LEAD POISONING PREVENTION COMMISSION

2012 ANNUAL REPORT

SUBMITTED ON BEHALF OF THE LEAD POISONING PREVENTION COMMISSION
BY THE
MARYLAND DEPARTMENT OF THE ENVIRONMENT

2012
ANNUAL REPORT
LEAD POISONING PREVENTION COMMISSION

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MARYLAND DEPARTMENT OF THE ENVIRONMENT

LEAD POISONING PREVENTION COMMISSION OVERVIEW

The Lead Poisoning Prevention Commission, established under Environment Article 6, Subtitle 8, advises the Department of the Environment, the Legislature, and the Governor regarding lead poisoning prevention in Maryland.

COMMISSION MEMBERSHIP

The Lead Poisoning Prevention Commission consists of 19 members. Of the 19 members:

(i) One shall be a member of the Senate of Maryland, appointed by the President of the Senate;
(ii) One shall be a member of the Maryland House of Delegates, appointed by the Speaker of the House; and
(iii) 17 shall be appointed by the Governor as follows:

1. The Secretary or the Secretary's designee;
2. The Secretary of Health and Mental Hygiene or the Secretary's designee;
3. The Secretary of Housing and Community Development or the Secretary's designee;
4. The Maryland Insurance Commissioner or the Commissioner's designee;
5. The Director of the Early Childhood Development Division, State Department of Education, or the Director's designee;
6. A representative of local government;
7. A representative from an insurer that offers premises liability coverage in the State;
8. A representative of a financial institution that makes loans secured by a rental property;
9. A representative of owners of rental property located in Baltimore City built before 1950;
10. A representative of owners of rental property located outside Baltimore City built before 1950;
11. A representative of owners of rental property built after 1949;
12. A representative of child health or youth advocacy group;
13. A health care provider;
14. A child advocate;
15. A parent of a lead poisoned child;
16. A lead hazard identification professional; and
17. A representative of child care providers.

In appointing members to the Commission, the Governor shall give due consideration to appointing members representing geographically diverse jurisdictions across the State.

The term of a member appointed by the Governor is 4 years. A member appointed by the President and Speaker serves at the pleasure of the appointing officer. The terms of members are staggered as required by the terms provided for the members of the Commission on October 1, 1994. At the end of a term, a member continues to serve until a successor is appointed and qualifies. A member who is appointed after a term has begun serves only for the remainder of the term and until a successor is appointed and qualifies. (1994, ch.114, § 1; 1995, ch. 3, § 1; 2001, ch. 707; 2006, ch.44.)

COMMISSION RESPONSIBILITIES

1. The Commission shall study and collect information on:

    - The effectiveness of legislation and regulations protecting children from lead poisoning and lessening risks to responsible property owners;

    - The effectiveness of the full and modified lead risk reduction standards, including recommendations for changes;

    - Availability and adequacy of third-party insurance covering lead liability, including lead hazard exclusion and coverage for qualified offers;

    - The ability of state and local officials to respond to lead poisoning cases;

    - The availability of affordable housing;

    - The adequacy of the qualified offer caps;

    - The need to expand the scope of this subtitle to other property serving persons at risk, including child care centers, family day care homes, and preschool facilities.

2. The Commission may appoint subcommittees to study subjects relating to lead and lead poisoning.

3. The Commission shall give consultation to the Department in developing regulations to implement Environment Article 26.16 (House Bill 760).

4. The Commission will prepare or participate in the preparation of the following reports:

    - Assist MDE and HCD to study and report on methods for pooling insurance risks, with recommendations for legislation as appropriate by January 1, 1995;

    - Develop recommendations in consultation with the Department of Housing and Community Development (HCD) by January 1, 1996, for a financial incentive or assistance program for window replacement in affected properties;

    - Provide an annual review of the implementation and operation of the Lead Poisoning Prevention Program under HB 760, beginning January 1, 1996.

COMMISSION MEETINGS

Frequency, times and places. - The Commission shall meet at least quarterly at the times and places it determines.

Chairman. – From among the members, the Governor shall appoint the Chairman of the Commission.

Quorum. – A majority of the members then serving on the Commission constitutes a quorum.

The Commission may act upon a majority vote of the quorum.

Compensation; expenses. A member of the Commission:
(1) May not receive compensation; but
(2) Is entitled to reimbursement from the Fund for reasonable travel expenses related to attending meetings and other Commission events in accordance with the Standard State Travel Regulations. (1994, ch. 114, § 1.)

LEAD POISONING PREVENTION COMMISSION MEMBERS

NAME/ADDRESS	MEMBER CATEGORY
Patrick T. Connor, President CONNOR Bare Hills Business Center 1421 Clarkview Road Baltimore, MD 21209-2188 Tel: (443) 322-1206 direct dial Cell: (443) 695-3824 Fax: (410) 296-3419 E-mail: pconnor@connorsolutions.com	Lead Hazard Identification Professional
Maura Dwyer, M.D. Center for Maternal Child Health Dept. of Health and Mental Hygiene 201 West Preston Street – Room 308 Baltimore, MD 21201 Tel: (410) 767-3702 Fax: (410) E-mail: mdwyer@dhmh.state.md.us	Designee for the Secretary of the Department of Health and Mental Hygiene
Cheryl Hall Maryland State Dept. of Education Division of Early Childhood Development Office of Child Care – Licensing Branch 200 W. Baltimore Street Baltimore, MD 21202 Tel: 410-767-7811 FAX: 410-333-8699 E-mail: Cheryl.Hall@msde.state.md.us	The Director of the Early Childhood Development Division, State Department of Education, or the Director's designee
Melbourne E. Jenkins, Jr. 1950 Old Gallows Road Suite 600 Vienna, VA 22182 Tel: (703) 902-9487 or 2000 Fax: n/a E-mail: melj@smcmail.com	A representative of owners of rental property located in Baltimore City built before 1950
Ed Landon Dept. of Housing and CD 100 Community Place Crownsville, MD 21032 Tel: (410) 514-7444 Fax: n/a E-mail: Landon@mdhousing.org	Designee for the Secretary of the Department of Housing and Community Development

