater than 100 percent due to families moving to and from the City.

Appendix C

List of Childhood Lead Poisoning Advisory Committee Members

Eliminating Childhood Lead Poisoning in New Hampshire

**NH Childhood Lead Poisoning Prevention Program
Statewide Advisory Committee Member List**

Member Name	Affiliation
Melissa McAllister	Anthem Blue Cross Blue Shield
Ralph Littlefield	Belknap/Merrimack County Community Action Program
Linda Slowik	Berlin/Gorham Health & Safety Partnership
Laura Viger	Berlin Health Department
Mary-Jo Landry	Berlin Housing Authority
Jeanne Galloway	Caring Communities Network of the Twin Rivers
Connie Thomas	CDC, Lead Poisoning Prevention Branch
Angel Miller	CMS, Division of Medicaid and Children's Health
Jack Lightfoot	Child & Family Services
Carol Kohen	Child Health Services
Robert Nordgren	Child Health Services
Elizabeth Winger	Child Health Services
Ellen Shemitz	Children's Alliance of NH
Kelly LaFlamme	Children's Alliance of NH, Child Advocacy Network
Patrice Jackson	Cigna Health Care
Joe Labontee	City of Concord, Code Enforcement
Charles Bodien	City of Franklin, Health Officer & Code Enforcement
Carrie Campbell	City of Manchester, Public Health Department
Sue Gagnon	City of Manchester, Public Health Department
Meredith Maruyama	City of Manchester, Public Health Department
Paul Etkind	City of Nahsua, Public Health Department
Heidi Peek	City of Nashua, Public Health Department
Stefan Russakow	City of Nashua, Public Health Department
Betty Wendt	City of Nashua, Public Health Department
Nancy Girard	Conservation Law Foundation
James Sargent	Dartmouth Hitchcock Medical Center
Nancy Serrell	Dartmouth Medical School - Center for Environmental Sciences
Andrew Gray	Governor's Office of Energy & Community Services
Christine Warburton	Franklin Housing Authority
Jean Learnard	Good Beginnings
Jodi Courtney	Granite State (property) Managers Association
William Straughn III	Hitchcock Clinic Manchester
Patti Allen	Home Builders and Remodelers Association of NH
Charlotte Debois	Laconia Housing and Redevelopment Authority
Brian Beals	Mountain Health Services
Jan Pendlebury	National Environmental Trust - NH Office
Michael Santa	NH Building Officials Association
Ruth Littlefield	NH Department of Education
Neil Twitchell	NH Department of Environmental Services
Kenneth Dufault	NH DHHS, Public Health Development Program
Lindsay Dearborn	NH DHHS, Asthma Control Program

Eliminating Childhood Lead Poisoning in New Hampshire

Member Name	Affiliation
Audrey Knight	NH DHHS, Bureau of Maternal & Child Health
Lisa Richards	NH DHHS, WIC
Louise Hannon	NH DHHS, Health Officer Liason
Betty Thompson	NH DHHS, Medicaid Administrative Services
William J. Kassler	NH DHHS, Medical Director
George Robinson	NH DHHS, Public Health Laboratories
Linda Ray Wilson	NH Division of Historical Resources
Michelle Dodge	NH EDS – Medicaid
Tricia Brooks	NH Healthy Kids
Bill Guinther	NH Housing Finance Authority
Elliot Berry	NH Legal Assistance
Bobbi Bagley	NH Minority Health Coalition
Jazmin Miranda-Smith	NH Minority Health Coalition
Linda Mattlage	NH Nurse Practitioner Association
Robert Best	NH Nurse Association
Lin Courtemanche	NH Poison Information Center
Susan Dobens	NH Property Owners Association
Joe Nelson	NH Property Owners Association
Kevin Sheehan	Parent
Paula Samson	Public Health & Safety Partnership of the Lakes Region
Jen Kozaczek	Southwestern Community Services Head Start
Lori LaBrie	Southwestern Community Services Head Start
Linda Kincaid	Southern NH Services Child Development Program
Heather MacDonald	Southern NH Services Child Development Program
Carol Delaurier	Strafford County Head Start
Emilia Belouin	The Way Home
Mary Sliney	The Way Home
Susan Linsey	Upper Valley Health Officers
Kristi Rea	US Environmental Protection Agency – New England

Appendix D

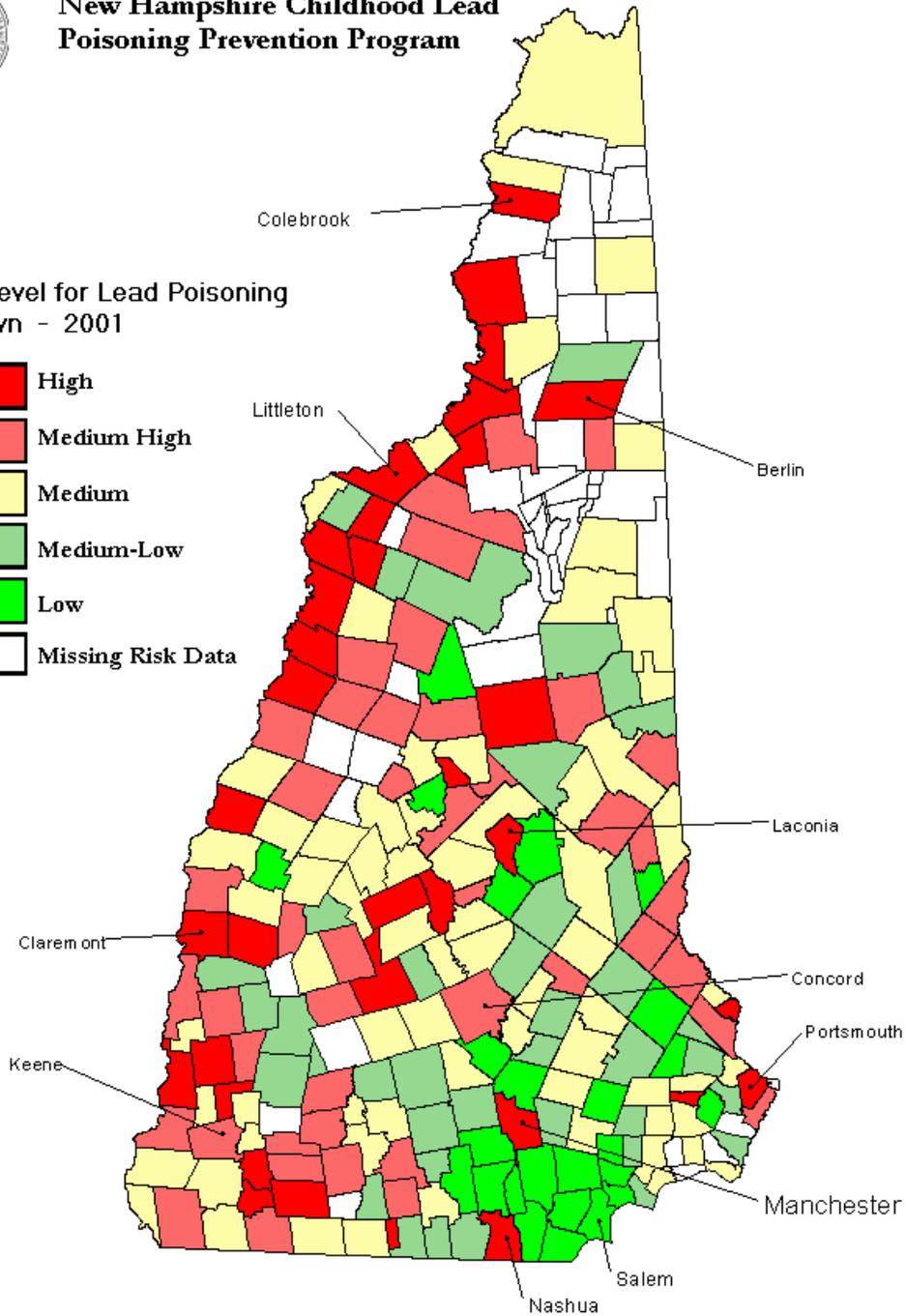
Risk Level for Poisoning by Town, 2001 Map

Eliminating Childhood Lead Poisoning in New Hampshire



New Hampshire Childhood Lead Poisoning Prevention Program

**Risk Level for Lead Poisoning
By Town - 2001**



Risk is determined by a combination of (1) percentage of housing built before 1950, (2) percentage of children under 6 enrolled in Medicaid, (3) percentage of children under age 6 enrolled in WIC, and (4) percentage of one and two year old children.

Missing risk data: values for one of these four factors is missing

10/16/2002

C. Cullinan

Appendix E

Blood Lead Testing Among Children Living in High Risk Towns

Eliminating Childhood Lead Poisoning in New Hampshire

Blood Lead Testing Among Children Living in High Risk Towns					
NH Children Under 6 Years of Age					
Calendar Year 2003					
	Elevated	Not Elevated	Total Screened	Pct Elevated Among Children Screened	Percent Pre-50 Housing
Berlin	31	220	251	12.4%	70.2%
Claremont	15	236	251	6.0%	48.0%
Franklin	19	101	120	15.8%	47.7%
Laconia	24	105	129	18.6%	48.1%
Manchester	195	2,042	2,237	8.7%	45.4%
Nashua	31	1,237	1,268	2.4%	46.3%
Newport	7	140	147	4.8%	45.0%
All Other Towns	464	10,053	10,517	4.4%	31.4%
NH Total	786	14,134	14,920	5.3%	32.1%

Appendix F

List of Local Lead Action Committee Members and Town Information

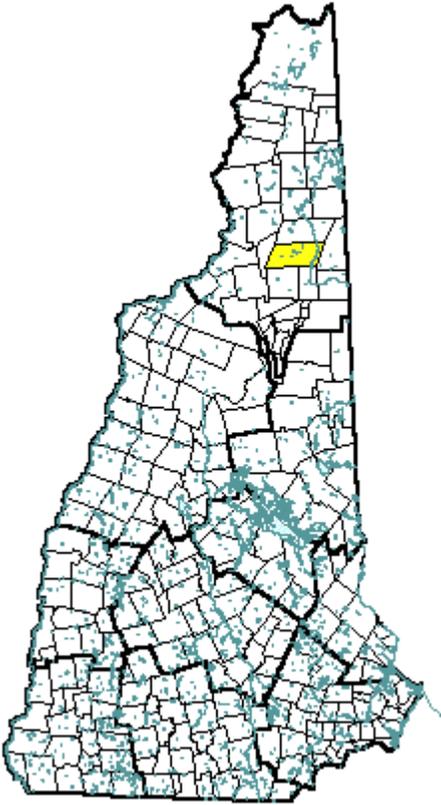
**NH Childhood Lead Poisoning Prevention Program
Berlin Local Lead Action Committee**

Member Name

Affiliation

Mary Jo Landry	Berlin Housing
Patty Poulin	Coos County Health Services
Randall Trull	Fire Chief
Laura Viger	Health Officer
Pam Laflamme	Planning Director
Linda Slowik	Public Health Network
Lawrence Kelly	Tri County CAP
Nancy Bangs	WIC Supervisor

Berlin, NH



Community Contact

City of Berlin
Patrick MacQueen, City Manager
168 Main Street, City Hall
Berlin, NH 03570

Telephone
Fax
E-mail
Web Site

(603) 752-7532
(603) 752-8550
bcm@ncia.net
www.ci.berlin.nh.us

Municipal Office Hours

Monday through Friday, 8:30 am - 4:30 pm

County
Tourism Region
Planning Commission
Regional Development

Coos
Great North Woods
North Country Council
Coos Economic Development Corp.

Election Districts

US Congress
Executive Council
State Senate
State Representative

District 2 (All Wards)
District 1 (All Wards)
District 1 (All Wards)
District 3 (All Wards)

Incorporated: 1829

Origin: First granted in 1771 as Maynesborough, after Sir William Mayne, an associate of Governor John Wentworth in the West Indies trade. The area was not settled by the original grantees, and the town was renamed Berlin in 1829 by new settlers from Berlin, Massachusetts. Berlin was incorporated as a city in 1897. It is the northernmost city in the state, and includes the village of Cascade.

Population, Year of the First Census Taken: 73 residents in 1830

Population Trends: Berlin experienced more population decline than growth since 1950, and had both the largest percent and largest numeric decrease over fifty years. After growing by seven percent between 1950-1960, the population decreased by at least ten percent each decade. Berlin's 1950 population of 16,615 dropped to 10,331 residents by 2000, declining by a total of 6,284 residents. The 2003 Census estimate for Berlin was 10,122 residents, which ranked 28th among New Hampshire's incorporated cities and towns.

Population Density, 2003: 171.5 persons per square mile of land area. Berlin contains 61.5 square miles of land area and 0.7 square miles of inland water area.

