Healthy Homes and Lead Poisoning Prevention Surveillance System (HHLPPSS)
Request for Extension

OMB No. 0920-0931
Expiration Date: April 30, 2015
Supporting Statement – Part A
Justification

January 25, 2021

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- Goal of the study:

  Improve health and quality of life by preventing disability through the control or elimination of lead exposure.

- Intended use of the resulting data:
  To determine whether targeted screening strategies are indeed identifying children at high risk in contact with lead contamination sources.

- Methods to be used to collect:

  Case management, home visits and healthy housing community outreach efforts.

- The subpopulation to be studied:
  Infant children to 6 years of age nationwide.

- How data will be analyzed:
  Descriptive statistics such as means and ranges will be used to characterize the collected data.

JUSTIFICATION A.1 Circumstances Making the Collection of Information Necessary

The Centers for Disease Control and Prevention (CDC) is requesting OMB approval for a three-year extension for the Healthy Homes and Lead Poisoning Prevention Surveillance System (HHLPPSS - OMB No. 0920-0931; expiration date: April 30, 2015). This data collection uses Section 301 of the Public Health Service Act (42 U.S.C. 241) as the authorizing law (Attachment A). The 60-day Federal Register Notice was published on 11/06/2014 (Attachment B), and is further discussed in Section A8.

Background

The mission of CDC's Healthy Homes and Lead Poisoning Prevention Program (HHLPPP – hereafter, the "Program") is to improve health and quality of life by preventing disability through the control or elimination of lead exposure in homes and elsewhere and of exposure to other housing-related health hazards. The Program fulfills its mission in a multi-faceted manner, which includes: providing financial and technical assistance to state, local, and territorial health departments for childhood lead poisoning prevention programs; providing a sound basis for policy decisions; and facilitating the integration of health issues in policies established by health, housing, and environmental agencies at the federal, state, local, and territorial levels. The significant and sustained decrease in blood lead levels among U. S. children is testament to the success of these activities.

Childhood and adult lead poisoning is just one of many adverse health conditions that are related to common housing deficiencies. Multiple hazards in housing (e.g., mold, vermin, radon and the lack of safety devices) continue to adversely affect the health of residents. For example, in older homes, water damage could cause leaded paint to peel and also support mold growth. This leads to both increased lead and mold exposures and poses a risk not only to increased blood lead and neurocognitive deficits of the resident children, but also a risk of more serious asthma. A visit to

the home for either lead or asthma could also identify high risk for radon exposure. It is in the interest of public health to expand from a single focus on lead poisoning prevention to a coordinated, comprehensive, and systematic approach to eliminating multiple housing-related health hazards. The CDC's National Center for Environmental Health (NCEH), through its experience with lead poisoning prevention and environmental health programs in states and communities, is recognized as a leader in the field of healthy housing by the World Health Organization, the U. S. Department of Housing and Urban Development and the U. S. Environmental Protection Agency.

Among adults, lead exposure causes acute and chronic adverse effects in multiple organ systems ranging from subclinical changes in function to symptomatic life-threatening intoxication. Moreover, evidence indicates that lead exposure at low doses can lead to adverse cardiovascular and kidney effects, cognitive dysfunction, and adverse reproductive outcomes. Current research has found decreased renal function associated with BLLs at 5 µg/dL and lower, and increased risk of hypertension and essential tremor at BLLs below 10 µg/dL. The vast majority of elevated blood lead levels (BLLs) in the United States are workplace-related. Most lead exposures at work occur in the manufacturing, construction, services, and mining industries. CDC National Institute for Occupational Safety and Health (NIOSH) is responsible for making recommendations for the prevention of work-related illnesses and injuries. NIOSH considers BLLs ≥10 µg/dL among adults to be elevated.

Housing conditions can significantly affect public health. In 1997, 7% of all U.S. households and 15% of low-income rental households lived in housing units with severe or moderate physical problems, with at least 2 million households living in severely inadequate housing (HUD, 2000). The US Department of Health and Human Services Healthy People 2010 goal called for a 52% reduction in the number of substandard occupied housing units. For the past decade, limited progress has been made towards accomplishing this goal.

In 2012, funding for the Program was reduced from $30 million to $1.5 million, which curtailed operational activities. The Program brought more state partners into production status using HHLPPSS in 2013. See Attachment G: 2013 HHLPPSS Deployment. The Program also collected lead data which was submitted to the CDC by the states in that same year. 2014 saw more emphasis placed on maintenance and systems updates for improving HHLPPSS. Software enhancements and information security controls were a significant part of this effort. This prepared the way for the Program to be restarted and accept new state partners to apply the most advanced version of HHLPPSS. They have begun to send the collected lead data to the states.