Patricia McLaine, RN, MPH 5328 Eliots Oak Road Columbia, MD 21044 Tel: (410) 706-5868 Cell: (443) 520-9678 Fax: (410) 706-0253 E-Mail mclaine@son.umaryland.edu	Representative of Child Health/Youth Advocate Group
Barbara Moore, MSN, RN, CPNP Mount Washington Pediatric Hospital 1708 West Rogers Avenue Baltimore, MD 21209 Tel: (410) 578-5172 Fax: (410) 465-3518 E-mail: bmoore@mwph.org and	Health Care Provider
Linda Roberts, Vice President Edgewood Management Corporation Silver Spring Metro Plaza II 8403 Colesville Road, Suite 400 Silver Spring, MD 20910 Tel: (301) 562-1766 Fax: (301) 562-1670 E-mail: lroberts@emcmgmt.com	Representative of owners of rental property built after 1949
Mary Snyder-Vogel Director of Social Work Kennedy Krieger Institute 716 North Broadway – Room 137 Baltimore, MD 21205 Tel: (443) 923-2812 Fax: (443) 923-9575 E-mail: vogel@kennedykrieger.org	Child Advocate
Karen Stakem Hornig Deputy Commissioner Maryland Insurance Administration Office of the Commissioner 200 Saint Paul Place Suite 2700 Baltimore, MD 21202-2004 Tel: (410) 468-2010 Fax: (410) 468-2020 E-mail: khornig@mdinsurance.state.md.us	The Maryland Insurance Commissioner or the Commissioner's designee
VACANT	A representative of Local Government
VACANT	A representative from an insurer that offers premises liability coverage in the State
VACANT	A representative of a financial institution that makes loans secured by a rental property

VACANT	A representative of owners of rental property located outside Baltimore City built before 1950
VACANT	A representative of child care providers
VACANT	The Secretary's or the Secretary's Designee for MDE
VACANT	Parent of a Lead Poisoned Child
LEGISLATIVE REPRESENTATIVES	
VACANT	Senate of Maryland
Nathaniel Oaks 317 Lowe Office Building 6 Gov. Bladen Boulevard Annapolis, MD 21401 410-841-3283 301-858-3283 Nathaniel.oaks@house.state.md.us Noaks@iwif.com	House of Delegates
DEPARTMENT OF THE ENVIRONMENT STAFF	
John O'Brien Maryland Department of the Environment Land Management Administration Lead Poisoning Prevention Program 1800 Washington Boulevard Baltimore, MD 21230-1719	Tel: (410) 537-3090 Fax: (410) 537-4112 email: jobrien@mde.state.md.us
Tracy Smith, Administrative Officer Maryland Department of the Environment Land Management Administration Lead Poisoning Prevention Division 1800 Washington Boulevard Baltimore, MD 21230-1719	Tel: (410) 537-3847 Fax: (410) 537-3002 email: tsmith@mde.state.md.us

ATTENDANCE RECORD 2012: GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

MEMBER NAME	1/5/12	2/2/12	3/1/12	4/5/2012	5/3/12	6/7/12	7/12/2012	8/11/2011	8/2/12	10/4/2012	11/8/12	12/6/12	ATTENDANCE AVERAGE
								C					
CONNOR, Patrick	P	P	P	P	P	P	P		A*	A*	A*	P	73%
DWYER, Maura	A*	A*	P	P	P	A*	A*		P	A*	A*	A*	36%
								A					
HALL, Cheryl	P	P	P	P	P	A*	P		P	P	P	A*	82%
HORNIG, Karen Stakem (June 2012)						6/15/12 official appt.	A*(wasn't notified of her appt.		P	P	P	P	100%
								N					
JENKINS, Melbourne	P	A*	P	P	A*	P	P		A*	P	A*	A*	55%
LANDON, Edward	P	P	P	P	P	P	P		P	P	P	A*	91%
MCLAINE, Patricia	P	P	P	P	P	P	P	C	P	P	P	P	100%
MOORE, Barbara	P	P	P	P	A*	P	P		P	P	P	P	91%
OAKS, Nathaniel (Delegate)	P	P	A*	P	P	P	A*	E	P	P	P	A*	73%
ROBERTS, Linda	P	A*	P	P	P	A*	P		A*	A*	A*	P	55%
SNYDER-VOGEL, Mary	P	P	A*	P	A*	A*	A*	L	A*	A*	P	A*	36%
VACANT - Secretary of the Environment or Designee													
VACANT - Local Government								E					
VACANT - Parent of a Lead Poisoned Child													
VACANT - Financial Institution								D					
VACANT - Child Care Providers													
VACANT - Insurer													
VACANT - Property Owner Pre-1950 Outside Balto City													
VACANT - Maryland Senate													

P - Present A - Absent A* - excused

Mary Snyder-Vogel's absences are excused due to medical. She is scheduled to return to meetings in February 2013