Villages and Place Names: Cascade, Berlin Mills



Coos County

MUNICIPAL SERVICES

Type of Government	Manager & Council
2004 Annual Budget	\$28,900,000
Zoning Ordinance	1964/00
Master Plan	1992
Capital Improvement Plan	Yes
Industrial Plans Reviewed By	Planning Board

Boards and Commissions

Elected:	City Council; School Board
Appointed:	Planning Board; Zoning Board; Library Trustees

Public Library Berlin Public

EMERGENCY SERVICES

Police Department	Full-time
Fire Department	Full-time
Town Fire Insurance Rating	5/9
Emergency Medical Service	Commercial

Nearest Hospital(s):

Androscoggin Valley, Berlin

Distance: Local Staffed Beds: 59

UTILITIES

Electric Supplier	PSNH
Natural Gas Supplier	Portland Natural Gas; KeySpan
Water Supplier	Berlin Water Works

Sanitation	Municipal
Municipal Wastewater Treatment Plant	Yes
Solid Waste Disposal	
Curbside Trash Pickup	Municipal
Pay-As-You-Throw Program	No
Recycling Program	Voluntary

Telephone Company	Verizon
Cellular Telephone Access	Yes
Cable Television Access	Yes
High Speed Internet Service:	Business Yes
	Residential Yes

PROPERTY TAXES

2003 Total Tax Rate (per \$1000)	\$44.42
2003 Equalization Ratio	70.9
2003 Full Value Tax Rate (per \$1000)	\$36.43

2003 Percent of Property Valuation by Type

Residential Land and Buildings	56.0%
Commercial Land and Buildings	18.3%
Other Property including Utilities	25.7%

HOUSING

2002 Total Housing Units	5,079
2002 Single-Family Units	2,496
Building Permits Issued	0
2002 Multi-Family Units	2,494
Building Permits Issued	-9
2002 Manufactured Housing Units	89

DEMOGRAPHICS

Total Population	Community	County
2003	10,122	33,019
2000	10,331	33,111
1990	11,824	34,828
1980	13,084	35,014
1970	15,256	34,189

Census 2000 Demographics

Population by Gender		
Male	4,922	Female 5,409

Population by Age Group

Under age 5	529
Age 5 to 19	1,914
Age 20 to 34	1,590
Age 35 to 54	2,965
Age 55 to 64	997
Age 65 and over	2,336
Median Age	42.5 years

Educational Attainment, population 25 years and over

High school graduate or higher	72.6%
Bachelor's degree or higher	6.7%

ANNUAL INCOME, 1999

(Census 2000)

Per capita income	\$15,780
Median 4-person family income	\$38,750
Median household income	\$29,647

Median Earnings, full-time, year-round workers

Male	\$33,190
Female	\$21,156

Families below the poverty level

9.1%

LABOR FORCE

Annual Average	1993	2003
Civilian labor force	5,659	5,098
Employed	5,070	4,827
Unemployed	589	271
Unemployment rate	10.4%	5.3%

EMPLOYMENT & WAGES

1993 2003

Goods Producing Industries		
Average Employment	1,930	1,057
Average Weekly Wage	\$659	\$776

Service Providing Industries

Average Employment	1,961	1,949
Average Weekly Wage	\$345	\$523

Total Private Industry

Average Employment	3,891	3,006
Average Weekly Wage	\$501	\$612

Government (Federal, State, and Local)

Average Employment	939	1,295
Average Weekly Wage	\$437	\$591

Total, Private Industry plus Government

Average Employment	4,830	4,301
Average Weekly Wage	\$488	\$606

n = indicates that data does not meet disclosure standards

EDUCATION AND CHILD CARE

Schools students attend: **Berlin operates grades K-12** District: **SAU 3**
 Career Technology Center(s): **Berlin High School** Region: **02**

Educational Facilities	Elementary	Middle/Junior High	High School	Private/Parochial
Number of Schools	4	1	1	1
Grade Levels	K 1-6	7-8	9-12	K-8
Total Enrollment	745	307	609	n/a

NH Licensed Child Care Facilities, 2003: Total Facilities: **8** Total Capacity: **296**

Nearest Community/Technical College: **Berlin**

Nearest Colleges or Universities: **College for Lifelong Learning-Berlin**

LARGEST EMPLOYERS	PRODUCT/SERVICE	EMPLOYEES	ESTABLISHED
Fraser Papers	Pulp, paper	500	1852
Androscoggin Valley Hospital	Health care	336	1971
Berlin City Dealerships	Auto dealerships	205	1981
City of Berlin	Municipal services	170	1825
Isaacson Steel	Steel fabricators	147	1962
Androscoggin Valley Home Care Services	Home care	132	1975
Appalachian Mountain Club	Outing club	125	1888
Royalty Inn & Athletic Club	Inn, health club, restaurant	78	
Berlin City Bank	Banking	70	1934

TRANSPORTATION

Road Access	Federal Routes	2
	State Routes	16, 110
Nearest Interstate, Exit	I-93, Exit 35	
Distance	43 miles	
Railroad	Canadian National/B&M	
Public Transportation	Yes	
Nearest Airport	Berlin	
Runway	5,200 feet	
Lighted?	Yes	
Nearest Commercial Airport	Portland, ME	
Distance	100 miles	
Driving distance to select cities:		
Manchester, NH	132 miles	
Portland, Maine	99 miles	
Boston, Mass.	171 miles	
New York City, NY	370 miles	
Montreal, Quebec	179 miles	

COMMUTING TO WORK

(Census 2000)

Workers 16 years and over	
Drove alone, car/truck/van%	81.4%
Carpooled, car/truck/van	12.1%
Public transportation	0.4%
Walked	4.6%
Other means	0.8%
Worked at home	0.7%
Mean Travel Time to Work	15.4 minutes
Percent of Working Residents:	
Working in community of residence	69%
Commuting to another NH community	29%
Commuting out-of-state	2%

RECREATION, ATTRACTIONS, AND EVENTS

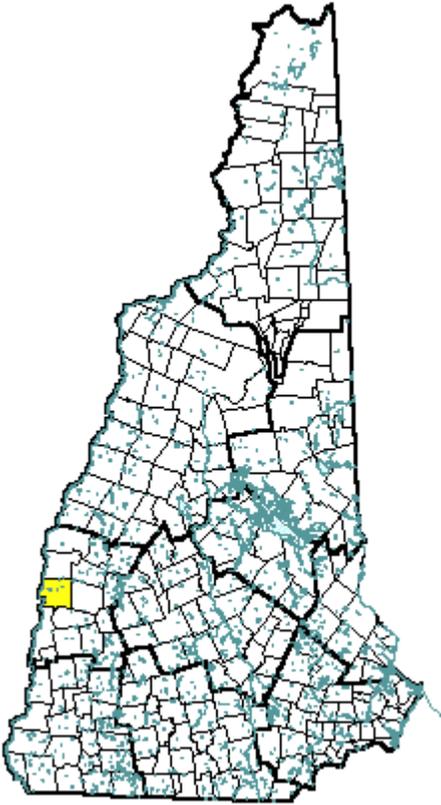
X	Municipal Parks
	YMCA/YWCA
	Boys Club/Girls Club
X	Golf Courses
	Swimming: Indoor Facility
	Swimming: Outdoor Facility
	Tennis Courts: Indoor Facility
X	Tennis Courts: Outdoor Facility
X	Ice Skating Rink: Indoor Facility
X	Bowling Facilities
X	Museums
X	Cinemas
X	Performing Arts Facilities
X	Tourist Attractions
X	Youth Organizations (i.e., Scouts, 4-H)
X	Youth Sports: Baseball
X	Youth Sports: Soccer
	Youth Sports: Football
X	Youth Sports: Basketball
X	Youth Sports: Hockey
	Campgrounds
X	Fishing/Hunting
X	Boating/Marinas
X	Snowmobile Trails
	Bicycle Trails
X	Cross Country Skiing
X	Beach or Waterfront Recreation Area
	Nearest Ski Area(s): Wildcat
	Other: Northern Forest Heritage Park; Nansen Ski Jump; Historic Churches; Moose Tours; Hiking; Canoe/Kayak; Boat Tours.

NH Childhood Lead Poisoning Prevention Program

Claremont-Newport Local Lead Action Committee

Members Name	Affiliation
Marie Miller	Claremont Headstart
Ellie Tsetsi	Good Beginnings
Louis Lambert	Lambert Building Supply Company
Gary Doiron	LaValley Building Supply
Lisa Cilley	Marro Home Center
Patty Miller	Marro Home Center
Jan Pendlebury	National Environmental Trust
Corrina Young	Newport Headstart
Jody Healy	Newport Headstart
Katie Lajoie	NH CLPPP
Ben Mortell	NH Legal Assistance
Jill Brooker	NH Poison Control
Jim Sullivan	Resident
Susan Linsey	Upper Valley Health Officer Coalition

Claremont, NH



Community Contact

Claremont Planning & Development
Anthony Lyons
14 North St.
Claremont, NH 03743

Telephone
Fax
E-mail
Web Site

(603) 542-7030
(603) 542-7033
alyons@claremontnh.com
www.claremontnh.com

Municipal Office Hours

Monday through Friday, 8:30 am - 5 pm

County
Tourism Region
Planning Commission
Regional Development

Sullivan
Dartmouth-Lake Sunapee
Upper Valley/Lake Sunapee
Western Region Development Corp.

Election Districts

US Congress
Executive Council
State Senate
State Representative

District 2 (All Wards)
District 1 (All Wards)
District 8 (All Wards)
District 22 (All Wards)

Incorporated: 1764

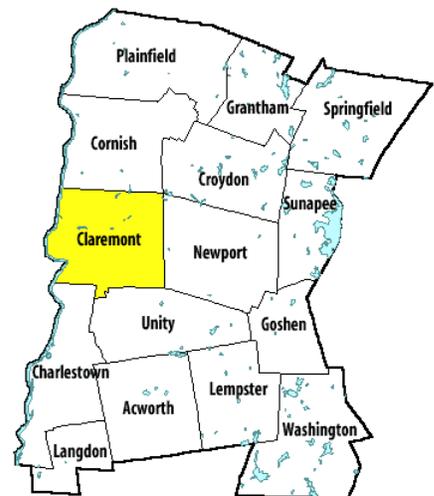
Origin: Named in honor of Thomas Pelham Holles, Earl of Clare and Duke of Newcastle, builder of Claremont Castle, and a cousin to Governor Benning Wentworth. The original grant was a six-mile square area bordering the Connecticut River. Claremont was incorporated as a city by popular vote in 1947. It is the home of New Hampshire's first Roman Catholic Church, built in 1823.

Population, Year of the First Census Taken: 88 residents in 1830

Population Trends: Claremont's population grew by a mere three percent over the last five decades, posting the sixth smallest fifty-year increase. The highest decennial growth was six percent between 1950-1960, and the lowest a five percent decrease between 1990-2000. Claremont's 1950 population of 12,811 increased by 340 residents, reaching 13,151 by the 2000 Census. The 2003 Census estimate for Claremont was 13,355 residents, which ranked 19th among New Hampshire's incorporated cities and towns.

Population Density, 2003: 305.6 persons per square mile of land area. Claremont contains 43.1 square miles of land area and 0.9 square miles of inland water area.

Villages and Place Names: Claremont, Claremont Junction, Puckershire, West Claremont



Sullivan County

MUNICIPAL SERVICES

Type of Government	Manager & Council
2003 Annual Budget	\$15,441,481
Zoning Ordinance	1952/03
Master Plan	2001
Capital Improvement Plan	Yes
Industrial Plans Reviewed By	Planning Board

Boards and Commissions

Elected:	City Council
Appointed:	Planning Board; Zoning Board; Library Trustees; Conservation Commission

Public Library **Fiske Free**

EMERGENCY SERVICES

Police Department	Full-time
Fire Department	Full-time
Town Fire Insurance Rating	4/9
Emergency Medical Service	Commercial

Nearest Hospital(s):

Valley Regional, Claremont
Distance: **Local** Staffed Beds: **28**

UTILITIES

Electric Supplier	PSNH; NH Elec. Coop.
Natural Gas Supplier	None
Water Supplier	Claremont Water Dept.

Sanitation	Municipal
Municipal Wastewater Treatment Plant	Yes
Solid Waste Disposal	None
Curbside Trash Pickup	None
Pay-As-You-Throw Program	Yes
Recycling Program	Mandatory

Telephone Company	Verizon
Cellular Telephone Access	Yes
Cable Television Access	Yes
High Speed Internet Service:	Yes
Business	Yes
Residential	Limited

PROPERTY TAXES

2003 Total Tax Rate (per \$1000)	\$33.84
2003 Equalization Ratio	94.2
2003 Full Value Tax Rate (per \$1000)	\$31.53

2003 Percent of Property Valuation by Type	
Residential Land and Buildings	66.5%
Commercial Land and Buildings	30.3%
Other Property including Utilities	3.2%

HOUSING

2002 Total Housing Units	6,067
2002 Single-Family Units	3,170
Building Permits Issued	5
2002 Multi-Family Units	2,425
Building Permits Issued	-2
2002 Manufactured Housing Units	472

DEMOGRAPHICS

Total Population	Community	County
2003	13,355	42,048
2000	13,151	40,458
1990	13,902	38,592
1980	14,557	33,063
1970	14,221	30,949

Census 2000 Demographics

Population by Gender		
Male	6,323	Female 6,828

Population by Age Group

Under age 5	775
Age 5 to 19	2,605
Age 20 to 34	2,406
Age 35 to 54	3,878
Age 55 to 64	1,270
Age 65 and over	2,217
Median Age	38.8 years

Educational Attainment, population 25 years and over

High school graduate or higher	78.7%
Bachelor's degree or higher	12.8%

ANNUAL INCOME, 1999**(Census 2000)**

Per capita income	\$20,267
Median 4-person family income	\$42,849
Median household income	\$34,949

Median Earnings, full-time, year-round workers

Male	\$30,782
Female	\$22,078

Families below the poverty level	5.4%
----------------------------------	-------------

LABOR FORCE

Annual Average	1993	2003
Civilian labor force	6,589	6,271
Employed	6,120	6,061
Unemployed	469	210
Unemployment rate	7.1%	3.3%

EMPLOYMENT & WAGES**1993 2003**

Goods Producing Industries		
Average Employment	1,787	985
Average Weekly Wage	\$472	\$744

Service Providing Industries		
Average Employment	3,558	3,621
Average Weekly Wage	\$343	\$526

Total Private Industry		
Average Employment	5,345	4,606
Average Weekly Wage	\$386	\$573

Government (Federal, State, and Local)		
Average Employment	701	752
Average Weekly Wage	\$484	\$632

Total, Private Industry plus Government		
Average Employment	6,046	5,358
Average Weekly Wage	\$397	\$581

n = indicates that data does not meet disclosure standards

EDUCATION AND CHILD CARE

Schools students attend: **Claremont operates grades K-12** District: **SAU 6**
 Career Technology Center(s): **Sugar River Valley Tech Center** Region: **10**

Educational Facilities	Elementary	Middle/Junior High	High School	Private/Parochial
Number of Schools	3	1	1	3
Grade Levels	P K 1-5	6-8	9-12	K-12
Total Enrollment	840	512	702	n/a