The overarching goal of this information collection is to establish the HHLPPSS at the state and national levels. Currently, 40 state and local Childhood Lead Poisoning Prevention Programs (CLPPP) and the state-based Adult Blood Lead Epidemiology and Surveillance (ABLES) program sponsored by NIOSH will report information (e.g., presence of lead paint, age of housing, and occupation of adults) to the HHLPPSS. Linking these two systems through HHLPPSS ensures that CDC can identify and intervene for occupational exposures, so-called 'take home' exposures when workers bring lead contaminated clothing or equipment home and expose children and childhood lead exposure from lead paint, contaminated water, soil, dust or consumer products. The Program anticipates up to 40 state and local programs will participate in the HHLPPSS information collection over the next three years.

A.2. Purpose and Use of Information Collection

Public Health Practice

HHLPPSS is a systematic assessment tool of programmatic activities under the nonresearch healthy homes cooperative agreement. In fiscal year 2011, the budget authorization, appropriation line, and Branch name were changed to reflect Congress' intention that the Program expand from a sole focus on lead poisoning to a broad mission to improve the nation's capacity to identify and address housing related health hazards.

This surveillance system will help CDC NCEH to monitor the activities of the healthy homes programs to ensure that services are timely and consistent with the terms of the cooperative agreement. An example of data screens developed for HHLPPSS are in Figures 1 & 2 (note the names and dates in the screen shots are fictional).

Figure 1. General Options (Setup) Screen

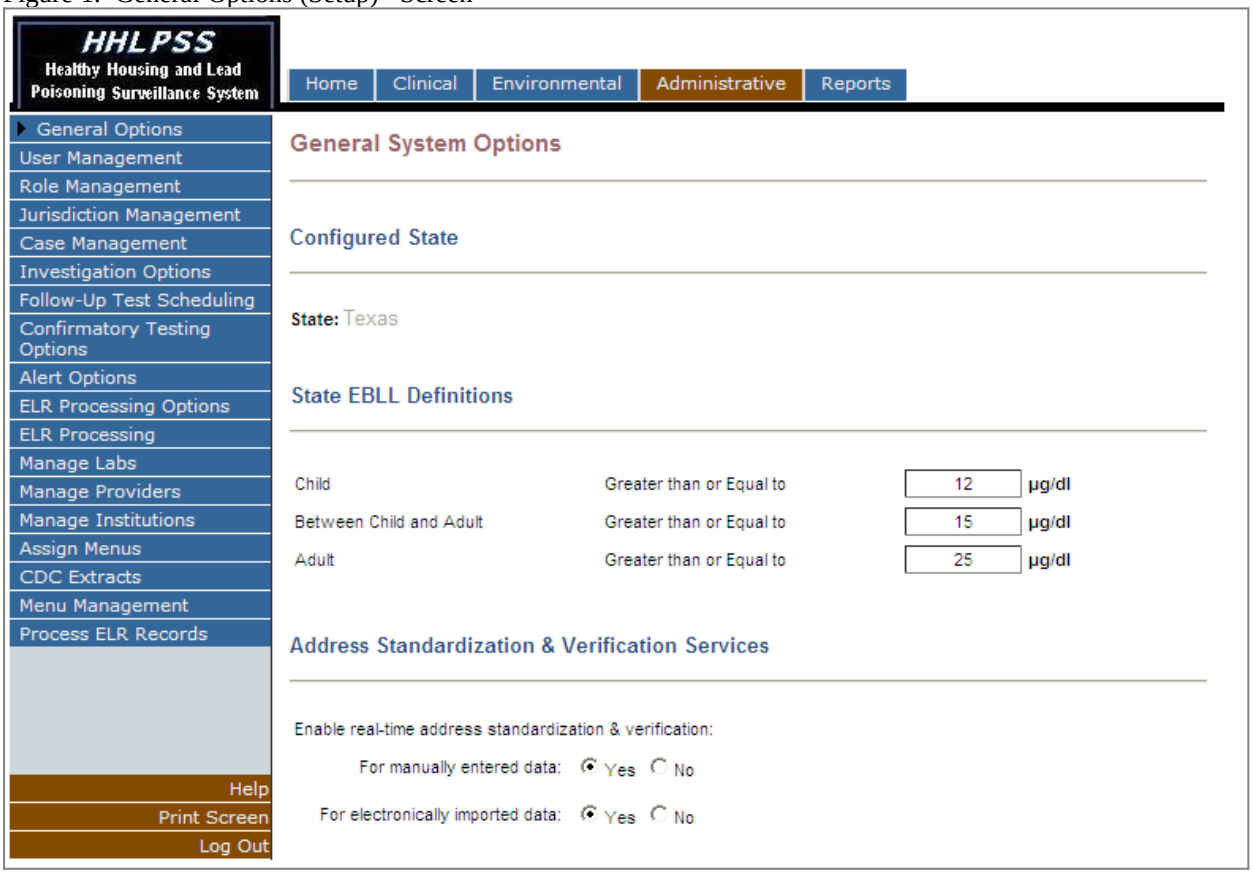
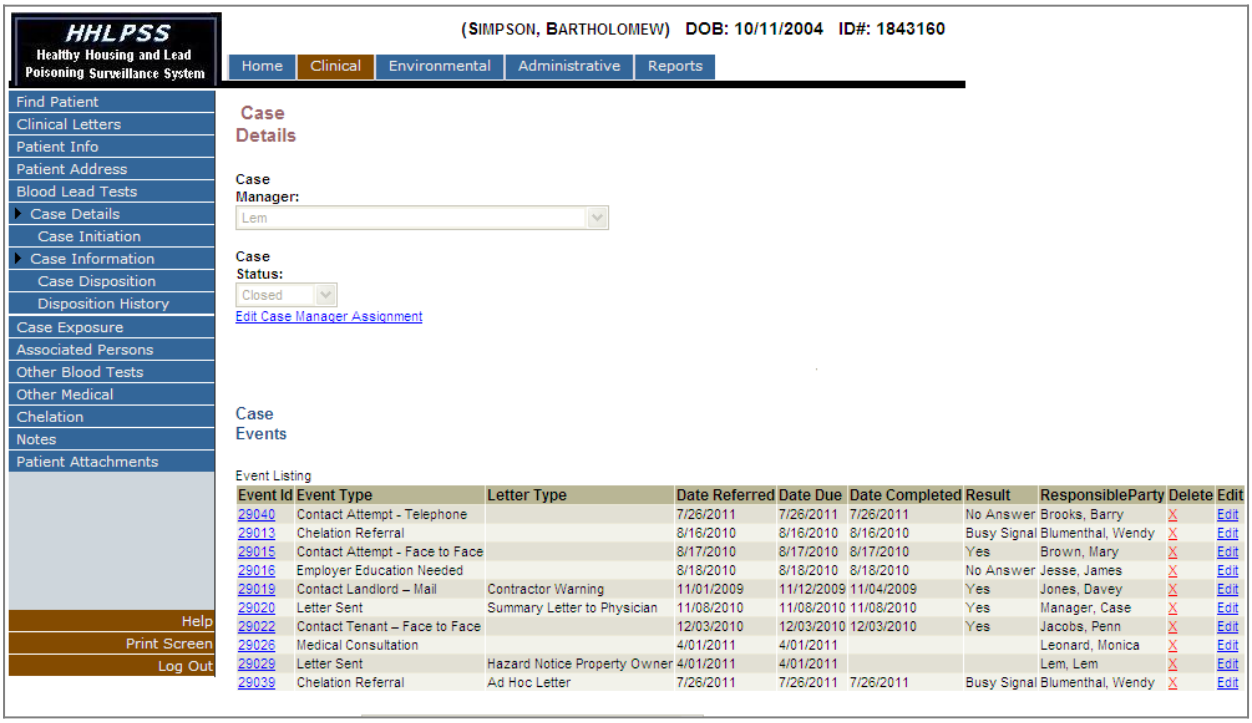