JANUARY 5, 2012

LEAD POISONING PREVENTION COMMISSION MEETING

MEMBERS

Governor's Lead Commission Meeting Attendance Sheet

1/5/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

Name/Signature	Representing	Telephone/Email
CONNOR, Patrick	Hazard ID Professional	
DWYER, M.D.Maura	Department of Health and Mental Hygiene	
HALL, Cheryl	Office of Child Care	
JENKINS, Melbourne	Property Owner Pre 1950	
LANDON, Edward	Dept. Housing and Community Dev.	410-514-7441
McLAINE, Patricia	Child Health/Youth Advocate	
MOORE, Barbara	Health Care Provider	
OAKS, Nathaniel (Delegate)	Maryland House of Delegates	
ROBERTS, Linda Lee	Property Owner Post 1949	
SNYDER-VOGEL, Mary	Child Advocate	443-923-7812
VACANT	Secretary of the Environment or Designee	
VACANT	Local Government	
VACANT	Parent of a Lead Poisoned Child	
VACANT	Financial Institution	
VACANT	Child Care Providers	
VACANT	Insurer	
VACANT	Property Owner Pre 1950 Outside Baltimore City	
VACANT	Maryland Insurance Administration	
VACANT	Maryland Senate	

GUESTS

Governor's Lead Commission Meeting Attendance Sheet

1/5/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

Name	Representing	Address/Telephone/Email
✓ Dan Schmidt	MMHA	dschmidt@mmhaonline.org 410 8256868
✓ Jeff Krupinsky	MDE	JKRUPINSKY@MDE.STATE.MD.US
✓ Ken Strong	Balto. City Housing	Ken.Strong@baltimorecity.gov
✓ Paula Montgomery	MDE	pmontgomery@mde.state.md.us
✓ Shaketta Denson	CECLP	sdenson@lelutsafe.org
✓ Wes Stewart	CECLP	"
✓ Sybil Wojcio	DHMH	swojcio@dhmh.state.md.us
✓ Geraldine Woodson	BCHD	geraldine.woodson@baltimorecity.gov
✓ JOHN O'BRIEN	MDE	(410) 537-3225 jobrien@mde.state.md.us
✓ Tracy Smith		
✓ Donna Webster	[illegible]	

LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Thursday, January 5, 2011
9:30 AM - 11:30 AM

PATUXENT Conference Room – 6th Floor

AGENDA

I. Introductions

II. Approval of December 1, 2011 minutes

III. Future meeting dates:

The next Lead Commission meeting is scheduled for Thursday, February 2, 2012 at MDE in the AERIS Conference Room – Front Lobby, 9:30 am – 11:30 am.

IV. Update from 2010 Plan Taskforce – **The next meeting - TBD**

V. Discussion:
   A. Update on the 2010 revisions
   B. Discussion of Plans for 2012

VI. Agency Updates
   A. Maryland Department of the Environment
   B. Department of Health and Mental Hygiene
   C. Department of Housing and Community Development
   D. Baltimore City Health Department
   E. Office of Childcare
   F. Maryland Insurance Administration
   G. Other Agencies

VII. Public Comment

GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

PATUXENT CONFERENCE ROOM
January 5, 2012
APPROVED Minutes (3-1-12)

COMMISSIONERS IN ATTENDANCE

Patrick Connor, Cheryl Hall, Melbourne Jenkins, Edward Landon, Pat McLaine, Barbara Moore, Linda Roberts, Delegate Nathaniel Oaks, and Mary Snyder-Vogel.

COMMISSIONERS UNABLE TO ATTEND

Dr. Maura Dwyer

GUESTS IN ATTENDANCE

Shakietta Denson – CECLP, Wes Stewart – CELP, Dana Schmidt -MMHA, Donna Messick – WCHD (via conference phone), Ken Strong – Baltimore City Housing, Sybil Wojcib – DHMH, Geraldine Woodson – BCHD, John O'Brien – MDE staff, John Krupinsky – MDE staff, Paula Montgomery – MDE staff and Tracy Smith – MDE staff.

INTRODUCTIONS

Pat McLaine began the meeting at 9:40am. Minutes were voted on and approved from the December 1, 2011 meeting.

There will be a task force meeting on January 12, 2012 at 9am. The summer study is in draft and is being worked on.

FUTURE MEETING DATES

The next scheduled meeting is February 2, 2012 at MDE in the AERIS conference room. The Commission will meet from 9:30am - 11:30am.

DISCUSSION

Mr. Ken Strong from Baltimore City Housing announced that a lead abatement division chief had been chosen. Mr. Strong discussed that his agency will be submitting an application to HUD for lead abatement funding, with a goal of abating at least 210 homes. The application includes additional outreach and education, including home visits in partnership with the Baltimore City Health Department for children at risk (blood lead levels between 4 – 9 µg/dl).

Mr. Strong requested a letter of support from the Commission for help with his agency's application and discussed the formation of a Baltimore City lead commission that is in-sync but not duplicative from the State's lead commission.

No official word on the status of potential reduced funding from both CDC and MSDE Office of Child Care. 2012 concerns will be addressed via legislation next month.

MDE discussed concerns with HELPS (including the manual input of data.) Data from the Baltimore City Health Department is being migrated into the database. DHMH has of all of software that is needed.

Wes Stewart reported that there have been 160 qualified offers; 86% of properties were non-compliant and not eligible for qualified offers. Qualified offers have not been a large part of the law. MDE is working with the Coalition to revise the contract.