NH Licensed Child Care Facilities, 2003: Total Facilities: **13** Total Capacity: **331**

Nearest Community/Technical College: **Claremont**
 Nearest Colleges or Universities: **Colby-Sawyer; Magdalen; Dartmouth**

LARGEST EMPLOYERS	PRODUCT/SERVICE	EMPLOYEES	ESTABLISHED
Valley Regional Health Care	Health care	533	1893
Claremont School District	Education	400	1867
Wal-Mart	Department store	300	1993
Customized Structures, Inc.	Prefabricated houses	125	1985
Holson Burnes Group	Photograph albums	90	1978
Crown Point Cabinetry	Custom Cabinets	90	1978
Claremont Savings Bank	Banking	84	1907
Eagle Times Newspaper	Local Newspaper	79	
Sullivan Industries, Inc.	Mining & construction equipment	73	1854
LaCrosse Footwear	Industrial boots	70	1981

TRANSPORTATION

Road Access	Federal Routes	
	State Routes	11, 12, 103, 120
Nearest Interstate, Exit		I-91, Exit 8
Distance		4 miles
Railroad		Amtrak, B & M, CCRR
Public Transportation		Yes
Nearest Airport		Claremont
Runway		3,100 feet
Lighted?	Yes	Navigational Aids? Yes
Nearest Commercial Airport		Lebanon
Distance		22 miles
Driving distance to select cities:		
Manchester, NH		71 miles
Portland, Maine		162 miles
Boston, Mass.		121 miles
New York City, NY		247 miles
Montreal, Quebec		206 miles

COMMUTING TO WORK

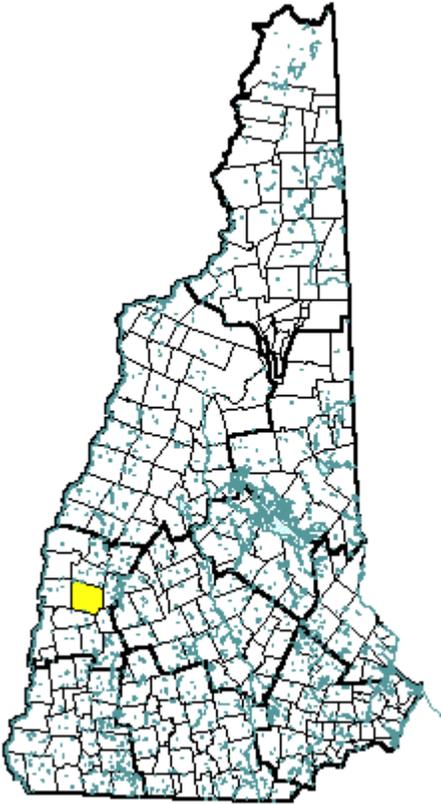
(Census 2000)

Workers 16 years and over	
Drove alone, car/truck/van%	77.1%
Carpooled, car/truck/van	15.6%
Public transportation	0.9%
Walked	2.0%
Other means	0.8%
Worked at home	3.4%
Mean Travel Time to Work	19.2 minutes
Percent of Working Residents:	
Working in community of residence	53%
Commuting to another NH community	37%
Commuting out-of-state	10%

RECREATION, ATTRACTIONS, AND EVENTS

X	Municipal Parks
	YMCA/YWCA
	Boys Club/Girls Club
X	Golf Courses
X	Swimming: Indoor Facility
X	Swimming: Outdoor Facility
	Tennis Courts: Indoor Facility
X	Tennis Courts: Outdoor Facility
	Ice Skating Rink: Indoor Facility
X	Bowling Facilities
X	Museums
X	Cinemas
X	Performing Arts Facilities
	Tourist Attractions
X	Youth Organizations (i.e., Scouts, 4-H)
X	Youth Sports: Baseball
X	Youth Sports: Soccer
X	Youth Sports: Football
X	Youth Sports: Basketball
X	Youth Sports: Hockey
	Campgrounds
X	Fishing/Hunting
X	Boating/Marinas
X	Snowmobile Trails
X	Bicycle Trails
X	Cross Country Skiing
	Beach or Waterfront Recreation Area
	Nearest Ski Area(s): Mount Ascutney & Okemo (VT); Mount Sunapee, Arrowhead
	Other: Historic Opera House, ATV trails

Newport, NH



Community Contact

Town of Newport Planning Department
Julie Collins, Planning & Zoning Coordinator
15 Sunapee Street, Municipal Building
Newport, NH 03773

Telephone
Fax
E-mail
Web Site

(603) 863-6278
(603) 863-8008
topaz@newportnh.net
www.newportnh.net

Municipal Office Hours

Monday through Friday, 8 am - 5 pm; Town Clerk: Monday through Friday 8 am - 4:30 pm

County
Tourism Region
Planning Commission
Regional Development

Sullivan
Dartmouth-Lake Sunapee
Upper Valley/Lake Sunapee
Western Region Development Corp.

Election Districts

US Congress
Executive Council
State Senate
State Representative

District 2
District 1
District 8
District 20

Incorporated: 1761

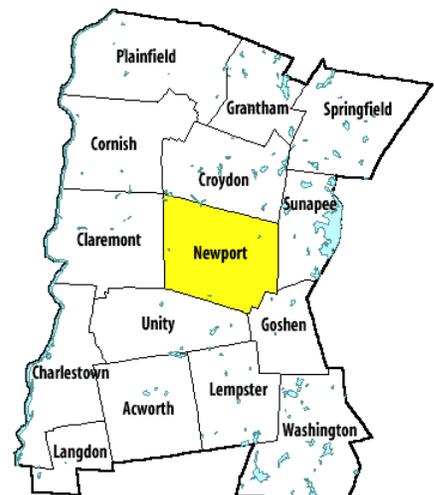
Origin: First settled in 1753, the town was named Grenville, after George Grenville, William Pitt's brother-in-law. In 1761, the town was incorporated as Newport, for Henry Newport, a distinguished English soldier and statesman. An early settler of the town was Gordon Buell, whose daughter, Sarah Josepha Buell Hale, was one of the first women editors in America. She edited the book "Poems for Children" that included "Mary Had A Little Lamb." She was also known for a successful appeal to President Lincoln for creation of a national holiday to be known as Thanksgiving Day. Newport is the county seat of Sullivan County, and includes the villages of Kellyville and Guild.

Population, Year of the First Census Taken: 780 residents in 1790

Population Trends: Newport's population has grown very little over the last five decades. Population growth stayed below ten percent each decade, and ranged from a two percent decrease between 1980-1990 to an eight percent increase between 1960-1970. Over fifty years, Newport grew by a total of 1,138 residents, going from 5,131 in 1950 to 6,269 residents in 2000. The 2003 Census estimate for Newport was 6,441 residents, which ranked 48th among New Hampshire's incorporated cities and towns.

Population Density, 2003: 145.7 persons per square mile of land area. Newport contains 43.5 square miles of land area and 0.1 square miles of inland water area.

Villages and Place Names: Chandlers Mills, Guild, Kelleyville, North Newport, Chandler Station



Sullivan County

MUNICIPAL SERVICES

Type of Government	Selectmen
2004 Annual Budget	\$6,100,000
Zoning Ordinance	1965/04
Master Plan	1995
Capital Improvement Plan	Yes
Industrial Plans Reviewed By	Planning Board

Boards and Commissions

Elected:	Board of Selectmen
Appointed:	Planning Board; Conservation Commission; Library Trustees; Zoning Board of Adjustment; Heritage Commission; Airport Commission; Recreation Advisory Council

Public Library **Richards Free**

EMERGENCY SERVICES

Police Department	Full-time
Fire Department	Full-time
Town Fire Insurance Rating	4/9
Emergency Medical Service	Municipal

Nearest Hospital(s):

Valley Regional, Claremont
Distance: **10 miles** Staffed Beds: **28**

UTILITIES

Electric Supplier	PSNH; NH Elec.; Conn. Valley
Natural Gas Supplier	None
Water Supplier	Newport Water Works
Sanitation	Municipal
Municipal Wastewater Treatment Plant	Yes
Solid Waste Disposal	
Curbside Trash Pickup	None
Pay-As-You-Throw Program	Yes
Recycling Program	Voluntary
Telephone Company	Verizon
Cellular Telephone Access	Yes
Cable Television Access	Yes
High Speed Internet Service:	
Business	Yes
Residential	Yes

PROPERTY TAXES

2003 Total Tax Rate (per \$1000)	\$35.43
2003 Equalization Ratio	68.6
2003 Full Value Tax Rate (per \$1000)	\$24.31
2003 Percent of Property Valuation by Type	
Residential Land and Buildings	66.3%
Commercial Land and Buildings	30.6%
Other Property including Utilities	3.1%

HOUSING

2002 Total Housing Units	2,654
2002 Single-Family Units	1,534
Building Permits Issued	4
2002 Multi-Family Units	844
Building Permits Issued	0
2002 Manufactured Housing Units	276

DEMOGRAPHICS

Total Population	Community	County
2003	6,441	42,048
2000	6,269	40,458
1990	6,110	38,592
1980	6,229	36,063
1970	5,899	30,949

Census 2000 Demographics

Population by Gender		
Male	3,086	Female 3,183

Population by Age Group

Under age 5	398
Age 5 to 19	1,391
Age 20 to 34	1,153
Age 35 to 54	1,845
Age 55 to 64	521
Age 65 and over	961
Median Age	37.1 years

Educational Attainment, population 25 years and over

High school graduate or higher	78.0%
Bachelor's degree or higher	11.8%

ANNUAL INCOME, 1999

(Census 2000)

Per capita income	\$16,964
Median 4-person family income	\$45,508
Median household income	\$37,442

Median Earnings, full-time, year-round workers

Male	\$31,807
Female	\$22,788

Families below the poverty level

10.8%

LABOR FORCE

Annual Average	1993	2003
Civilian labor force	3,010	3,076
Employed	2,844	2,976
Unemployed	166	100
Unemployment rate	5.5%	3.3%

EMPLOYMENT & WAGES

1993 2003

Goods Producing Industries		
Average Employment	2,042	1,563
Average Weekly Wage	\$528	\$744
Service Providing Industries		
Average Employment	1,337	1,479
Average Weekly Wage	\$353	\$498
Total Private Industry		
Average Employment	3,379	3,042
Average Weekly Wage	\$459	\$624
Government (Federal, State, and Local)		
Average Employment	981	754
Average Weekly Wage	\$421	\$491
Total, Private Industry plus Government		
Average Employment	4,361	3,795
Average Weekly Wage	\$450	\$598

n = indicates that data does not meet disclosure standards

EDUCATION AND CHILD CARE

Schools students attend: **Newport operates grades K-12** District: **SAU 43**
 Career Technology Center(s): **Sugar River Valley Tech Center** Region: **10**

Educational Facilities	Elementary	Middle/Junior High	High School	Private/Parochial
Number of Schools	2	1	1	
Grade Levels	K 1-5	6-8	9-12	
Total Enrollment	505	329	443	

NH Licensed Child Care Facilities, 2003: Total Facilities: 5 Total Capacity: 169

Nearest Community/Technical College: **Claremont**
 Nearest Colleges or Universities: **Dartmouth; Colby-Sawyer**

LARGEST EMPLOYERS	PRODUCT/SERVICE	EMPLOYEES	ESTABLISHED
Sturn Ruger & Co.	Sporting firearms	1,100	
Arlington American Sample Co.	Sample books, cards	140	
LaValley Building Supply	Building components	100	
Gloenco-Newport, Inc.	Plastic heat shrink guns	75	
Hartford/Eiclenhauer	Heating elements	70	
Latva Machine Co., Inc.	Precision machine parts	53	
United Construction	Construction contractor	50	
Carroll Concrete	Concrete products	34	
Roymal Coatings & Chemicals, Inc.	Protective coatings	27	

TRANSPORTATION

Road Access	Federal Routes	
	State Routes	10, 11, 103
Nearest Interstate, Exit		I-89, Exit 13
	Distance	10 miles
Railroad		No
Public Transportation		Yes
Nearest Airport		Newport
	Runway	3,450 feet
	Lighted?	No
	Navigational Aids?	Yes
Nearest Commercial Airport		Lebanon
	Distance	24 miles
Driving distance to select cities:		
	Manchester, NH	60 miles
	Portland, Maine	152 miles
	Boston, Mass.	110 miles
	New York City, NY	258 miles
	Montreal, Quebec	212 miles

COMMUTING TO WORK

(Census 2000)

Workers 16 years and over	
Drove alone, car/truck/van%	81.3%
Carpooled, car/truck/van	10.7%
Public transportation	0.2%
Walked	4.0%
Other means	0.5%
Worked at home	3.3%
Mean Travel Time to Work	22 minutes
Percent of Working Residents:	
Working in community of residence	54%
Commuting to another NH community	42%
Commuting out-of-state	4%

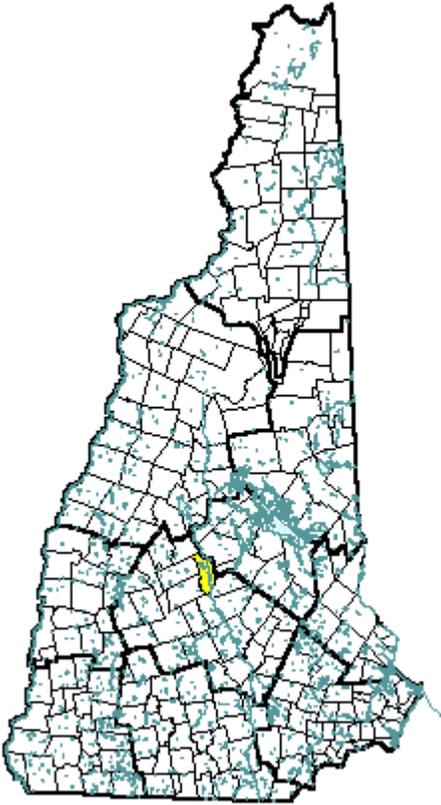
RECREATION, ATTRACTIONS, AND EVENTS

X	Municipal Parks
	YMCA/YWCA
	Boys Club/Girls Club
X	Golf Courses
	Swimming: Indoor Facility
	Swimming: Outdoor Facility
X	Tennis Courts: Indoor Facility
X	Tennis Courts: Outdoor Facility
	Ice Skating Rink: Indoor Facility
X	Bowling Facilities
X	Museums
	Cinemas
X	Performing Arts Facilities
X	Tourist Attractions
X	Youth Organizations (i.e., Scouts, 4-H)
X	Youth Sports: Baseball
X	Youth Sports: Soccer
X	Youth Sports: Football
X	Youth Sports: Basketball
X	Youth Sports: Hockey
X	Campgrounds
X	Fishing/Hunting
X	Boating/Marinas
X	Snowmobile Trails
X	Bicycle Trails
X	Cross Country Skiing
X	Beach or Waterfront Recreation Area
	Nearest Ski Area(s): Mount Sunapee
	Other: Covered bridges; Lake Sunapee; Parlin Field Airport; Rails to Trails; Sugar River