Figure 2. Case Details Screen



A.3. Use of Improved Information Technology and Burden Reduction

Reporting data to the Program using the HHLPPSS will not result in any federally-sponsored burden on residents of the homes that are visited.

The HHLPPSS software extracts these data fields from the data currently collected by the state, local, and territorial healthy home programs. These programs collect far more extensive data during home visits than are reported to the Program. For example, for a typical lead paint hazard inspection, while the home visitor records the lead concentration and paint conditions of all painted surfaces inside and outside the house, HHLPPSS only collects 8 data fields related to the lead inspection (See Attachment C).

State ABLES programs: 1) collect data on adult BLLs from laboratories and physicians through mandatory reporting; 2) assign unique identifiers to each adult to account for multiple BLL records, to protect individual privacy, and to permit longitudinal analyses; and 3) follow-up on adults with BLLs ≥25 µg/dL with laboratories, health-care providers, employers, or workers to ensure completeness of information (e.g., the industry where the adult is employed and whether the exposure source is occupational, nonoccupational, or both). All respondents (state, local, and territorial programs) will submit data electronically to CDC.

A.4. Efforts to Identify Duplication and Use of Similar Information

The HHLPPSS is a program management system designed to provide information on health and housing parameters and how they are addressed, and to record and transmit data. No other survey collects all of the elements that are collected through HHLPPSS. HHLPPSS data are also used by State ABLES programs to monitor blood lead levels among adults. Unlike the nationally representative CDC surveys such as the National Health and Nutrition Examination Survey

(NHANES), National Health Interview Survey (NHIS), Behavioral Risk Factor Surveillance System (BRFSS), and the U.S. Census American Housing Survey (AHS), HHLPPSS can provide more specific information about addresses and is available in real time. HHLPPSS can also be used to provide insight into trends in local areas as well as to understand the relationship with demographic and housing characteristics among those for whom measurements are available. This allows federal, state and local partners to use all the available data to target resources, to determine priorities and to modify these priorities if necessary. In addition only HHLPPSS can be used for program management and to evaluate the effectiveness of housing interventions in specific addresses as they are implemented via the state, local, and territorial programs funded by the Program.