Pat McLaine inquired about the status of on-line registration that has been in effect since November 14th. MDE explained that there have been some system changes but the process is going a lot better than anticipated.

MDE has performed a lot of outreach in the last 3 – 4 months, specifically with regards to changes in inspection requirements as a result of changes to [LAW}. MDE has had 8 meetings with property owner associations, 4 contractor meetings and inspection certificate exchanges.

Pat McLaine mentioned the comment period on emergency regulations. Comments on regulations are to be directed to Paula Montgomery

A Healthy Home demonstration will be presented at the Commission's March meeting.

Agency Updates

DHCD - Ed Landon

Indicated that property maintenance training has begun in the State.

Baltimore City Health Department – Geraldine Woodson

Nothing to report

Office of Child Care – Cheryl Hall

The potential loss of $147,000 (2 Sanitarians and an administrative person) for child care agency in Baltimore City was discussed, including the hiring of independent inspectors to perform lead testing. Concern that the child care operator may have to pay for these inspections. Loans from the State are available but take time to be approved. Day care centers are not eligible for money from HUD.

Ken Strong, Baltimore City Housing, provided an update on progress and requested the Commission's help in a letter of support for Baltimore City Housing's application for funding from HUD. Eight commission members voted in favor of sending a letter of support, one abstention. Pat McLaine will prepare and circulate a letter of support.

Wes Stewart reported that the coalition will conduct property owner training in Carroll County today and in College Park next week.

There were no legislative issues today. The summer study report should be completed by the end of the week.

The meeting was adjourned at 11:06am.

With regards to the MDE update, would it be possible to address these issues:

1. What is MDE's preliminary assessment related to potential reduction in CDC funding?
   RESPONSE: No official word from CDC on reduction of funding at this time; the 2011 Summer Study Group is addressing long-term funding for the Lead Program.

2. Which County HDs have at least one currently accredited Lead Risk Assessor on staff? **RESPONSE:** These are all what are believed to be current Risk Assessors in Baltimore City for the Baltimore City Hlth Dept, Healthy Homes Division. None are funded through the current MOU MDE has with BCHD.

   For the performance of LPC investigations:

   Baltimore City Health Department has at least seven (7): Geraldine Woodson, William Carter, Karen Di Ferdinano (PT), Jennifer Gabella, Ephraim Maduabuchi, Valerie Millings, Valerie Parker,

   Prince George's County has one (1): Ali Golshiri - funded by PG County

3. Based on court ruling, what is cost savings to MDE based on elimination of qualified offer counseling services? How many dollars have been recaptured from existing contracts?
RESPONSE: MDE is working with the Contractor (The Coalition) in revising the contract.

4. Any update on new CLR software?
   RESPONSE: The online system is up and operational for the public, rental registry personnel, and to other MDE staff.

   There are some system changes that are being worked on with the aid of IT and the vendors. These are to allow changes to data such as the ability to update owner's information, add units to properties already registered, and add additional features for searches.

   The online system is processing registrations/renewals and collecting fees for both transactions.

   The new online system has the ability to easily create a report for how many mailed-in payments are pending. The report will be checked weekly and the staff will receive

feedback on their progress. Adjustments will be made if necessary to deal with the changing load.

5. 2011 Lead Summer Report – draft is being finalized as we speak.

THE GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

January 18, 2012

Jon L. Gant, Director
Office of Healthy Homes and Lead Hazard Control
U.S. Department of Housing and Community Development
451 7th Street, SW
Washington, DC 20410

Re: HUD Lead Hazard Reduction Demonstration Grant Program – The Baltimore City Lead Hazard Reduction Program (BC-LHRP) Proposal

Dear Mr. Gant,

The State of Maryland's Lead Poisoning Prevention Commission endorses and supports the Baltimore City Department of Housing and Community Development's application, *Baltimore City Lead Abatement Program Proposal,* in response to Notice of Funding Availability for HUD's Fiscal Year (FY) 2012 Lead Hazard Reduction Demonstration Grant. The City's application seeks $2.9 million in federal funding to make 210 Baltimore City households lead safe or lead free during the three year grant period and includes additional funding commitments from the State Department of Housing and Community Development and the Baltimore City Community Development Block Grant program to match the requested federal funding.

We believe that the partnership between the Baltimore City Health Department and the Baltimore Department of Housing and Community Development is a strength of this program proposal. Enforcement activities for lead paint violations and the provision of lead abatement services must go hand-in-hand to best protect children from lead poisoning.

We are fully supportive of protecting Baltimore children from the dangers of lead poisoning by securing the federal, state, and local support needed to implement this proposal. We ask HUD to fully fund this proposal.