**NH Childhood Lead Poisoning Prevention Program
Franklin Local Lead Action Committee**

Member Name	Affiliation
Jean Galloway	CCNTR
Julie Ellerbeck	CCNTR
Charles Bodien	Franklin Health Officer
Rick Silverberg	Health First
Linda Eaton	Health First
Pam Sayre	NH CLPPP
LuAnn Speikers	NH CLPPP
Suzanne Allison	NH CLPPP
Emilia Belouin	The Way Home
Jason Grevier	Rental Property Owner
Chris Seufert	Lawyer
Jerry Spaulding	Belnap-Merrimack CAP
Daphne Feeney	USDA Rural Development
Dana Nute	Belnap-Merrimack CAP

Franklin, NH



Community Contact	City of Franklin Greg Doyon, City Manager 316 Central Street, City Hall Franklin, NH 03235
Telephone	(603) 934-3900
Fax	(603) 934-7413
E-mail	not available
Web Site	not available
Municipal Office Hours	Monday through Friday, 8 am - 5 pm
County	Merrimack
Tourism Region	Lakes
Planning Commission	Lakes Region
Regional Development	Capitol Region Economic Development Council
Election Districts	
US Congress	District 2 (All Wards)
Executive Council	District 2 (All Wards)
State Senate	District 7 (All Wards)
State Representative	District 33 (All Wards)

Incorporated: 1828

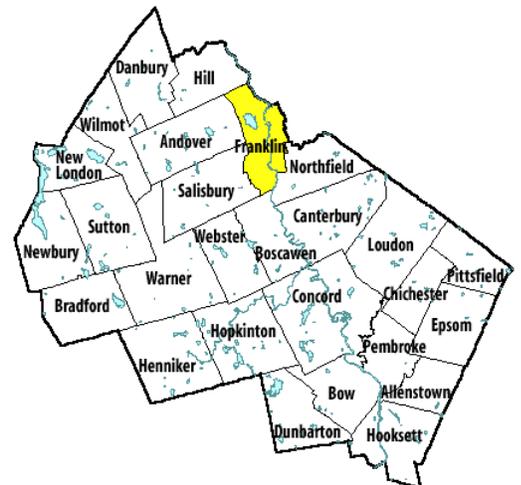
Origin: Situated as the junction of the Pemigewasset and Winnepesaukee Rivers, the town was originally known as Pemigewasset Village. It was taken from portions of Salisbury, Andover, Sanbornton, and Northfield. The name Franklin was adopted in 1820 in honor of Benjamin Franklin, and the town was incorporated as a city in 1895.

Population, Year of the First Census Taken: 1,370 residents in 1830

Population Trends: Franklin's population grew well below the statewide average rate, increasing by less than ten percent over each of the last five decades. Decennial growth rates ranged from a one percent increase between 1990-2000 to an eight percent increase between both 1960-1970 and 1970-1980. Franklin grew by a total of 1,853 residents, going from 6,552 in 1960 to 8,405 residents in 2000. The 2003 Census estimate for Franklin was 8,613 residents, which ranked 31st among New Hampshire's incorporated cities and towns.

Population Density, 2003: 305.5 persons per square mile of land area. Franklin contains 27.7 square miles of land area and 1.5 square miles of inland water area.

Villages and Place Names: Webster Lake, Webster Place, West Franklin



Merrimack County

MUNICIPAL SERVICES

Type of Government	Council - Manager
2003 Annual Budget	\$19,125,062
Zoning Ordinance	1971/04
Master Plan	2000
Capital Improvement Plan	Yes
Industrial Plans Reviewed By	City Planner

Boards and Commissions

Elected:	City Council
Appointed:	Planning Board; Zoning Board; Library Trustees; Conservation Commission

Public Library **Franklin Public**

EMERGENCY SERVICES

Police Department	Full-time
Fire Department	Full-time
Town Fire Insurance Rating	4/9
Emergency Medical Service	Municipal

Nearest Hospital(s):

Franklin Regional, Franklin
Distance: **Local** Staffed Beds: **47**

UTILITIES

Electric Supplier	PSNH; NH Electric Coop.
Natural Gas Supplier	KeySpan
Water Supplier	Franklin Water Works
Sanitation	Municipal
Municipal Wastewater Treatment Plant	Yes
Solid Waste Disposal	Municipal
Curbside Trash Pickup	Municipal
Pay-As-You-Throw Program	No
Recycling Program	None
Telephone Company	Verizon
Cellular Telephone Access	Yes
Cable Television Access	Yes
High Speed Internet Service:	unknown
Business	unknown
Residential	unknown

PROPERTY TAXES

2003 Total Tax Rate (per \$1000)	\$21.19
2003 Equalization Ratio	91.9
2003 Full Value Tax Rate (per \$1000)	\$19.50
2003 Percent of Property Valuation by Type	
Residential Land and Buildings	72.9%
Commercial Land and Buildings	20.2%
Other Property including Utilities	6.9%

HOUSING

2002 Total Housing Units	3,723
2002 Single-Family Units	2,180
Building Permits Issued	28
2002 Multi-Family Units	1,360
Building Permits Issued	0
2002 Manufactured Housing Units	183

DEMOGRAPHICS

Total Population	Community	County
2003	8,613	143,622
2000	8,405	136,225
1990	8,304	120,005
1980	7,901	98,302
1970	7,292	80,925

Census 2000 Demographics

Population by Gender		
Male	4,074	Female 4,331

Population by Age Group

Under age 5	613
Age 5 to 19	1,766
Age 20 to 34	1,526
Age 35 to 54	2,496
Age 55 to 64	771
Age 65 and over	1,233
Median Age	37.3 years

Educational Attainment, population 25 years and over

High school graduate or higher	80.3%
Bachelor's degree or higher	13.6%

ANNUAL INCOME, 1999**(Census 2000)**

Per capita income	\$17,155
Median 4-person family income	\$41,698
Median household income	\$34,613

Median Earnings, full-time, year-round workers

Male	\$32,318
Female	\$25,062

Families below the poverty level**8.9%****LABOR FORCE**

Annual Average	1993	2003
Civilian labor force	4,103	4,798
Employed	3,772	4,580
Unemployed	331	218
Unemployment rate	8.1%	4.5%

EMPLOYMENT & WAGES**1993 2003**

Goods Producing Industries		
Average Employment	1,390	1,241
Average Weekly Wage	\$541	\$777
Service Providing Industries		
Average Employment	1,414	1,447
Average Weekly Wage	\$346	\$528
Total Private Industry		
Average Employment	2,804	2,689
Average Weekly Wage	\$443	\$643
Government (Federal, State, and Local)		
Average Employment	378	403
Average Weekly Wage	\$398	\$579
Total, Private Industry plus Government		
Average Employment	3,181	3,091
Average Weekly Wage	\$437	\$635

n = indicates that data does not meet disclosure standards

EDUCATION AND CHILD CARE

Schools students attend: **Franklin operates grades K-12** District: **SAU 18**
 Career Technology Center(s): **J. Oliva Huot Tech Ctr.; Winnisquam Agricultural Ed Ctr.** Region: **08**

Educational Facilities	Elementary	Middle/Junior High	High School	Private/Parochial
Number of Schools	2	1	1	
Grade Levels	P K 1-4	5-8	9-12	
Total Enrollment	536	453	472	

NH Licensed Child Care Facilities, 2003: Total Facilities: 8 Total Capacity: 130

Nearest Community/Technical College: **Laconia**
 Nearest Colleges or Universities: **Colby-Sawyer; Plymouth State University**

LARGEST EMPLOYERS	PRODUCT/SERVICE	EMPLOYEES	ESTABLISHED
Webster Valve & Foundry	Plumbing, heating controls	515	1956
Franklin Regional Hospital	Health care	359	1910
Polyclad Laminates, Inc.	Laminates for printed circuit boards	295	1980
City of Franklin	Municipal services	253	
Freudenberg - NOK	Automotive Products	185	
Hannaford Brothers	Supermarket	140	1992
Wyman Gordon Investment Castings, Inc.	Titanium products	91	1995
Vitex Extrusion	Aluminum extrusions	65	1996
Insulfab Plastics, Inc.	Plastic fabrication	60	1953
Acme Staple Co., Inc.	Industrial stapling systems	21	1959

TRANSPORTATION

Road Access	Federal Routes	3
	State Routes	3A, 11
Nearest Interstate, Exit		I-93, Exit 20
	Distance	4 miles
Railroad		No
Public Transportation		Yes
Nearest Airport		Laconia
	Runway	5,286 feet
	Lighted?	Yes
	Navigational Aids?	Yes
Nearest Commercial Airport		Manchester
	Distance	30 miles
Driving distance to select cities:		
	Manchester, NH	38 miles
	Portland, Maine	116 miles
	Boston, Mass.	88 miles
	New York City, NY	285 miles
	Montreal, Quebec	239 miles

COMMUTING TO WORK

(Census 2000)

Workers 16 years and over	
Drove alone, car/truck/van%	77.1%
Carpooled, car/truck/van	17.0%
Public transportation	0.2%
Walked	2.3%
Other means	1.2%
Worked at home	2.2%
Mean Travel Time to Work	21.7 minutes
Percent of Working Residents:	
Working in community of residence	35%
Commuting to another NH community	65%
Commuting out-of-state	0%

RECREATION, ATTRACTIONS, AND EVENTS

X	Municipal Parks
	YMCA/YWCA
	Boys Club/Girls Club
X	Golf Courses
	Swimming: Indoor Facility
X	Swimming: Outdoor Facility
	Tennis Courts: Indoor Facility
X	Tennis Courts: Outdoor Facility
	Ice Skating Rink: Indoor Facility
	Bowling Facilities
	Museums
X	Cinemas
X	Performing Arts Facilities
	Tourist Attractions
X	Youth Organizations (i.e., Scouts, 4-H)
X	Youth Sports: Baseball
	Youth Sports: Soccer
X	Youth Sports: Football
X	Youth Sports: Basketball
	Youth Sports: Hockey
X	Campgrounds
X	Fishing/Hunting
X	Boating/Marinas
X	Snowmobile Trails
X	Bicycle Trails
X	Cross Country Skiing
	Beach or Waterfront Recreation Area
	Nearest Ski Area(s): Veteran's Memorial Ski Area
	Other: Daniel Webster Birthplace

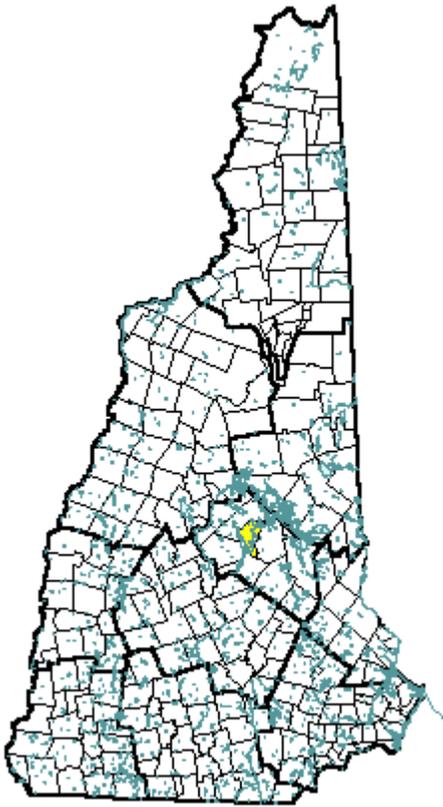
**NH Childhood Lead Poisoning Prevention Program
Laconia Local Lead Action Committee**

Member Name

Affiliation

Corey Albert	Laconia Housing
Debbie Brady	Laconia Head Start
Gifford Swanson	Lakes Region Rental Association
Jane MacDonald	Laconia Area Community Land Trust
Julie Farina	Lakes Region Child Care Services
Kristen Awrich	Community Health & Hospice
Pamela Sayre	NH CLPPP
Paula Samson	Public Health & Safety Partnership of Lakes Region
Suzanne Allison	NH CLPPP

Laconia, NH



Community Contact

City of Laconia
Eileen Cabanel, City Manager
45 Beacon Street East
Laconia, NH 03246

Telephone
Fax
E-mail
Web Site

(603) 527-1270
(603) 527-1292
citymanager@city.laconia.nh.us
www.cityoflaconianh.org

Municipal Office Hours

Monday through Friday, 8:30 am - 4:30 pm

County
Tourism Region
Planning Commission
Regional Development

Belknap
Lakes
Lakes Region
Belknap County Economic Development Council

Election Districts

US Congress
Executive Council
State Senate
State Representative

District 1 (All Wards)
District 1 (All Wards)
District 4 (All Wards)
District 30 (All Wards)

Incorporated: 1855

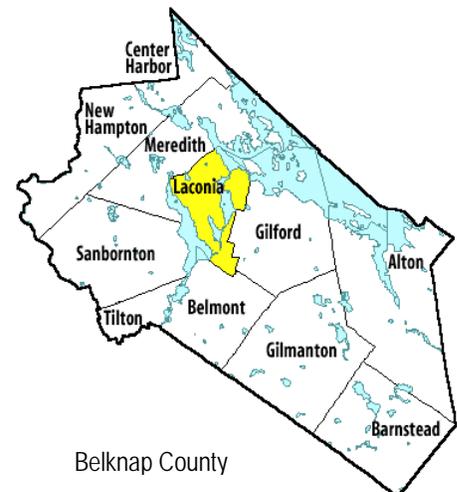
Origin: First explored in the 1620's, Laconia was for many years a part of Meredith and Gilford known as Meredith Bridge. Early explorers had hoped to follow the Piscataqua River north to Lake Champlain, in search of the great lakes and rivers of Canada told of in Indian lore. These explorers were known as the Laconia Adventurers, Laconia being a region of ancient Greece. Incorporated as a city in 1893, Laconia includes the villages of Lakeport and Weirs Beach. "Weirs" is the name of primitive fishing devices discovered at the outlet of Lake Winnepesaukee.