A.5. Impact on Small Businesses or Other Small Entities

The collection of this information does not directly impact small businesses or small entities.

A.6. Consequences of Collecting the Information Less Frequently

Respondents will submit data on healthy homes and child blood lead levels to CDC on a quarterly basis. Adults blood lead levels will be sent to CDC on an annual basis. NIOSH will analyze adult blood lead data. The collection of this data with this frequency is necessary in order for CDC to monitor short-term trends, to monitor the progress toward elimination of housing hazards, and to oversee programmatic activities in a timely fashion.

A.7 Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

There are no special circumstances with this information collection package. This request fully complies with the regulation 5 CFR 1320.5.

A.8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A. The 60 day Federal Register Notice for this information collection, published in *Federal Register* Volume 79, Number 215, on November 6, 2014. No comments were received during the public comment period.

B. During the design phase of creating HHLPPSS, CDC's NCEH Healthy Homes and Lead Poisoning Prevention Program consulted with scientists and program managers from HUD and other CDC Programs. We have discussed availability of data and frequency of collection issues with subject matter experts (Table 1).

Table 1. List of experts consulted regarding study design and frequency of data collection

Name	Title	Affiliation	Contact information	Year of Consultation
Peter Ashley, DrPH	Director, Policy and Standards	U.S. Dept. of Housing and Urban Development (HUD)	Peter.J.Ashley@hud.gov Phone: 202-402-7595	2009

	Division			
Ralph Caraballo, PhD	Program Chief,	CDC, Epidemiology Program, Office on Smoking and Health, National Center for Chronic Disease Prevention & Health Promotion	Rfc8@cdc.gov Phone: 770-488-5732	2009
Michael Ballesteros, PhD	Deputy Associate Director for Science (acting)	CDC, Division of Unintentional Injury Prevention National Center for Injury Prevention & Control (NCIPC)	Zzb0@cdc.gov Phone:770-488-1308	2009
Jeanne Moorman, PhD	Survey Statistician	CDC, Epidemiologist, Air Pollution and Respiratory Health Program Division of Environmental Hazards and Health Effects	zva9@cdc.gov Phone: 770-488-3726	2009

In 2008-2010, the Program met with state and local healthy homes programs and asked them to identify those data elements related to healthy homes that they expected to collect under an expanded healthy homes program. During these meeting the data elements, questions and home assessment tools were standardized across programs. The changes to the asthma and ethnicity/race questions wording will be officially made available to the CDC-funded programs through a letter from the Program Chief and will become part of the cooperative agreement (Figures 3 and 4).

Figure 3: Healthy Homes - Asthma Page (Note identifying information is fictitious)