Sincerely,

Patricia McLaine

Patricia McLaine, DrPH, MPH, RN
Acting Chair
Lead Commission

FEBRUARY 2, 2012

LEAD POISONING PREVENTION COMMISSION MEETING

MEMBERS

Governor's Lead Commission Meeting Attendance Sheet

2/2/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

	Name/Signature	Representing	Telephone/Email
✓	CONNOR, Patrick PC	Hazard ID Professional	
X	DWYER, M.D.Maura	Department of Health and Mental Hygiene	
✓	HALL, Cheryl	Office of Child Care	
X	JENKINS, Melbourne	~~Property~~ Owner Pre 1950	
✓	LANDON, Edward EL	Dept. Housing and Community Dev.	
✓	McLAINE, Patricia	Child Health/Youth Advocate	
✓	MOORE, Barbara BMoore	Health Care Provider	
✓	OAKS, Nathaniel (Delegate)	Maryland House of Delegates	
X	ROBERTS, Linda Lee	Property Owner Post 1949	
✓	SNYDER-VOGEL, Mary	Child Advocate	443 723-2812
	VACANT	Secretary of the Environment or Designee	
	VACANT	Local Government	
	VACANT	Parent of a Lead Poisoned Child	
	VACANT	Financial Institution	
	VACANT	Child Care Providers	
	VACANT	Insurer	
	VACANT	Property Owner Pre 1950 Outside Baltimore City	
	VACANT	Maryland Insurance Administration	
	VACANT	Maryland Senate	

GUESTS

Governor's Lead Commission Meeting Attendance Sheet

2/2/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

	Name	Representing	Address/Telephone/Email
✓	Shalletta Denson	LECLP	
✓	Wes Stewart	CBCLP	gwstewart@leadlife.org
✓	John O'Brien		
✓	John Kavinsky		
✓	Paula T. Montgomery	MDE	pmontgomery@mde.state.md.us
✓	[illegible]	MMAHA	
✓	Donna Messick	via	phone
✓	Traughber	MDE	

LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Thursday, February 2, 2012
9:30 AM - 11:30 AM

AERIS Conference Room – Front Lobby

AGENDA

I. Introductions

II. Approval of January 5, 2012 minutes

III. Future meeting dates:

The next Lead Commission meeting is scheduled for Thursday, March 1, 2012 at MDE in the AERIS Conference Room – Front Lobby, 9:30 am – 11:30 am.

IV. Update from 2010 Plan Taskforce – **The next meeting – February 9, 2012, 9 am - MDE in the MDEStat Room – front lobby.**

V. Discussion:
   A. Discussion of the 2011 Lead Summer Study Report – Horacio Tablada
   B. Discussion of Reports from the Agencies and Public

VI. Agency Updates
   A. Maryland Department of the Environment
   B. Department of Health and Mental Hygiene
   C. Department of Housing and Community Development
   D. Baltimore City Health Department
   E. Office of Childcare
   F. Maryland Insurance Administration
   G. Other Agencies

VII. Public Comment

GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

February 2, 2012
Approved Minutes (3-1-12)

COMMISSIONERS IN ATTENDANCE

Patrick Connor, Cheryl Hall, Edward Landon, Pat McLaine, Barbara Moore, Delegate Nathaniel Oaks, and Mary Snyder-Vogel.

COMMISSIONERS UNABLE TO ATTEND

Dr. Maura Dwyer, Melbourne Jenkins and Linda Roberts.

GUESTS IN ATTENDANCE

Shakietta Denson – CECLP, Wes Stewart – CELP, Dana Schmidt -MMHA, Donna Messick – WCHD (via conference phone), John O'Brien – MDE staff, John Krupinsky – MDE staff, Paula Montgomery – MDE staff and Tracy Smith – MDE staff.

INTRODUCTIONS

Pat McLaine began the meeting @ 9:30am. Minutes from January's meeting will be voted on at the March 1 meeting.

FUTURE MEETING DATES

The next scheduled meeting is March 1, 2012 at MDE in the AERIS conference room. The Commission will meet from 9:30am - 11:30am.

DISCUSSION

Horacio Tablada presented a briefing on the summer study report, which is posted on MDE's web-site and can be e-mailed upon request. Comments from this report are not needed by MDE.

CDC is contemplating changing blood lead level of concern. Impact on Maryland will not be known until there is a final decision.

The summer study group recommended that MDE seek delegation for the RRP Rule. Legislation pursuant to Federal accreditation requirements, requirements for dust testing when properties are sold, clarifying authorizing lead abatement at the local level, changing the date of an affected rental property, and changing fees for rental registration may be introduced.

MDE would need to see a bill(s) before taking a position. MDE will forward any proposed legislation to Commission members.

A fee of 25 cents/gallon container of paint may be introduced for paying for abatement orders. A tax credit for window replacements is being considered. There have been 2 formal briefings in Annapolis with regards to the Court of Appeals decision and a bill is being worked on related to this court decision.

Alvin Bowles officially retired on February 1st. Alvin's position has been posted and Paula Montgomery is the acting Program Manager.

Donna Webster commented about concerns with how fee proposed changes could affect the housing market in addition to property owners who are also complying with local requirements.

Agency Updates
DHMH – no representative

DHCD – Ed Landon – nothing to report

Wicomico County – Donna Messick – nothing to report

MDE - Paula Montgomery
MDE has not received any full risk reduction visual inspections, only certificates, due to MDE's extensive outreach efforts. John Krupinsky commented that Baltimore City data migration is near completion.

Paula Montgomery commented that MDE did not change language in the emergency regulations but that MDE had confirmed with legal that there were no concerns with the language change. The comment period for the emergency regulations is over.

John Krupinsky reported that it will be at least 3-4 months before there is a decision from CDC for lowering blood lead levels from 10 – 5 µg/dl. Budget cuts will be known by July. CDC may be invited via a conference call to a future meeting. MDE will check if there is an objection to sending a letter of inquiry to CDC.

Wes Stewart commented that the Baltimore City Health Department will know by April 18th whether HUD will approve their application for lead abatement funding.

Pat McLaine will invite representatives from Baltimore City Health and Housing Departments to the March meeting. Maura will follow-up with regards to confirming DHMH's representative on the Commission (not clear).