Population, Year of the First Census Taken: 1,806 residents in 1860

Population Trends: Laconia has grown very slowly over the last five decades. The city's 11 percent increase over the fifty-year period was the fifth lowest positive growth rate, with decennial growth ranging from a three percent decrease between 1960-1970 to a five percent increase between 1970-1980. Laconia grew by a total of 1,666 residents, going from 14,745 in 1950 to 16,411 residents in 2000. The 2003 Census estimate for Laconia was 17,134 residents, which ranked 15th among New Hampshire's incorporated cities and towns.

Population Density, 2003: 828.4 persons per square mile of land area. Laconia contains 20.1 square miles of land area and 6.0 square miles of inland water area.

Villages and Place Names: Interlaken Park, Lakeport, Pendleton Beach, Weirs Beach, Paugus Bay



MUNICIPAL SERVICES

Type of Government	Manager & Council
2004 Annual Budget	\$43,850,196
Zoning Ordinance	1948/01
Master Plan	1992
Capital Improvement Plan	Yes
Industrial Plans Reviewed By	City Planner

Boards and Commissions

Elected:	City Council; Police Commission
Appointed:	Planning Board; Zoning Board; Library Trustees; Conservation Commission; Board of Assessors

Public Library **Laconia Public**

EMERGENCY SERVICES

Police Department	Full-time
Fire Department	Full-time
Town Fire Insurance Rating	3/9
Emergency Medical Service	Other

Nearest Hospital(s):

Lakes Region General, Laconia
Distance: **Local** Staffed Beds: **106**

UTILITIES

Electric Supplier	PSNH; NH Electric Coop.
Natural Gas Supplier	KeySpan
Water Supplier	Laconia Water Works
Sanitation	Municipal
Municipal Wastewater Treatment Plant	Yes
Solid Waste Disposal	Municipal
Curbside Trash Pickup	No
Pay-As-You-Throw Program	Voluntary
Recycling Program	Voluntary
Telephone Company	Verizon
Cellular Telephone Access	Yes
Cable Television Access	Yes
High Speed Internet Service:	Yes
Business	Yes
Residential	Yes

PROPERTY TAXES

2003 Total Tax Rate (per \$1000)	\$17.89
2003 Equalization Ratio	96.0
2003 Full Value Tax Rate (per \$1000)	\$16.93
2003 Percent of Property Valuation by Type	
Residential Land and Buildings	83.1%
Commercial Land and Buildings	15.5%
Other Property including Utilities	1.5%

HOUSING

2002 Total Housing Units	8,700
2002 Single-Family Units	4,826
Building Permits Issued	60
2002 Multi-Family Units	3,610
Building Permits Issued	4
2002 Manufactured Housing Units	264

DEMOGRAPHICS

Total Population	Community	County
2003	17,134	60,356
2000	16,411	56,325
1990	15,743	49,216
1980	15,575	42,884
1970	14,888	32,367

Census 2000 Demographics

Population by Gender		
Male	7,969	Female 8,442

Population by Age Group

Under age 5	869
Age 5 to 19	3,186
Age 20 to 34	3,203
Age 35 to 54	4,746
Age 55 to 64	1,579
Age 65 and over	2,828
Median Age	38.8 years

Educational Attainment, population 25 years and over

High school graduate or higher	81.9%
Bachelor's degree or higher	19.6%

ANNUAL INCOME, 1999**(Census 2000)**

Per capita income	\$19,540
Median 4-person family income	\$45,307
Median household income	\$37,796

Median Earnings, full-time, year-round workers

Male	\$31,714
Female	\$22,818

Families below the poverty level**7.5%****LABOR FORCE**

Annual Average	1993	2003
Civilian labor force	7,468	8,185
Employed	6,889	7,862
Unemployed	579	323
Unemployment rate	7.8%	3.9%

EMPLOYMENT & WAGES**1993 2003**

Goods Producing Industries		
Average Employment	2,800	2,328
Average Weekly Wage	\$482	\$750
Service Providing Industries		
Average Employment	6,337	6,748
Average Weekly Wage	\$382	\$567
Total Private Industry		
Average Employment	9,137	9,075
Average Weekly Wage	\$412	\$614
Government (Federal, State, and Local)		
Average Employment	1,156	1,596
Average Weekly Wage	\$505	\$676
Total, Private Industry plus Government		
Average Employment	10,293	10,672
Average Weekly Wage	\$423	\$623

n = indicates that data does not meet disclosure standards

EDUCATION AND CHILD CARE

Schools students attend: **Laconia operates grades K-12** District: **SAU 30**
 Career Technology Center(s): **J. Oliva Huot Tech Ctr.; Winnisquam Agricultural Ed Ctr.** Region: **08**

Educational Facilities	Elementary	Middle/Junior High	High School	Private/Parochial
Number of Schools	3	1	1	3
Grade Levels	P K 1-5	6-8	9-12	K-12
Total Enrollment	1,075	619	800	n/a

NH Licensed Child Care Facilities, 2003: Total Facilities: **18** Total Capacity: **640**

Nearest Community/Technical College: **Laconia**
 Nearest Colleges or Universities: **Plymouth State University**

LARGEST EMPLOYERS	PRODUCT/SERVICE	EMPLOYEES	ESTABLISHED
Aavid Engineering Corp.	Semiconductor heat sinks	620	1966
NH Ball Bearings, Inc.	Spherical bearings	478	1968
Lewis & Sanders, Inc.	Metal tubular assemblies	130	1956
Wilcom Products, Inc	Telecommunications test equipment	85	
Baron Machine Co., Inc.	Machine parts, heat treating	70	1957
Freudenberg-NOK	Automotive seals		1999
Lakes Region General Hospital	Medical Care		

TRANSPORTATION

Road Access	Federal Routes	3
	State Routes	106, 107
Nearest Interstate, Exit		I-93, Exit 20
	Distance	7 miles
Railroad		State owned line
Public Transportation		Yes
Nearest Airport		Laconia
	Runway	5,286 feet
	Lighted?	Yes
	Yes	Navigational Aids? Yes
Nearest Commercial Airport		Manchester
	Distance	50 miles
Driving distance to select cities:		
	Manchester, NH	45 miles
	Portland, Maine	109 miles
	Boston, Mass.	95 miles
	New York City, NY	292 miles
	Montreal, Quebec	242 miles

COMMUTING TO WORK

(Census 2000)

Workers 16 years and over	
Drove alone, car/truck/van%	78.9%
Carpooled, car/truck/van	12.1%
Public transportation	0.8%
Walked	3.7%
Other means	1.6%
Worked at home	3.0%
Mean Travel Time to Work	21.3 minutes
Percent of Working Residents:	
Working in community of residence	52%
Commuting to another NH community	45%
Commuting out-of-state	2%

RECREATION, ATTRACTIONS, AND EVENTS

X	Municipal Parks
	YMCA/YWCA
	Boys Club/Girls Club
X	Golf Courses
X	Swimming: Indoor Facility
X	Swimming: Outdoor Facility
	Tennis Courts: Indoor Facility
X	Tennis Courts: Outdoor Facility
X	Ice Skating Rink: Indoor Facility
X	Bowling Facilities
	Museums
X	Cinemas
	Performing Arts Facilities
X	Tourist Attractions
X	Youth Organizations (i.e., Scouts, 4-H)
X	Youth Sports: Baseball
X	Youth Sports: Soccer
X	Youth Sports: Football
X	Youth Sports: Basketball
X	Youth Sports: Hockey
X	Campgrounds
X	Fishing/Hunting
X	Boating/Marinas
X	Snowmobile Trails
X	Bicycle Trails
X	Cross Country Skiing
X	Beach or Waterfront Recreation Area
	Nearest Ski Area(s): Gunstock
	Other: Mount Washington Cruises; Weirs Beach; Scenic Railroad; Prescott Farm Audubon Center

Eliminating Childhood Lead Poisoning in New Hampshire

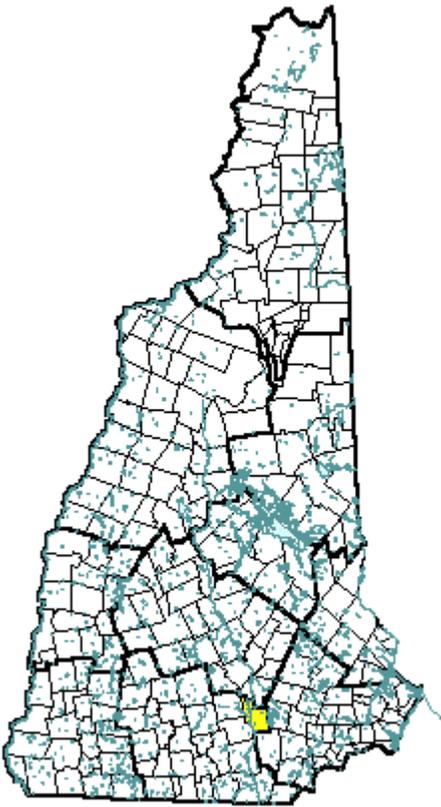
**NH Childhood Lead Poisoning Prevention Program
Manchester Local Lead Action Committee**

Member Name	Affiliation
Maria-Tu Scott	
Niki Watson	
Bob Clohosey	Catholic Charities of NH
Jean Jacques	Catholic Medical Center – Community Services
Nancy Serrell	Center for Environmental Health Sciences
Sue Dery	Child Health Services
Dr. Rob Nordgren	Child Health Services
Elizabeth Winger	Child Health Services
Selma Deitch	Child Health Services
Beth Etlinger	Dartmouth Hitchcock Manchester
Claudia Aldarado	Division of Child and Youth Services
Rebecca Campos	Doctors Park Pediatricsq
Ann Smith	Easter Seals NH
Elizabeth Castrogiovanni	Elliot Hospital
Karen Rosenberg	Fair Housing Project
Stephanie Savard	Families In Transition
Karen Lesmerises	FNA Parent/Baby Program
Al Tremblay	Food Bank
Linda Kincaid	Head Start Program
William Straughn III	Hitchcock Dartmouth Manchester
Florentina Dinu	International Insititute of NH
Montse Goodrich	Latin American Center
Jill Davis	Manchester Community Health
Bud Stevenson	Manchester Community Health Center
Kim McNamara	Manchester Health Department
Carrie Campbell	Manchester Health Department
Sandy Buseman	Manchester Health Department
Joline Manseau	Manchester Health Department
Phil Alexakos	Manchester Health Department
Rosemary Caron	Manchester Health Department
Elaine Douville	Manchester Health Department
Barbara Gleason	Manchester Health Department
Aaron Krycki	Manchester Health Department
Susan Gagnon	Manchester Health Department
Leon LaFreniere	Manchester Health Department
Larry Caron	Manchester Health Department
Diane Guimond	Manchester Health Department
Meredith Maruyama	Manchester Health Department
Jennifer Vadney	Manchester Ntighborhood Housing Services
Ken Snow	Mental Health Center of Greater Manchester
Jazmin Miranda-Smith	Minority Health Coalition
Sienna Larson	Minority Health Coalition
Heather Fairchild	NH CLPPP
Rick Blais	NH Property Owners Association

Eliminating Childhood Lead Poisoning in New Hampshire

Debbie Cote	Nutrition Coordinator WIC Program
Marty Boldin	Office of Youth Services
Pamela Dubois	Pediatric Health Associates
Stephanie Flegenheimer	Pediatric Health Associates
Richard Duckoff	QCTA
Karen Holmes	River Road Pediatrics
Louise Bergeron	Souther NH Services
Karen Conlon	The Salvation Army
Emilia Belouin	The Way Home
Doreen Noble	The Way Home
Milessa Patnaude	The Way Home
Mary Sliney	The Way Home
Sherry Dupuis	VNA Child Care Center

Manchester, NH



Community Contact	Manchester Economic Development Office Jane F. Hills, Assistant Economic Development Director One City Hall Plaza, Suite 110 Manchester, NH 03101-2099
Telephone	(603) 624-6505
Fax	(603) 624-6308
E-mail	econdev@ci.manchester.nh.us
Web Site	www.ManchesterNH.gov
Municipal Office Hours	Monday through Friday, 8 am - 5 pm
County	Hillsborough
Tourism Region	Merrimack Valley
Planning Commission	Southern NH
Regional Development	Capitol Region Economic Development Council
Election Districts	
US Congress	District 1 (All Wards)
Executive Council	District 4 (All Wards)
State Senate	District 16 (Wards 1, 2, & 12), 18 (Wards 5-9), and 20 (Wards 3, 4, 10, & 11)
State Representative	District 49 (Wards 1 & 12), 50 (Wards 2, 3, 10, & 11), 51 (Ward 4), 52 (Ward 5), 53 (Ward 7), 54 (Ward 6), 55 (Ward 9), and 56 (Ward 8)

Incorporated: 1751

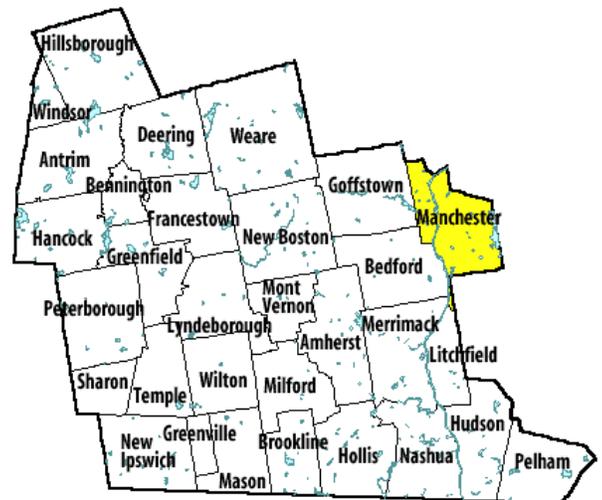
Origin: First known as Harrytown and Tyng's Town, the town was granted as Derryfield in 1751. The name Manchester was suggested by Samuel Blodgett, a businessman who found that the Amoskeag Falls impeded shipping on the Merrimack River. After visiting Manchester, England, he was determined to build a canal like those in England. The canal was first opened in May 1807. Mr. Blodgett's goal was to make the town a great city, and although he died in September 1807, it was renamed Manchester in 1810, and incorporated as a city in 1846.