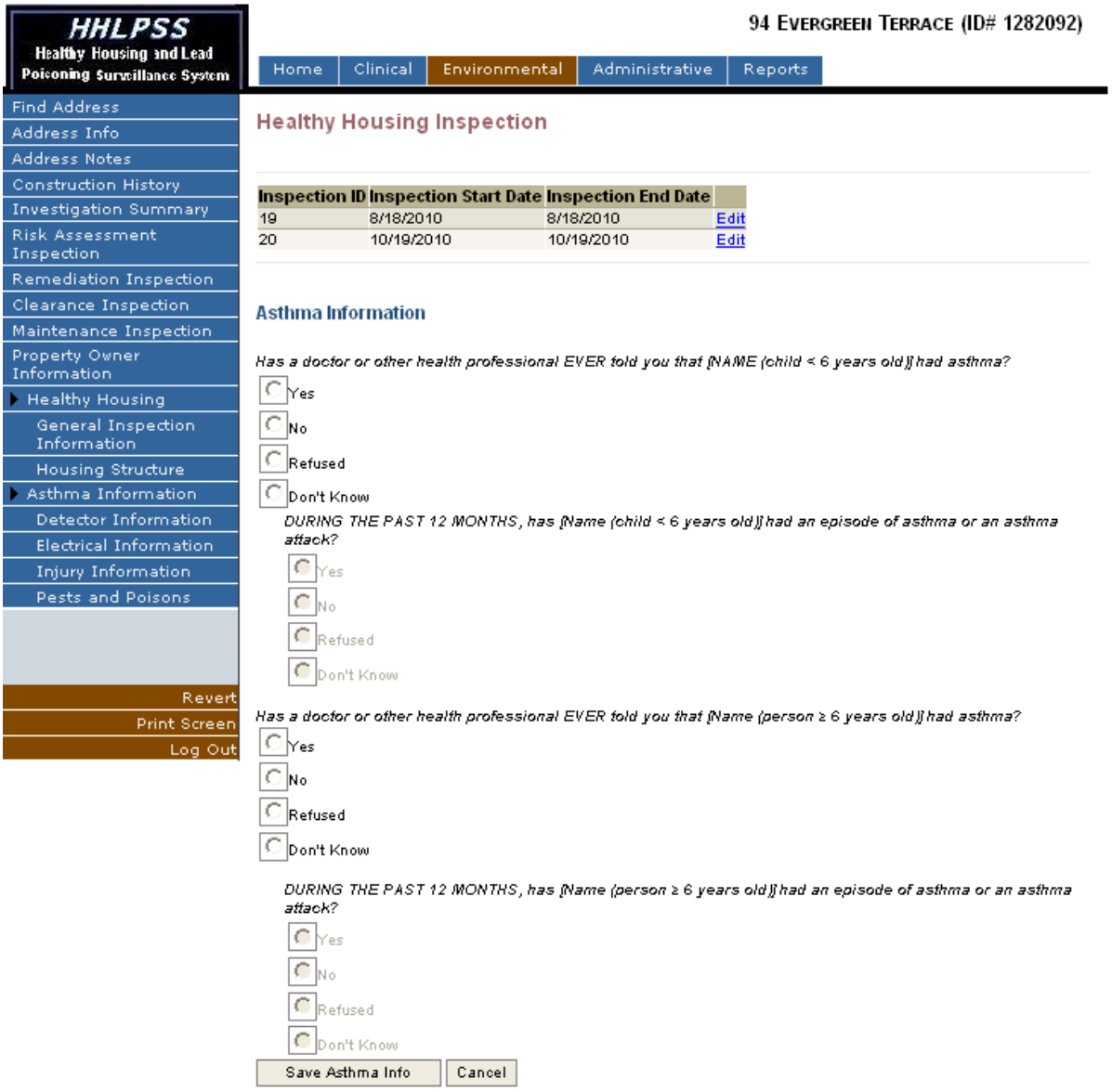
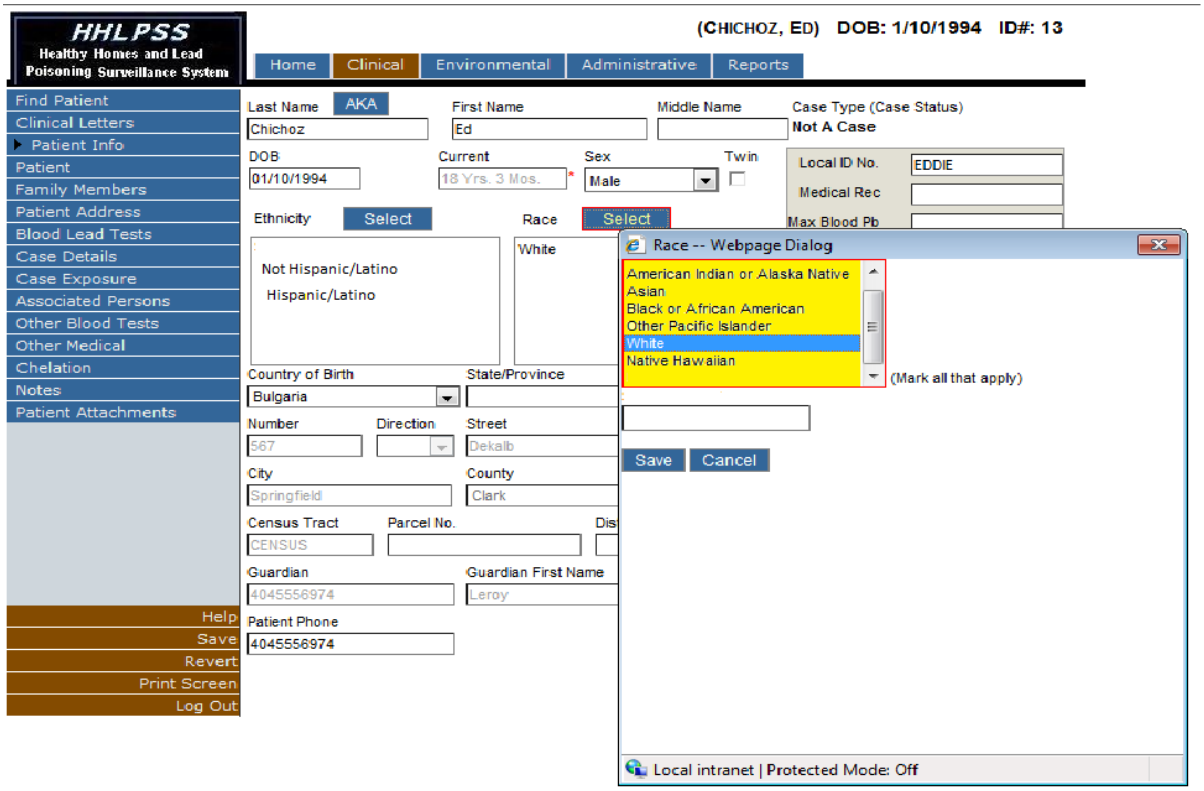