Ed Landon asked about having a representative at a future Commission meeting who could answer lab questions. The Commission will invite DHMH Laboratory Administration to attend the April Commission meeting.

John Krupinsky will inquire about a contact from DHMH. John Krupinsky noted that there will be a Healthy Homes presentation at the March Commission meeting and presentations from the lower Eastern Shore and Baltimore City at March's Commission meeting.

Office of Child Care - Cheryl Hall
Regional Licensing Offices addresses and phone numbers for the Regional Manager may be found at:

http://marylandpublicschools.org/MSDE/divisions/child_care/licensing_branch/licensing_offices

The Office of Child Care does not maintain a database for facilities that have had lead dust wipe testing. The Baltimore City Health Department Environmental Sanitarian contract provides environmental inspections prior to licensing and once yearly for certain facilities. These individual inspections are contained in a database at the BCHD. Individual reports of facilities successfully passing the inspection are contained in the facility licensing file. Facilities having completed a lead paint inspection and dust wipe test are not maintained in a database.

Patrick Connor noted that having inspection certificates available on-line would be useful.

Coalition to End Childhood Lead Poisoning - Wes Stewart
reported that the Coalition held a meeting yesterday with regards to concerns about federal funding cuts and CDC lowering the blood lead level of concern. Specific concerns were raised about Maryland waiting until after July 1st with regards to determining what to do about potential cuts and about whether the State will be prepared for Federal cuts after September 1st.

Pat McLaine adjourned the meeting at 11:30 am.

MARCH 1, 2012

LEAD POISONING PREVENTION COMMISSION MEETING

MEMBERS

Governor's Lead Commission Meeting Attendance Sheet

3/1/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

Name/Signature	Representing	Telephone/Email
CONNOR, Patrick	Hazard ID Professional	
DWYER, M.D.Maura M. Dwyer	Department of Health and Mental Hygiene	
HALL, Cheryl	Office of Child Care	
JENKINS, Melbourne	Property Owner Pre 1950	
LANDON, Edward	Dept. Housing and Community Dev.	
McLAINE, Patricia	Child Health/Youth Advocate	
MOORE, Barbara B Moore	Health Care Provider	
OAKS, Nathaniel (Delegate) excused	Maryland House of Delegates	
ROBERTS, Linda Lee	Property Owner Post 1949	
SNYDER-VOGEL, Mary excused	Child Advocate	
VACANT	Secretary of the Environment or Designee	
VACANT	Local Government	
VACANT	Parent of a Lead Poisoned Child	
VACANT	Financial Institution	
VACANT	Child Care Providers	
VACANT	Insurer	
VACANT	Property Owner Pre 1950 Outside Baltimore City	
VACANT	Maryland Insurance Administration	
VACANT	Maryland Senate	

GUESTS

Governor's Lead Commission Meeting Attendance Sheet
3/1/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

	Name	Representing	Address/Telephone/Email
✓	JOE WRIGHT	LEAD REGISTRY	1 P00 WASHINGTON BLVD X3392 jwright@mdc.state.md.us
✓	Geraldine Woodson	BCHD	1800N Charles St. 5th flr. 443 984 2491 geraldine.woodson@baltimorecity.gov
✓	JOHN KRAPCHESKY	MDE	—
✓	Dana Schmidt	MMHA	dschmidt@mmhaonline.org
✓	Paula T. Montgomery	MDE	pmontgomery — — .
✓	Genevieve Birkey	BCHD	genevieve.birkey@baltimorecity.gov
✓	Hosanna Asfaw-Means	BCHD	1800 N. Charles 5th fl. ; hosanna.asfaw-means@baltimorecity.gov
✓	Horacio Tablada	MDE	Hosanna.Asfaw@
✓	Donna Messick via phone		
✓	RAN	CECLP	
✓	~~Keista~~ Shakietta Denson	CECLP	
✓	John O'Brien	MDE	
✓	Heather Barthel	MDE	
✓	Ken Strong	Balto City HCD	ken.strong@baltimorecity.gov
	Shenecka Frasier-Kyer	"	shenecka.frasier-kyer@baltimorecity.gov
✓	Tracy Smith	MDE	

LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Thursday, March 1, 2012
9:30 AM - 11:30 AM

AERIS Conference Room – Front Lobby

AGENDA

I. Introductions

II. Approval of January 5 and February 2, 2012 minutes

III. Future meeting dates:

The next Lead Commission meeting is scheduled for Thursday, April 4, 2012 at MDE in the AERIS Conference Room – Front Lobby, 9:30 am – 11:30 am.

IV. Update from 2010 Work Group Planning – **The next meeting – March 9, 2012, 9 am - MDE in the MDEStat Room – front lobby.**

V. Discussion:
A. 2012 Proposed Lead Legislation in Maryland General Assembly
1. MDEoverview – Horacio Tablada
2. Coalition's Bill Synopsis – Wes Stewart/Ruth Ann Norton
3. Commission support for legislation
B. Lower Shore Lead and Healthy Homes Primary Prevention Initiative
Donna Messick/John Krupinsky

VI. Agency Updates
A. Maryland Department of the Environment –Registration & General Program Progress – Joe Wright/Paula Montgomery
B. Department of Health and Mental Hygiene
C. Department of Housing and Community Development
D. Baltimore City Health Department – Lead and Healthy Homes Program – Genevieve Birkby; Baltimore City Housing Program – Ken Strong
E. Office of Childcare
F. Maryland Insurance Administration
G. Other Agencies

VII. Public Comment

GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

March 1, 2012
APPROVED Minutes (3-1-12)

COMMISSIONERS IN ATTENDANCE

Patrick Connor, Dr. Maura Dwyer, Cheryl Hall, Melbourne Jenkins, Edward Landon, Pat McLaine, Barbara Moore, and Linda Roberts.