Population, Year of the First Census Taken: 362 residents in 1790

Population Trends: Manchester continues to reign as the state's largest city, and was the first to reach 100,000 residents. Population increased by a total of 24,274 residents, the third largest increase, going from 82,732 in 1950 to 107,006 residents in 2000. But decennial growth rates were low, ranging from a one percent decrease between 1960-1970 to a nine percent increase between 1980-1990. The 2003 Census estimate for Manchester was 108,871 residents, which ranked first among New Hampshire's incorporated cities and towns.

Population Density, 2003: 3,270.3 persons per square mile of land area, the state's highest population density. Manchester contains 33.0 square miles of land area and 1.9 square miles of inland water area.

Villages and Place Names: Goffs Falls, Massabesic, Youngsville, Bakersville, Bald Hill District, Amoskeag



Hillsborough County

MUNICIPAL SERVICES

Type of Government	Mayor & 14 Aldermen
2004 Annual Budget	\$106,546,576
Zoning Ordinance	1927/01
Master Plan	1993
Capital Improvement Plan	Yes
Industrial Plans Reviewed By	City Planning Board

Boards and Commissions

Elected:	Board of Mayor and Aldermen
Appointed:	Planning Board; Conservation Commission; Library Trustees; 25 others

Public Library Manchester City; West Side Community

EMERGENCY SERVICES

Police Department	Full-time
Fire Department	Full-time
Town Fire Insurance Rating	2
Emergency Medical Service	Municipal & volunteer

Nearest Hospital(s):

Elliot or Catholic Medical Center, Manchester
Distance: Local Staffed Beds: 244; 225

UTILITIES

Electric Supplier	PSNH
Natural Gas Supplier	KeySpan
Water Supplier	Manchester Water Works
Sanitation	Municipal
Municipal Wastewater Treatment Plant	Yes
Solid Waste Disposal	Municipal
Curbside Trash Pickup	Municipal
Pay-As-You-Throw Program	No
Recycling Program	Yard waste-mandatory; Recyclables-voluntary
Telephone Company	Verizon
Cellular Telephone Access	Yes
Cable Television Access	Yes
High Speed Internet Service:	Business Yes
	Residential Yes

PROPERTY TAXES

2003 Total Tax Rate (per \$1000)	\$26.40
2003 Equalization Ratio	65.1
2003 Full Value Tax Rate (per \$1000)	\$16.68
2003 Percent of Property Valuation by Type	
Residential Land and Buildings	60.6%
Commercial Land and Buildings	37.2%
Other Property including Utilities	2.2%

HOUSING

2002 Total Housing Units	46,271
2002 Single-Family Units	18,980
Building Permits Issued	79
2002 Multi-Family Units	27,130
Building Permits Issued	124
2002 Manufactured Housing Units	161

DEMOGRAPHICS

Total Population	Community	County
2003	108,871	394,663
2000	107,006	380,841
1990	99,332	336,073
1980	90,936	276,608
1970	87,754	223,941

Census 2000 Demographics

Population by Gender			
Male	52,394	Female	54,612

Population by Age Group

Under age 5	7,162
Age 5 to 19	20,928
Age 20 to 34	25,525
Age 35 to 54	31,468
Age 55 to 64	8,094
Age 65 and over	13,829
Median Age	34.9 years

Educational Attainment, population 25 years and over

High school graduate or higher	80.7%
Bachelor's degree or higher	22.3%

ANNUAL INCOME, 1999

(Census 2000)

Per capita income	\$21,244
Median 4-person family income	\$50,039
Median household income	\$40,774

Median Earnings, full-time, year-round workers

Male	\$34,287
Female	\$26,584

Families below the poverty level

7.7%

LABOR FORCE

Annual Average	1993	2003
Civilian labor force	52,960	62,761
Employed	49,284	59,921
Unemployed	3,676	2,840
Unemployment rate	6.9%	4.5%

EMPLOYMENT & WAGES

1993 2003

Goods Producing Industries			
Average Employment	9,446	9,539	
Average Weekly Wage	\$559	\$833	
Service Providing Industries			
Average Employment	40,254	49,318	
Average Weekly Wage	\$489	\$741	
Total Private Industry			
Average Employment	49,700	58,857	
Average Weekly Wage	\$503	\$756	
Government (Federal, State, and Local)			
Average Employment	6,901	7,888	
Average Weekly Wage	\$624	\$811	
Total, Private Industry plus Government			
Average Employment	56,602	66,746	
Average Weekly Wage	\$517	\$763	

n = indicates that data does not meet disclosure standards

EDUCATION AND CHILD CARE

Schools students attend: **Manchester operates grades K-12** District: **SAU 37**
 Career Technology Center(s): **Manchester School of Technology** Region: **15**

Educational Facilities	Elementary	Middle/Junior High	High School	Private/Parochial
Number of Schools	15	4	3	12
Grade Levels	P K R 1-5	6-8	9-12	K-12
Total Enrollment	7,201	3,765	6,610	n/a

NH Licensed Child Care Facilities, 2003: Total Facilities: **70** Total Capacity: **4,644**

Nearest Community/Technical College: **Manchester**

Nearest Colleges or Universities: **Hesser; St. Anselm; Southern NH University; UNH-Manchester**

LARGEST EMPLOYERS	PRODUCT/SERVICE	EMPLOYEES	ESTABLISHED
Elliott Hospital	Health care	2,145	
Verizon	Utility	2,100	
Catholic Medical Center	Health care	1,400	
Bank of New Hampshire	Banking	1,260	
PSNH	Utility	1,250	
Citizens Bank	Banking	1,200	
Anthem Blue Cross Blue Shield of NH	Insurance	801	
Hannaford Brothers	Supermarket	725	
Osram Sylvania	Electronics	675	
Freudenberg NOK	Electronics	550	

TRANSPORTATION

Road Access	Federal Routes	3
	State Routes	3A, 28, 101, 114
Nearest Interstate, Exit		I-293 & I-93, Exit 6-10
	Distance	Local access
Railroad		Boston & Maine
Public Transportation		Yes
Nearest Airport		Manchester
Runway		9,250 feet
Lighted?	Yes	Navigational Aids? Yes
Nearest Commercial Airport		Manchester
Distance		Local
Driving distance to select cities:		
Manchester, NH		0 miles
Portland, Maine		94 miles
Boston, Mass.		53 miles
New York City, NY		246 miles
Montreal, Quebec		259 miles

COMMUTING TO WORK

(Census 2000)

Workers 16 years and over	
Drove alone, car/truck/van%	81.0%
Carpooled, car/truck/van	11.9%
Public transportation	1.4%
Walked	2.9%
Other means	0.7%
Worked at home	2.2%
Mean Travel Time to Work	21.3 minutes
Percent of Working Residents:	
Working in community of residence	52%
Commuting to another NH community	41%
Commuting out-of-state	7%

RECREATION, ATTRACTIONS, AND EVENTS

X	Municipal Parks
X	YMCA/YWCA
X	Boys Club/Girls Club
X	Golf Courses
X	Swimming: Indoor Facility
X	Swimming: Outdoor Facility
X	Tennis Courts: Indoor Facility
X	Tennis Courts: Outdoor Facility
X	Ice Skating Rink: Indoor Facility
X	Bowling Facilities
X	Museums
X	Cinemas
X	Performing Arts Facilities
X	Tourist Attractions
X	Youth Organizations (i.e., Scouts, 4-H)
X	Youth Sports: Baseball
X	Youth Sports: Soccer
X	Youth Sports: Football
X	Youth Sports: Basketball
X	Youth Sports: Hockey
	Campgrounds
X	Fishing/Hunting
X	Boating/Marinas
X	Snowmobile Trails
X	Bicycle Trails
X	Cross Country Skiing
X	Beach or Waterfront Recreation Area

Nearest Ski Area(s): **McIntyre**

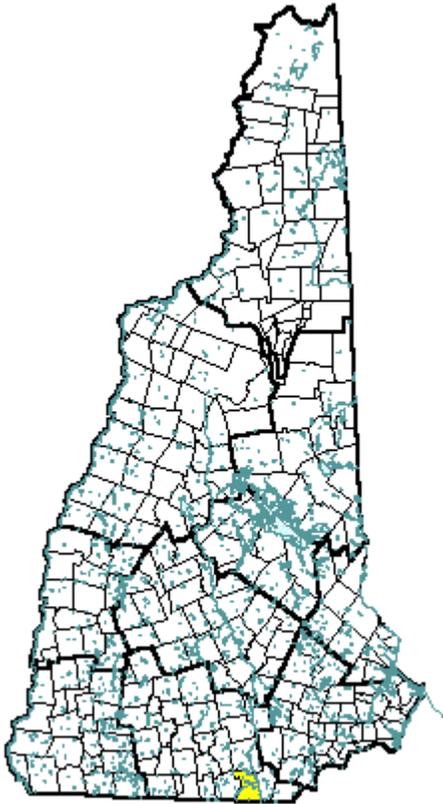
Other: **Gill Stadium; Currier Gallery of Art; Amoskeag Fishways Learning Center; Verizon Wireless Arena**

Eliminating Childhood Lead Poisoning in New Hampshire

**NH Childhood Lead Poisoning Prevention Program
Nashua Local Lead Action Committee**

Member Name	Affiliation
Mary Febonio	Neighborhood Housing Services
Angeline Kopka	NH House of Representatives
Betty Wendt RN	Nashua Public Health
Chick Beaulieu	Window Replacement Contractor
Scott Costa	Nashua Housing Authority
Heidi E Peek	City of Nashua Environmental Health
James Lambert	GM Roth Contractors
Klaas Nijhuis	City of Nashua Urban Programs Department
Linda Kincaid RN	SNH Services Child Development Program
Louise Burque Mermer	Nashua Pediatrics
Mary Gorman	NH House of Representatives
Pamela Sayre	NH CLPPP
Stefan Russakow MA RS	Nashua Public Health
Sue Dobens	NH Property Owners Association
Samia Medina-Rodgers, RN	Nashua Public Health

Nashua, NH



Community Contact

City of Nashua
Katherine Hersh, Community Development Division Director
PO Box 2019, 229 Main Street
Nashua, NH 03061-2019

Telephone
Fax
E-mail
Web Site

(603) 589-3098
(603) 589-3119
not available
www.gonashua.com

Municipal Office Hours

Monday through Friday, 8 am - 5 pm

County
Tourism Region
Planning Commission
Regional Development

Hillsborough
Merrimack Valley
Nashua Regional
Gateway Industrial Development Corp.

Election Districts

US Congress
Executive Council
State Senate
State Representative

District 2 (All Wards)
District 5 (All Wards)
District 12 (Wards 1, 2, 3, & 7), and 13 (Wards 4, 5, 6, 8, & 9)
District 59 (Ward 2), 60 (Ward 3), 61 (Ward 1),
62 (Wards 4 & 6), 63 (Ward 5), 64 (Ward 9),
and 65 (Wards 7 & 8)

Incorporated: 1746

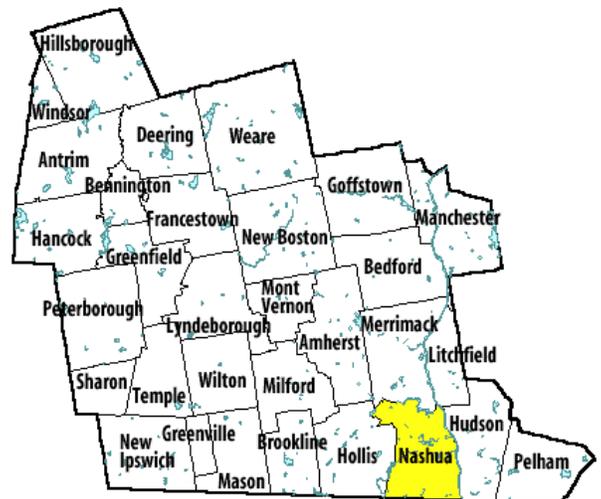
Origin: Originally part of a grant to Edward Tyng of Dunstable, England, the 200 square mile area, called Dunstable, included Nashua, Tyngsboro MA, and other border towns. In 1741 the town was cut in half when the Massachusetts-New Hampshire border was established. The northern half kept the name Dunstable. In 1836 the town took the Nashua River's name, a Nashaway Indian word for "beautiful river with a pebbly bottom." Nashua became a manufacturing center, powered by the Middlesex Canal which connected the Merrimack River to Boston. It was incorporated as a city in 1853.

Population, Year of the First Census Taken: 632 residents in 1790

Population Trends: Although Nashua ranked first in numeric population increase over fifty years, the rates of growth were at or below the statewide average. Decennial growth rates ranged from a nine percent increase between 1990-2000 to a 43 percent increase between 1960-1970. Nashua's population grew by 51,936 residents between the 1950 count of 34,669 and the 2000 count of 86,605. The 2003 Census estimate for Nashua was 87,285 residents, which ranked second among New Hampshire's incorporated cities and towns.