HHLPSS
Healthy Housing and Lead Poisoning Surveillance System
94 EVERGREEN TERRACE (ID# 1282092)
Home
Clinical
Environmental
Administrative
Reports
Find Address
Address Info
Address Notes
Construction History
Investigation Summary
Risk Assessment Inspection
Remediation Inspection
Clearance Inspection
Maintenance Inspection
Property Owner Information
Healthy Housing
General Inspection Information
Housing Structure
Asthma Information
Detector Information
Electrical Information
Injury Information
Pests and Poisons
Revert
Print Screen
Log Out
Healthy Housing Inspection
Inspection ID
Inspection Start Date
Inspection End Date
19
8/18/2010
8/18/2010
Edit
20
10/19/2010
10/19/2010
Edit
Asthma Information
Has a doctor or other health professional EVER told you that [NAME (child < 6 years old)] had asthma?
Yes
No
Refused
Don't Know
DURING THE PAST 12 MONTHS, has [Name (child < 6 years old)] had an episode of asthma or an asthma attack?
Yes
No
Refused
Don't Know
Has a doctor or other health professional EVER told you that [Name (person ≥ 6 years old)] had asthma?
Yes
No
Refused
Don't Know
DURING THE PAST 12 MONTHS, has [Name (person ≥ 6 years old)] had an episode of asthma or an asthma attack?
Yes
No
Refused
Don't Know
Save Asthma Info
Cancel

Figure 4: Ethnicity and Race Selection (Note identifying information is fictitious)



The questions listed in Attachment C are the questions that programs use in the field when assessing for the presence of one of the 5 priority housing related health hazards. Even if the healthy homes programs were not required to report information to the Program under the terms of the cooperative agreement, they would ask these standardized questions during home visits.

A.9 Explanation of Any Payment or Gift to Respondents

No payments will be provided.

A.10 Assurance of Confidentiality Provided to Respondents

A.10.1. Privacy Impact Assessment Information

HHLPPSS is hosted on the grantees networks, thus no Privacy Impact Assessment is required by OCISO. This submission has been reviewed by the NCEH/ATSDR OMB PRA Coordinator who has determined that the Supporting Statement A will take the place of a full Privacy Impact Assessment.

Overview of the data collection system

Data will be collected quarterly on healthy homes and child blood lead levels by CDC. Adults blood lead levels will be sent to CDC on an annual basis. NIOSH will analyze adult blood lead data. Attachment C provides a comprehensive list of all of the healthy homes and lead poisoning surveillance variables that will be collected by CDC via HHLPPSS.

Under cooperative agreement, the state, local, and territorial programs enter their data into a secured HHLPPSS website that is housed internally on their premises (cookies are not applicable to this website). In addition, there is no website content directed at children less than 13 years of age.

The CDC Program staff will explain to the funded surveillance programs that the intended uses of the data are for assessing trends in lead and housing data, and also to evaluate programmatic benchmarks (e.g., case management and referrals for housing-related problems) of their funded programs.

Items of information to be collected

Table 2. Home and health information collected by HHLPPSS.

Type of Data	Will be collected under HHLPPSS
Blood Lead Test Data	X
Race / ethnicity	X
Lead related housing characteristics (e.g. age of home, measurements of lead concentration in paint or oil)	X
Safety features (e.g. child safety locks, smoke detectors, show grab bars, window guards)	X
Other housing characteristics (e.g. water and mold damage, insect and rodent infestations, structural problems)	X
Behavioral characteristics (e.g. smoking in the home, unvented combustion appliances)	X
Resident Health (e.g. asthma of children or adults, recent childhood injuries in the home)	X

Table 3. Information In Identifiable Form (IIF) collected in HHLPPSS.

IIF Category collected by state, local, and territorial health departments	IIF Category sent to the CDC
Name	X
Date of birth	X
Phone numbers	
Medical information and notes	X
Email address	
Home address	X

CDC staff will receive electronic files with date of birth, medical and biological information, home address, and name. With the exception of the HHLPPSS ID number, these identifiers are removed when children turn six years of age. Each adult is given by the state a unique identifier and only date of birth is included in the dataset.

How the information will be shared and for what purpose
The Program staff will explain to the funded surveillance programs with whom information will be shared (i.e., to HUD and/ or EPA for enforcement of the Federal Lead Disclosure Rule Section 1018 of Title X and the Lead-Safe Housing Rule (45 CFR 164.512(b)), and the legal authority for the data collection (i.e., through the Public Health Service Act).

As described in more detail in Part B, CDC NCEH will share the de-identified data and/or results of the surveillance with interested parties through its website, publications, and peer-reviewed manuscripts. The limitations as well as the strengths of HHLPPSS data will be described in each of the venues including that HHLPPSS is not derived from a population-based representative sample. Specifically, consistent with the existing terms of clearance for this collection, the following language will ***always*** accompany any aggregate statistics that the federal government disseminates, including reports or testimony to Congress, on its web site, or as the justification for policy decisions or budget requests.