COMMISSIONERS UNABLE TO ATTEND

Delegate Nathaniel Oaks and Mary Snyder-Vogel.

GUESTS IN ATTENDANCE

Shakietta Denson – CECLP, Ruth Ann Norton – CELP, Dana Schmidt -MMHA, Donna Messick – WCHD (via conference phone), Geraldine Woodson – BCHD, Genevieve Birkby – BCHD, Hosanna Asfau-Means – BCHD, Ken Strong – Baltimore City HCD, Sheneka Frasier-Kyer – Baltimore City HCD, Horacio Tablada – MDE, Heather Barthel – MDE, John O'Brien – MDE staff, John Krupinsky – MDE staff, Paula Montgomery – MDE staff, Joe Wright – MDE staff, and Tracy Smith – MDE staff.

INTRODUCTIONS

Pat McLaine began the meeting @ 9:30am. Minutes from January and February meetings were approved with edits.

FUTURE MEETING DATES

The next scheduled meeting is **Wednesday**, April 4, 2012 at MDE in the AERIS conference room. The Commission will meet from 9:30am - 11:30am.

2010 Work Group met twice and will meet on March 9th. There has been a lot of progress.

DISCUSSION

MDE Overview – Horacio Tablada/Coalition's Bill Synopsis – Ruth Ann Norton

Horacio Tablada stated that most of the hearings for proposed legislation will be discussed next Wednesday. MDE does not have a final position on the bills.

Ruth Ann Norton commented about concerns that there was not a defined committee to decide (including not having a representative on the committee) for a privately funded compensation fund [HB 472 (introduced by Delegate McIntosh)/SB 873]. Additional concerns with the proposed legislation included fees paid by both non-compliant and compliant owners and how/who decides compensation. There may be five (5) amendments that may go in to this proposed legislation that may be go to a study.

Horacio Tablada stated that HB 554 (Lead Safe Income Tax Credit) was heard last week.
Horacio Tablada stated that HB 644/SB947 included several recommendations from last year's Summer study, including:

- expanding the definition of an affected property to 1978,
- explicit authority for ordering lead abatements,
- reversing rebuttable presumption,
- authority for implementing the RRP Federal rule, and
- dust testing before settling when purchasing (that the settler can waive)

Ruth Ann Norton commented that the reversing rebuttable presumption was not from the Summer study. The Coalition opposes the clear and convincing evidence provision but will support the bill.

Ruth Ann Norton commented that the Coalition supports Delegate Rosenberg's HB 977 as it is more effective (to perform dust sampling) at the time of disturbance and not at the time of sale.

Horacio Tablada requested clarification that the Coalition supported HB 977 (and not HB 644).

Barbara Moore (nurse from Mt. Washington Pediatric Hosp.) commented that owners performing work themselves are not being captured. Ruth Ann Norton commented about looking at the bigger pool of risk and what and where would be the largest impact.

Patrick Connor questioned whether conceptually the proposed legislation is preventative. Currently, purchasers have up to seven (7) days (for testing) prior to settlement. Most people are already maxed out when buying.

Patrick Connor questioned if purchasers can waive the results of lead testing. Horacio Tablada commented that tests but not results can be waived.

Ed Landon commented that DHCD had no position on this bill.

Ruth Ann Norton commented on concerns with public access for inspections.

Horacio Tablada commented that more information will be on line but that IT projects cost money. Rental registration only currently on-line (and not inspection certificates.)

Horacio Tablada commented that HB 955 involved replacing windows for a triggering event and lowering blood lead levels from 10 – 5 µg/dl. HHS has to make a decision with regards to CDC's recommendations for lowering blood lead levels of concern. The Summer study recommended to wait for CDC's position. Horacio Tablada commented that there were some legal concerns with the title/wording of the bill that can be fixed.

Cheryl Hall commented if lead-free replacement windows would need to be replaced again. Horacio Tablada stated that this was not required. Ruth Ann Norton commented that only leaded windows would need to be replaced and that the Coalition would be supporting HB 955 (replacing windows.)

Ruth Ann Norton commented that there is science supporting children being affected by lower levels of lead exposure and that Maryland should follow Cleveland and 6 other states who take action @ blood lead levels of 5 µg/dl. Ruth Ann Norton commented on Pat McLaine's work in Rhode Island.

Genevieve Birkby commented that lowering levels of concern for lead in blood would have an impact on enforcement and staff capacity.

Pat McLaine commented that reducing levels of lead in blood from 10 -5 µg/dl would result in 4 or 5 times of children being impacted from lead (and not just a doubling of the number of children being affected.)

Genevieve Birkby commented that the Baltimore City Health Department has been working with Baltimore Housing with regards to primary prevention (and outreach) from levels of blood lead from 5 – 9 µg/dl but complicates enforcement.

Pat McLaine commented that there is good science that blood lead levels are lower when windows have been replaced.

Ruth Ann Norton commented about concerns with capacity, funding and budgets.

Ken Strong commented that blood lead levels between 5 – 9 µg/dl are being looked at in partnership with the Coalition and the Baltimore City Health Department.

Linda Roberts (?) commented if only windows in a unit or the entire complex/property would need to be replaced.