Population Density, 2003: 2,843.5 persons per square mile of land area, the second highest density. Nashua contains 30.8 square miles of land area and 1.0 square miles of inland water area.

Villages and Place Names: Broad Acres, Lincoln Park, Dunstable, Crown Hill



Hillsborough County

MUNICIPAL SERVICES

Type of Government	Mayor & Council
2004 Annual Budget	\$200,614,253
Zoning Ordinance	1930/03
Master Plan	2002
Capital Improvement Plan	Yes
Industrial Plans Reviewed By	Planning Board

Boards and Commissions

Elected:	Board of Aldermen
Appointed:	Planning Board; Conservation Commission; Library Trustees; Cemetery Trustees

Public Library **Nashua Public**

EMERGENCY SERVICES

Police Department	Full-time
Fire Department	Full-time
Town Fire Insurance Rating	2
Emergency Medical Service	Municipal, other & commercial

Nearest Hospital(s):

Southern NH Regional or St. Joseph, Nashua
 Distance: **Local** Staffed Beds: **178; 135**

UTILITIES

Electric Supplier	PSNH
Natural Gas Supplier	KeySpan
Water Supplier	Pennichuck Water Works
Sanitation	Municipal
Municipal Wastewater Treatment Plant	Yes
Solid Waste Disposal	Municipal
Curbside Trash Pickup	Municipal
Pay-As-You-Throw Program	No
Recycling Program	Voluntary
Telephone Company	Verizon
Cellular Telephone Access	Yes
Cable Television Access	Yes
High Speed Internet Service:	Business unknown
	Residential unknown

PROPERTY TAXES

2003 Total Tax Rate (per \$1000)	\$24.37
2003 Equalization Ratio	68.9
2003 Full Value Tax Rate (per \$1000)	\$16.63
2003 Percent of Property Valuation by Type	
Residential Land and Buildings	62.3%
Commercial Land and Buildings	35.1%
Other Property including Utilities	2.6%

HOUSING

2002 Total Housing Units	35,737
2002 Single-Family Units	18,569
Building Permits Issued	115
2002 Multi-Family Units	16,287
Building Permits Issued	40
2002 Manufactured Housing Units	881

DEMOGRAPHICS

Total Population	Community	County
2003	87,285	394,663
2000	86,605	380,841
1990	79,662	336,073
1980	67,865	276,608
1970	55,820	223,941

Census 2000 Demographics

Population by Gender			
Male	42,775	Female	43,830

Population by Age Group

Under age 5	5,644
Age 5 to 19	17,735
Age 20 to 34	18,734
Age 35 to 54	27,055
Age 55 to 64	7,395
Age 65 and over	10,042
Median Age	35.8 years

Educational Attainment, population 25 years and over

High school graduate or higher	86.6%
Bachelor's degree or higher	31.5%

ANNUAL INCOME, 1999

(Census 2000)

Per capita income	\$25,209
Median 4-person family income	\$61,102
Median household income	\$51,969

Median Earnings, full-time, year-round workers

Male	\$43,893
Female	\$29,171

Families below the poverty level

5.0%

LABOR FORCE

Annual Average	1993	2003
Civilian labor force	45,166	49,802
Employed	41,581	46,918
Unemployed	3,585	2,884
Unemployment rate	7.9%	5.8%

EMPLOYMENT & WAGES

1993 2003

Goods Producing Industries			
Average Employment	12,227	11,398	
Average Weekly Wage	\$809	\$1,274	
Service Providing Industries			
Average Employment	28,402	35,345	
Average Weekly Wage	\$439	\$683	
Total Private Industry			
Average Employment	40,629	46,743	
Average Weekly Wage	\$550	\$827	
Government (Federal, State, and Local)			
Average Employment	3,311	4,659	
Average Weekly Wage	\$712	\$922	
Total, Private Industry plus Government			
Average Employment	43,940	51,402	
Average Weekly Wage	\$562	\$836	

n = indicates that data does not meet disclosure standards

EDUCATION AND CHILD CARE

Schools students attend: **Nashua operates grades K-12** District: **SAU 42**
 Career Technology Center(s): **Nashua, Alvirne & Milford High Schools** Region: **16**

Educational Facilities	Elementary	Middle/Junior High	High School	Private/Parochial
Number of Schools	12	3	2	8
Grade Levels	P K 1-6	7-9	10-12	K-12
Total Enrollment	7,227	3,156	2,997	N/a

NH Licensed Child Care Facilities, 2003: Total Facilities: **62** Total Capacity: **4,051**

Nearest Community/Technical College: **Nashua**
 Nearest Colleges or Universities: **Daniel Webster; Rivier; Thomas More**

LARGEST EMPLOYERS	PRODUCT/SERVICE	EMPLOYEES	ESTABLISHED
BAE Systems North America	Optics Manufacturing	1,000+	
Southern NH Medical Center	Health care	1,000+	
St. Joseph Hospital & Trauma Center	Health care	1,000+	
Teradyne Connection Systems Inc.	Connectors	1,000+	
City of Nashua	Municipal services	1,000+	
Compaq Computer Corp.	Computer software	500+/-	
Nashua Corporation	Label Papers/carbonless papers/ toner & developer	500+/-	
GL & V Pulp Group Inc.	Machinery Pulp Equipment	250+/-	
G N Netcom/Unex Inc.	Telephone Headsets and headset amplifiers	250+/-	

TRANSPORTATION

Road Access	Federal Routes	3
	State Routes	3A, 101A, 102, 130
Nearest Interstate, Exit	Everett Tpk., Exit 1-10	
	Distance	Local access
Railroad	Boston & Maine	
Public Transportation		Yes
Nearest Airport	Nashua	
Runway	5,501 feet	
Lighted? Yes	Navigational Aids? Yes	
Nearest Commercial Airport	Manchester	
Distance	18 miles	
Driving distance to select cities:		
Manchester, NH	18 miles	
Portland, Maine	112 miles	
Boston, Mass.	45 miles	
New York City, NY	231 miles	
Montreal, Quebec	276 miles	

COMMUTING TO WORK

(Census 2000)

Workers 16 years and over	
Drove alone, car/truck/van%	83.5%
Carpooled, car/truck/van	9.2%
Public transportation	1.5%
Walked	2.5%
Other means	0.7%
Worked at home	2.7%
Mean Travel Time to Work	24.7 minutes
Percent of Working Residents:	
Working in community of residence	47%
Commuting to another NH community	26%
Commuting out-of-state	26%

RECREATION, ATTRACTIONS, AND EVENTS

X	Municipal Parks
X	YMCA/YWCA
X	Boys Club/Girls Club
X	Golf Courses
X	Swimming: Indoor Facility
X	Swimming: Outdoor Facility
X	Tennis Courts: Indoor Facility
X	Tennis Courts: Outdoor Facility
X	Ice Skating Rink: Indoor Facility
X	Bowling Facilities
	Museums
X	Cinemas
X	Performing Arts Facilities
X	Tourist Attractions
X	Youth Organizations (i.e., Scouts, 4-H)
X	Youth Sports: Baseball
X	Youth Sports: Soccer
X	Youth Sports: Football
X	Youth Sports: Basketball
X	Youth Sports: Hockey
	Campgrounds
X	Fishing/Hunting
X	Boating/Marinas
	Snowmobile Trails
X	Bicycle Trails
	Cross Country Skiing
	Beach or Waterfront Recreation Area
	Nearest Ski Area(s): Pat's Peak
	Other: Indoor rock climbing

Appendix G

Letters of Commitment from Critical Partners

Available Upon Request from Childhood Lead Poisoning Prevention Program

Appendix H

Workplan for July 2004 through June 2005

Workplan for July 2004 through June 2005

Reference for Staff Abbreviations Used in This Section

NCM	Nurse Case Managers
ELS	Environmental Lead Specialists
DCC	Data Control Clerk
DSM	Data/Surveillance Manager
HPA	Health Promotion Advisors
PM	Program Manager
PHL	Public Health Laboratories
AA	Administrative Assistant
MHD	Manchester Health Department
CHS	Child Health Services
NHD	Nashua Health Department

Primary Prevention Goal - Prevent lead exposure in young children.

Objective 1.1- Continue to distribute and annually evaluate *The Strategic Plan for the Elimination of Childhood Lead Poisoning in New Hampshire by 2010* (Elimination Plan).

Tasks	Start Date	End Date	Staff
Continue to distribute the Elimination Plan to stakeholders.	7/1/04	on-going	AA
Annually evaluate progress using the Logic Model.	7/1/04	on-going	PM
Revise and provide revisions to stakeholders annually.	4/1/05	6/30/05	PM, HPA
Evaluation Plan for Objective: Document evaluation, revisions, and distribution.			

Objective 1.2 - Maintain Statewide Lead Advisory Committee and Local Lead Action Committees in high-risk areas.

Tasks	Start Date	End Date	Staff
Continue to meet with the Statewide Advisory Committee at least twice per year.	7/1/04	on-going	PM
Meet with the Local Lead Action Committees at least quarterly.	7/1/04	on-going	HPA, ELS, NCM
Ensure two-way communication between the Statewide Advisory Committee and the Local Lead Action Committees.	7/1/04	on-going	PM
Evaluation Plan for Objective: Document meetings with meeting agendas and minutes. Document communication between committees.			

Eliminating Childhood Lead Poisoning in New Hampshire

Objective 1.3 – Collaborate with critical partners (Home Visiting New Hampshire, Head Start, The Way Home, NH Minority Health Coalition and Local Lead Action Committees) to provide intensive lead poisoning prevention education to at least 350 pregnant women and/or families with young children in high-risk areas through home visits and outreach.

Tasks	Start Date	End Date	Staff
Provide train-the-trainer session for critical partners on lead poisoning prevention curriculum.	7/1/04	6/30/05	ELS, NCM, HPA
Provide on-going technical assistance, support, materials and resources to critical partners.	7/1/04	on-going	ELS, NCM, HPA
Track screening rates and blood lead levels of children of home visiting enrollees at 12 and 24 months of age.	7/1/04	on-going	DSM, DCC
Evaluation Plan for Objective: Document prevention education for pregnant women and families with young children in the high-risk areas provided by critical partners. Surveillance of screening and blood lead levels.			

Objective 1.4 - Continue to provide lead poisoning prevention education to families of WIC children.

Tasks	Start Date	End Date	Staff
Ensure lead poisoning prevention materials are distributed to 100% of families with WIC vouchers.	7/1/04	6/30/05	HPA
Continue to provide ongoing education to WIC staff.	7/1/04	6/30/05	HPA
Explore additional methods for collaboration and materials distribution.	7/1/04	6/30/05	HPA, PM, NCM
Evaluation Plan for Objective: Document number of educational materials sent to WIC clinics. Document training of WIC staff. Document meetings with WIC to explore collaboration.			

Objective 1.5 - Continue to provide lead poisoning prevention education to Medicaid families.

Tasks	Start Date	End Date	Staff
Ensure prenatal lead education brochure is distributed in 100% of Medicaid enrollment packets for pregnant women.	7/1/04	6/30/05	HPA
Ensure lead referral card is distributed to 100% of Medicaid families with young children.	7/1/04	6/30/05	HPA
Explore additional methods for collaboration and materials distribution.	7/1/04	6/30/05	HPA, PM
Evaluation Plan for Objective: Document number of prenatal lead education brochures sent to Medicaid enrollees. Document number of referral cards sent to Medicaid enrollees. Document meetings with Medicaid to explore collaboration.			

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Objective 1.6 - Continue collaboration with New Hampshire Poison Information Center to distribute lead poisoning prevention education materials to 100% of pamphlet requests.

Tasks	Start Date	End Date	Staff
Ensure lead education insert is distributed in Poison Information Center pamphlet.	7/1/04	6/30/05	HPA
Evaluation Plan for Objective: Document number of lead education inserts distributed by Poison Information Center.			

Objective 1.7 – Pilot a comprehensive education campaign in one high-risk area utilizing best practices in health promotion, behavior change methodology, health literacy and social marketing.

Tasks	Start Date	End Date	Staff
Collaborate with the Center for Environmental Health Sciences at Dartmouth Medical School and the Greater Manchester Partners Against Lead Poisoning to create a comprehensive lead poisoning prevention campaign.	7/1/04	6/30/05	PM, HPA
Pilot and evaluate the campaign in Manchester.	7/1/04	6/30/05	PM, HPA
Make plans for using the campaign in other high-risk areas.	7/1/04	6/30/05	PM, HPA
Evaluation Plan for Objective: Plan development and implementation will be documented through meeting notes. The logic model will be used to evaluate the campaign in order to determine successful outcomes, next steps and detail best practice methods for other high-risk areas. Document plans for campaign in other high-risk areas.			

Objective 1.8 - Continue to build community capacity to mainstream lead-safe work practices through training at least 175 members of strategic partner groups in lead safety.

Tasks	Start Date	End Date	Staff
Provide a six-hour HUD approved Lead Safe Renovator course in each of the high-risk areas.	11/1/04	4/1/05	HPA, ELS
Provide a Property Owner workshop in each of the high-risk areas. Integrate other healthy homes topics.	4/1/05	6/30/05	HPA, ELS
Continue to explore collaboration and training needs of: Community Action Program Agencies, childcare providers, building trades program, code enforcement officers, private home inspectors and insurance agencies.	7/1/04	6/30/05	HPA, ELS, NCM
Evaluation Plan for Objective: Document number of trainings and number of participants trained. Document meetings and contacts with strategic partner groups.			

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Objective 1.9 - Provide New Hampshire Housing Finance Authority (NHHFA) with 100% of address information identifying housing units where children with blood levels of ≥ 20 $\mu\text{g}/\text{dL}$ on a single test or 15-19 $\mu\text{g}/\text{dL}$ on two tests taken at least 3 months apart reside.

Tasks	Start Date	End Date	Staff
Revise MOU with New Hampshire Housing Finance Authority.	7/1/04	7/31/04	PM
Provide monthly reports to NHHFA.	7/1/04	6/30/05	ELS, PM
Evaluation Plan for Objective: Document the number of units identified by CLPPP and transmitted to NHHFA. Submit report to NH Housing Financing Authority.			