These data were collected for program management purposes. The data are not generalizable at the national, state, or local level. Furthermore, because inclusion criteria vary across grantees, comparisons of aggregate statistics across programs can be misleading (i.e., state policies and practices for blood lead testing vary and local priorities drive decisions regarding which homes receive assessments for other housing hazards). However, descriptive statistics can be used to compare changes over time in a given area when the method by which housing units are chosen for inclusion remains the same. With a thoughtful understanding of the approach used to include housing units in a given location, HHLPPSS can be used to make associations between the number of individuals in a given area and a specific housing hazard or health condition and geographic descriptors such as poverty, age of housing, tenancy, and health conditions.

Each of the participating state, local, and territorial health departments will have access only to their respective program's identifiable data. CDC will share address information with HUD and EPA for their use in assessing compliance and enforcing regulations to protect children's health.

Impact the proposed collection will have on respondent privacy
If there were a breach of security for any of the above IIF at CDC, some effect on the respondent's privacy could occur; however, there are a variety of safeguards in place as described below in Information Security.

Whether individuals are informed that providing the information is voluntary or mandatory
Blood lead tests are performed under state regulations for blood lead screening and are thus mandatory. However, providing information about the mandate in clinical affairs is not uniform.

Opportunities to consent, if any, to sharing and submission of information

No consent form for collection of this data is required as the data are part of state, local, and territorial surveillance efforts. Consent to share with other federal agencies is not required when it involves enforcement of the Federal Lead Disclosure Rule Section 1018 of Title X and Lead-Safe Housing Rule (45 CFR 164.512(b)).

Requirements for Disclosure of Known Lead-Based paint and/or Lead-Based Paint Hazards in Housing (24 CFR Part 35, Subpart H and 40 CFR Part 745, Subpart F). These joint HUD and EPA regulations require lessors of virtually all pre-1978 dwellings to disclose known information about lead hazards and provide an approved educational pamphlet to prospective tenants.

Please see Attachment F.

How the information will be secured
All collected data is secured in a password protected surveillance system. Only authorized state, local and territorial programs and CDC staff will have access to the raw data in HHLPPSS. Additionally, data from state, local, and territorial programs are uploaded using encryption software. Encrypted data files will be sent electronically to CDC. Physical controls will also be implemented. Data will be stored on highly-secured CDC servers in Atlanta, GA. Access to all CDC campuses is restricted by armed guards. The servers are housed in a secure computer room complete with climate control, emergency power, and an uninterruptible power supply (UPS). Daily back-ups and integrated security are implemented through the CDC computer services infrastructure. All data access is password-protected, and all network communications use encryption. All servers and PCs that are part of the CDC infrastructure are protected by both host-based firewalls and software in order to prevent the undetected installation of "spyware".

Whether a system of records is being created under the Privacy Act.
This submission has been reviewed by the CDC Information Collection Request Office (ICRO), which has determined that the Privacy Act does not apply.

A.11 Justification for Sensitive Questions

Questions that could be considered sensitive by at least a segment of the population such as information on pregnancy, smoking and injuries such as ever having been scalded because of water in the home are being asked about the individuals living in the homes as part of home inspections and blood lead assessment, and these variables are integral to accomplishing the purpose of this surveillance system. Table 7 describes the specific use of the possibly sensitive questions.

Table 4. Questions of a possibly sensitive nature

Questions (possibly sensitive)	Specific uses of information
Pregnant at time of test? (at time of blood lead test)	To assess prevalence of pregnant women with elevated blood lead, this provides important data for clinical follow up of

	women and their fetuses.
Race/ethnicity?	For targeting resources to subpopulations with high risk for elevated blood lead or housing risk factors
In the past 6 months, has anyone been scalded by the water in this home?	To assess efficacy of outreach activities and other interventions to decrease water temperature settings in the home
Do you (inspector) smell a musty odor anywhere in the home?	To assess risk for mold, evaluate effectiveness of related referrals and health education. Mold sampling is highly technical and recent publications have shown that mold odor is a predictor not only of mold exposure but is predictive of respiratory symptoms in some populations.
Does anyone who lives in this home smoke?	To assess risk for exposure to smoking, evaluate effectiveness of related referrals and health education. Smoking affects particulate matter in homes and can affect respiratory symptoms of residents.
Do you see evidence of cockroaches (bodies or fecal pellets)	To assess prevalence of cockroach exposures and efficacy of any interventions.
Do you see evidence of rodents (bodies, fecal pellets or gnaw marks)?	To assess prevalence of rodent exposures and efficacy of any interventions.

A.12 Estimates of Annualized Burden Hours and Costs

A. The respondents will be CDC cooperative agreement fund recipients from official state or territorial health departments, and/or departments of the environment who have received funds for developing and implementing a healthy homes and lead poisoning prevention program. The funded programs vary from year-to-year base upon conclusions of CDC objective review panels and the amount of funding available. Past experience with awardees funded by the Program informed the estimate of burden hours for the responses listed in Table 8. Data will be collected quarterly on healthy homes and child blood lead levels by CDC. Adults blood lead levels will be sent to CDC on an annual basis. NIOSH will analyze adult blood lead data. To maximize the burden hour estimates, we assumed that all awardees would submit quarterly reports.

Table 5. Estimated Annualized Burden Hours

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
State, Local, and Territorial Health Departments	Healthy Homes and Lead Poisoning Prevention Surveillance System (HHLPPSS) Variables	40	4	4	640

Total	640

B. Cost to respondents is estimated to be $36.60 per hour. This is based on the median hourly rate of pay for a computer programmer (http://www.bls.gov/oes/current/oes151131.htm) to extract and format data, initiate computer runs, and verify and transmit data to CDC.

Table 6. Estimated Annualized Burden Costs

Type of Respondents	Form Name	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
State, Local, and Territorial Health Departments	Healthy Homes and Lead Poisoning Prevention Surveillance System (HHLPPSS) Variables	40	4	4	640	$36.60	$23,424
Total							$23,424

A.13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

The cost estimate includes the following:

a) a total capital and start-up cost component – approximately $40,000 for computer hardware and software required for HHLPPSS. Many of the state, local, and territorial programs (e.g., health departments) already have existing equipment that can be used for HHLPPSS.

b) a total operation and maintenance and purchase of services – maintenance of HHLPPSS is approximately $5,000 per year. However, many of the state, local, and territorial programs (e.g., health departments) already have existing computer servicing and software contracts in place and these can be used for HHLPPSS.

A.14. Annualized Cost to the Government

For the past several years, the CDC Program had a congressional appropriation for lead-related activities. For Fiscal Year (FY) 2010, the appropriation was expanded to include healthy homes activities. The Program's FY 2014 budget is $15,000,000. For HHLPPSS, five federal and contracted employees, two of whom will be contributing on a full-time basis, will carry major responsibility or oversight of the national surveillance system and management and analysis of the data. Other tasks involve the extraction and formatting of data, initiate computer runs, and verify data that is transmitted to CDC.

See the included table below.

FY14 – HHLPPSS

Contractor Salaries	$541,851.87
Travel (Budget Estimate)	$45,000.00
Materials	$42,330.00
Training	$10,000.00
G&A on ODCs (excludes training)	$10,808.13
TOTAL Contractor Price (ODC – 108138.13))	--
Total Contract Price	**$640,000**

The total overall operational and maintenance costs for HHLPPSS is $640,000 annually.

In FY14, a detailed review of HHLPPSS by the CDC IT Project Manager determine additional development and management needs were required, including additional database, coding and analyst contractor support. Due to those findings, DEEHS/HHLPPP increased the contract support funding for HHLPPSS to $735,048 (this includes a fee to GSA for contract support). In FY15, the planned contract amount for HHLPPSS is estimated at $640,000. This amount is again determined upon the needs of the program, as reviewed by the CDC IT Project Manager, and an Independent Government Cost Estimate completed by the Deputy Program Manager. That contact will, as it did for FY14 spending, cover 4.5 contract support specialists ranging from database administrator to direct user support, and will focus primarily on management and operations of the system, along with a finite amount of development related to state/local health agency user requests.

A. 15. Explanation for Program Changes or Adjustments

This is an extension of a previously approved data collection.

A.16. Plans for Tabulation and Publication and Project Time Schedule

Each state, local, and territorial program has developed a plan for timely analysis and dissemination of summary data to appropriate state-level agencies and individuals. CDC will analyze the national data set and on an annual basis will disseminate results to the state, local, and territorial programs and to a broader audience via public health publications and other media. CDC will also provide this information to Executive Program officials, Congress, healthy homes constituents, and other federal, state, and local agencies. The dissemination of these results will always include the following caveats:

These data were collected for program management purposes. The data are not generalizable at the national, state, or local level. Furthermore, because inclusion criteria vary across grantees, comparisons of aggregate statistics across programs can be misleading (i.e., state policies and practices for blood lead testing vary and local priorities drive decisions regarding which homes receive assessments for other housing hazards). However, descriptive statistics can be used to compare changes overtime in a given area when the method by which housing units are chosen for inclusion remains the same. With a thoughtful understanding of the approach used to include housing units in a given location, HHLPPSS can be used to make associations between the

number of individuals in a given area and a specific housing hazard or health condition and geographic descriptors such as poverty, age of housing, tenancy, and health conditions.

Table 7. Project Time Schedule

Activity	Time Schedule
States will submit data files quarterly, except for reporting of adult blood lead levels which will be submitted semi-annually	1-3 months after OMB approval and every 3 months thereafter
Analyze data	Approximately 12 months after OMB approval
Disseminate publication/ Data	Approximately 12 months after OMB approval

The analysis plan includes descriptive statistics to show prevalence of environmental exposures and health outcomes (i.e., peeling paint in homes, presence of carbon monoxide and smoke alarms, elevated blood lead levels, and asthma). Statistical approach is described in Part B.

A.17. Reason(s) Display of OMB Expiration Date is Inappropriate

Exemption from displaying the expiration date for the OMB approval of forms is not being requested.

A.18 Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.