Objective 1.10 - Work to increase availability and maintenance of lead safe housing in high-risk areas.

Tasks	Start Date	End Date	Staff
Continue to provide list of all Manchester outstanding Orders to the Manchester's Lead Hazard Control Program, to give the properties priority status for abatement.	7/1/04	6/30/05	ELS
Provide technical assistance to The Way Home.	7/1/04	6/30/05	ELS
Develop draft model safe housing codes for adoption by local jurisdictions.	1/1/05	6/30/05	ELS, HPA, PM
Research model lead safe housing registries.	1/1/05	6/30/05	ELS, HPA, PM
Evaluation Plan for Objective: Analyze data extracted from the LEAD database to determine the number of units that have complied with the Order. Document the technical assistance provided to groups. Draft submitted to CDC. Model safe housing registries compiled and evaluated for use in local jurisdictions.			

Objective 1.11 - Promote compliance to 75% of property owners with an active Order of Lead Hazard Reduction (Order).

Tasks	Start Date	End Date	Staff
Inform property owners and building occupants of the legal responsibilities regarding Order.	7/1/04	6/30/05	ELS
Contact property owners with overdue Orders requesting status of compliance.	7/1/04	6/30/05	ELS
Notice of Administrative Fines will be issued when a property owner fails to comply.	7/1/04	6/30/05	ELS, PM
Refer cases of long-term non-compliance to the Attorney Generals Office.	7/1/04	6/30/05	ELS, PM
Evaluation Plan for Objective: Analyze LEAD database to determine status of properties under Order and verified to be in compliance. Track number of property owner's contacted regarding compliance status.			

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Secondary Prevention Goal – Increase screening for children at highest risk for lead poisoning.

Objective 2.1 - Collaborate with other programs within the Office of Community and Public Health (OCPH) to ensure that 100% of contractors under the authority of the OCPH are testing all 1 & 2 yr olds.

Tasks	Start Date	End Date	Staff
Ensure that all contracts for Title V Child Health and Primary Care services are meeting their stated performance measures that require they report to OCPH annually; and if not, that they include a plan to improve performance.	7/1/04	6/30/05	PM
Evaluation Plan for Objective: Successful accomplishment of this objective will be demonstrated by the OCPH reporting effective screening rates.			

Objective 2.2 - Maintain communication with health care providers to keep them informed of any further revisions to the Guidelines, and to provide consultation, support and feedback. Based on individual needs, services will be provided to 100% of providers requesting a service.

Tasks	Start Date	End Date	Staff
Provide presentations regarding the Guidelines to 100% of health care provider groups in the designated high-risk areas.	7/1/04	6/30/05	NCM, HPA, DSM
Provide consultation to 100% of health care providers requesting clarification of the Guidelines for their specific recommendation areas.	7/1/04	6/30/05	NCM, HPA
Document calls from health care providers using the existing phone log database, to help identify gaps in the communication of Guidelines.	7/1/04	6/30/05	NCM, HPA
Continue to publish and distribute quarterly newsletter <i>LeadLine</i> to educate and communicate the screening recommendations and prevention efforts to health care providers.	7/1/04	6/30/05	HPA
Annually review and revise the Guidelines as necessary with input from the Statewide Advisory Committee and Medical Consultants.	7/1/04	6/30/05	NCM, HPA
Evaluation Plan for Objective: Successful accomplishment of this objective will be demonstrated by the continued distribution of the screening recommendations to health care providers in the state. Process indicators include: the number of presentations provided; the number of Guidelines distributed; number of additional resource materials distributed to physician offices; phone logs documenting the number of calls resulting in technical assistance being provided about the Guidelines. Document distribution of <i>LeadLine</i> .			

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Objective 2.3 - Ensure access to screening of one- and two- year olds in high-risk areas.

Tasks	Start Date	End Date	Staff
Provide screening of uninsured children at Manchester Health Departments, the Manchester WIC Clinic and refugee resettlement agencies.	7/1/04	6/30/05	MHD
Perform blood lead analysis for uninsured children.	7/1/04	6/30/04	PHL
Refer families with no access to health care to Child Health and Primary Care Centers, and Child Health Insurance Program.	7/1/04	6/30/05	NCM
Evaluation Plan for Objective: Document number of children tested at the Manchester Health Department, Manchester WIC clinic and at the refugee resettlement agencies, as well as the number of referrals provided to families with no access to health care.			

Objective 2.4 - Identify and report to providers those children enrolled in Medicaid who are due for screening.

Tasks	Start Date	End Date	Staff
Cross-match Medicaid enrollment records with the lead test database to identify screening status of Medicaid children.	7/1/04	6/30/05	DSM, DCC
Provide Medicaid screening ratio quarterly to OCPH finance office and secure payment from Medicaid for cost allocation.	9/30/04	6/30/05	DSM, PM
Provide Medicaid screening history to providers.	9/30/04	6/30/05	DSM, HPA
Evaluation Plan for Objective: Record Medicaid screening rates. Analyze and report on lead levels among Medicaid children. Document changes in elevations and screening rates among Medicaid children.			

Objective 2.5 - Continue to promote screening to one- and two-year old WIC enrollees.

Tasks	Start Date	End Date	Staff
Continue the mailing of the reminder postcard, developed during FY 00, to 100% of caretakers of WIC children at 12- and 24-months, to encourage screening and provide referrals.	7/1/04	6/30/05	HPA
Cross-match WIC children and lead screening data monthly and provide to New England Partners project.	7/1/04	6/30/05	DSM
Evaluate screening and EBLs of WIC children.	7/1/04	6/30/05	DSM
Evaluate impact of New England Partners pilot project on screening rates for WIC children upon its completion.	7/1/04	6/30/05	DSM
Evaluation Plan for Objective: Document number of reminder postcards mailed to caregivers. Record WIC screening rates. Analyze and report on lead levels among WIC children. Document changes in elevations and screening rates among WIC children.			

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Objective 2.6 - Increase the screening rate in high-risk communities among children age one by 3% and children age two by 5%. Analyze risk factors and redefine them if necessary.

Tasks	Start Date	End Date	Staff
Analyze data to determine screening rates for CY 2003 & 2004.	9/1/04	6/30/05	DSM
Provide information to health care providers.	1/1/04	6/30/05	NCM, HPA, PM
Increase health care provider compliance with federal and state mandates for screening Medicaid children at 12- and 24-months.	7/1/04	on-going	PM, NCM, HPA
Evaluation Plan for Objective: Screening rates for CY 2003 & 2004. Document reporting.			

Objective 2.7 - Assure that at least 90% of children with capillary BLL \geq 15 $\mu\text{g}/\text{dL}$ (pending cases) will have timely confirmatory testing done.

Tasks	Start Date	End Date	Staff
Continue contract with MHD, CHS and NHD to provide case management services.	7/1/04	6/30/05	PM
Assign each pending case to a primary case manager.	7/1/04	6/30/05	NCM
Contact health care provider to advise confirmatory testing within recommended timeframes specified in the Guidelines.	7/1/04	6/30/05	NCM
Analyze data to determine timeliness of confirmatory testing.	7/1/04	6/30/05	DSM
Address the delayed confirmatory testing.	7/1/04	6/30/05	PM, NCM
Evaluation Plan for Objective: Percentage of children with capillary BLL \geq 15 $\mu\text{g}/\text{dL}$ who had confirmatory testing done within the timeframes and percentage with delayed confirmatory testing performed within 6 months of recommended timeframes.			

Objective 2.8 - Assure that at least 80% of active cases (cases identified with venous BLL \geq 10 $\mu\text{g}/\text{dL}$) will have follow-up blood lead tests within the timeframes in the Guidelines.

Tasks	Start Date	End Date	Staff
For each new case, contact health care provider to advise appropriate follow-up.	7/1/04	6/30/05	NCM
Generate weekly STELLAR reports of cases due for follow-up.	7/1/04	6/30/05	DCC
Contact health care provider if child is overdue for follow-up.	7/1/04	6/30/05	NCM
Work with health care providers with poor rates of timely follow-up testing.	7/1/04	6/30/05	NCM, PM
Evaluation Plan for Objective: Percent of children with confirmed BLL \geq 10 $\mu\text{g}/\text{dL}$ who had follow-up testing done within recommended timeframes and percent that had delayed follow-up testing performed, but were late by less than 50% of recommended timeframe.			

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Objective 2.9 - Provide lead hazard risk reduction education to 100% of caregivers/guardians of children newly identified with a venous BLL ≥ 10 $\mu\text{g/dL}$.

Tasks	Start Date	End Date	Staff
Contact health care providers to gather missing required reporting data for all children newly identified with venous BLL ≥ 10 $\mu\text{g/dL}$.	7/1/04	6/30/05	DCC, NCM
Send letter and educational packet to caregivers of each child newly identified with venous BLL ≥ 10 $\mu\text{g/dL}$.	7/1/04	6/30/05	AA, NCM
Provide phone consultation to all caregivers who call CLPPP for guidance and/or information.	7/1/04	6/30/05	NCM, ELS
Provide technical assistance and consultation to health care providers.	7/1/04	6/30/05	NCM
Contact by telephone caregivers of children newly identified with venous BLL ≥ 10 $\mu\text{g/dL}$ for counseling re: lead hazard risk reduction.	7/1/04	6/30/05	NCM
Evaluation Plan for Objective: Document letters and information sent to caregivers/guardians of all newly identified children with venous BLL greater than 10 $\mu\text{g/dL}$. Document number of phone contacts with caregivers/guardians and health care providers. Review, provide feedback and submit quarterly reports from Manchester Health Department, Nashua Health Department, and Child Health Services.			

Objective 2.10 - Improve caregivers' knowledge and adoption of preventive behaviors in 50% of families with children with EBLs of ≥ 20 $\mu\text{g/dL}$.

Tasks	Start Date	End Date	Staff
Conduct initial environmental questionnaire among 100% of caregivers of children with an EBL of ≥ 20 $\mu\text{g/dL}$ to assess knowledge of key concepts and practice of preventive behaviors.	7/1/04	6/30/05	ELS, NCM
Conduct three-month follow-up assessment among 50% of caregivers of children with an EBL to assess knowledge of key concepts and practice of preventive behaviors.	7/1/04	6/30/05	NCM
Provide educational counseling and materials for lead poisoning prevention at initial visit and follow-up contact.	7/1/04	6/30/05	HPA, ELS, NCM
Evaluation Plan for Objective: Assess feedback from caregivers, ELS and NCM. Assess changes in caregivers' knowledge and behavior by comparing results of baseline and follow-up questionnaire. Track improves in educational counseling and materials.			

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Objective 2.11 - Conduct environmental investigations to identify potential sources of lead exposure for at least 75% of children identified with venous blood lead levels ≥ 20 $\mu\text{g/dL}$ or persistent venous blood lead levels of 15 - 19 $\mu\text{g/dL}$. At least 75% of completed inspections will be done within the time frames specified in CLPPP environmental protocols.

Task	Start Date	End Date	Staff
Make referrals for environmental investigations of children identified with a confirmed BLL ≥ 20 $\mu\text{g/dL}$ or with persistent BLL 15 - 19 $\mu\text{g/dL}$.	7/1/04	6/30/05	NCM
Administer questionnaire to caregivers/guardians to identify potential sources of lead exposure.	7/1/04	6/30/05	ELS, NCM
As allowed by law, conduct environmental inspections to identify lead paint hazards in the homes of children with confirmed BLL ≥ 20 $\mu\text{g/dL}$ or persistent BLL between 15 - 19 $\mu\text{g/dL}$.	7/1/04	6/30/05	ELS
As allowed by law, conduct environmental inspection and collect dust samples to identify lead paint hazards in other properties a child (with confirmed BLL ≥ 20 $\mu\text{g/dL}$) frequents.	7/1/04	6/30/05	ELS
As needed, collect soil and water samples to identify possible sources of the child's lead exposure.	7/1/04	6/30/05	ELS
On all home visits, determine if renovations have occurred.	7/1/04	6/30/05	ELS, NCM
Evaluation Plan for Objective: Analyze data from LEAD database to determine the number of new cases and the number of initial investigations conducted. Identify the number dust wipe tests analyzed. Identify number of tests on soil and water samples. Determine the timeliness of inspections conducted.			

Surveillance Goal – Maintain the integrity of surveillance data.

Objective 3.1 - Evaluate and improve surveillance data quality and completeness.

Tasks	Start Date	End Date	Staff
Monitor data quality & completeness for blood lead test data received from laboratories.	7/1/04	7/30/05	DSM, DCC
Work with labs and providers to ensure proper compliance to laboratory reporting requirements.	7/1/04	6/30/05	DSM, DCC, PM, PHL
Evaluation Plan for Objective: Document results of quality/completeness investigations. Documented activities related to improvements in quality/completeness.			

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Objective 3.2 - Submit 100% of reports to CDC Surveillance Database as scheduled by CDC.

Tasks	Start Date	End Date	Staff
Submit to CDC surveillance program.	7/1/04	6/30/05	DSM
Receive feedback on problem records & correct as necessary.	7/1/04	6/30/05	DSM, DCC
Evaluation Plan for Objective: Document successful submission of surveillance extract to CDC for each year of data within the timeframe requested to CDC.			

Objective 3.3 - Migrate from use of the STELLAR surveillance software to Lead Trax (from Welligent) for all surveillance record keeping, reporting and analysis.

Tasks	Start Date	End Date	Staff
Install and test Lead Trax software. Migrate legacy data to the new system. Set up reports and analysis.	9/1/04	10/30/04	DSM
Train CLPPP staff to use Lead Trax, set up procedures at reporting labs to upload lead test results to Lead Trax.	10/31/04	11/30/04	DSM, DCC
Use production Lead Trax system for regular surveillance activities.	1/1/05	6/30/05	DSM, DCC
Evaluation Plan for Objective: Track completion of tasks along project timeline. Document any barriers to completion of project, adjusting tasks and completion dates if necessary.			