Paula Montgomery commented that she will be meeting with HCD on April 28th, including clarifying the impact on historical properties when windows are required to be replaced.

John Krupinsky questioned if HB 955 would affect only affected properties and if a risk assessment would be required or if a property owner would be notified via a Notice of Defect.

Ruth Ann Norton commented for concerns with knowing if windows are replaced.

Paula Montgomery commented that owners would have to prove that windows do not have lead.

Pat McLaine commented that Patrick Connor's lab accuracy concerns with DHMH would be addressed at next month's Commission meeting.

Horacio Tablada commented that HB 977 involves work practice standards when > 3 ft^2 of paint is disturbed, dust testing requirements, and authority for implementing the RRP Rule.

Ruth Ann Norton questioned whether EPA is supporting MDE.

Horacio Tablada commented that MDE is seeking the authority to delegate the RRP Rule to MDE.

Patrick Connor commented if only interior surfaces would be regulated for the proposed bill.

Pat McLaine commented that exterior surfaces may have more lead. Concerns were raised whether clearance would be required for the entire unit or for the work area and whether child occupied facilities would be covered under HB 977.

HB 1013 proposes money from the General Fund to include funding abatement orders in owner occupied properties. Ruth Ann Norton commented about concerns that would not be preventative. A brush fee may be introduced. Concerns with home owners on a limited income who can't pay for lead abatements.

Patrick Connor commented about the definition of occupants (visitors), that is not currently in Environment Article § 6-801. HCD will oppose HB 977. MDE has no position on this bill.

Horacio Tablada commented that HB 1268 (plumbing for drinking water) will be handled by a different administration @ MDE. Horacio Tablada commented that Alvin Bowles' position is in the process of being filled.

Ruth Ann Norton commented what MDE was doing if the CDC money was not available for surveillance and positions.

John Krupinsky commented that CDC money funds 3 positions at MDE, Donna Messick on the Eastern shore, and 6 educators at the Baltimore City Health Department.

Pat McLaine commented that the Commission is in agreement and that MDE to follow up for this funding concern. Horacio Tablada commented that MDE is aware and working on funding if CDC funding is lost.

Commission Support for Legislation
8/10 Commission members that were present voted on a letter of support for proposed legislation, including authorization for MDE to implement the RRP Rule, primary prevention, abatements authorized at local levels, increased funding for MDE, and changing affected date from 1950 to 1978.

Five Commissioners approved a letter of support, two opposed a letter (Linda Roberts and Mel Jenkins), and Patrick Connor abstained from a vote. Pat McLaine and Barbara Moore will work on a letter that will be circulated (including to Mary Snyder Vogel).

Linda Roberts commented about early detection, prevention, outreach, better data, and focusing on current laws on the books with regards to building codes.

Ruth Ann Norton commented that fines, penalties could generate funding for RRP. Patrick Connor commented that this money currently goes to the General Fund. Paula Montgomery commented that contractors are already paying for their RRP licenses (and not through penalties). The Summer Study indicated that it will take $ 350,000 for MDE to administer an RRP program.

Agency Updates:
Lower Shore Lead and Healthy Homes Primary Prevention Initiative – Donna Messick/John Krupinsky - John Krupinsky agreed to defer on the presentation on the lower Eastern shore until the April meeting.

MDE - Registration – Joseph Wright
Joseph Wright presented rental registration statistics, including on-line registration data. There are currently 123,477 active units and 33,261 active property owners. MDE is actively pursuing non-paying property owners.

MDE - General Program Progress - Paula Montgomery
Paula Montgomery stated that MDE opened 1,584 cases in FY 11, which included 617 enforcement actions and 3,800 inspections. $ 670,000 in penalties were collected. Most cases are generated by complaints. The second largest number of cases are generated based on audits. MDE will be providing additional data and information at the next Commission meeting.

BCHD –Lead and Healthy Homes Program – Genevieve Birkby
Genevieve Birkby stated that she is the acting Director for the Baltimore City Health Department as Olivia Farrow has left for a position in the Mayor's cabinet. A memo has been circulated to the Mayor's office with regards to the possible loss of $350,000 in CDC funding. Case management staff case involve blood lead levels for 10 µg/dl and higher. City government has concerns with lead poisoning.

Ken Strong thanked the Commission for the letter of support and introduced the new director for the lead abatement program, Sheneka Frasier-Kyer.

The meeting adjourned at 11:48 A.M.

2012 LEGISLATION

2/29/2012

BILL NO.	TITLE	SUMMARY	REMARKS	HEARING DATE/ SPONSOR	SUPPORT, SUPPORT WITH AMENDMENTS, OPPOSE, NO POSITION
HB 21	Environment - Reduction of Lead Risk in Housing - Repeal of Obsolete Language	Removing obsolete language in provisions relating to reduction of lead risk in rental housing; and making conforming changes.	Del McConkey - No fiscal and policy note available	**House** - Environmental Matters hearing 3/7 at 1 PM - **Senate** - No Action	
HB 472/ SB 873	Reduction of Lead Risk in Housing - Creation of Lead Poisoning Compensation Fund	Establishing the Lead Poisoning Compensation Fund; requiring specified owners of residential rental property to pay a Lead Poisoning Compensation fee; requiring the Fund to provide coverage to specified rental property owners for claims arising out of the alleged ingestion of lead; etc.	Del Mcintosh and Feldman/Sen Pugh -No fiscal and policy note available	**House** - Environmental Matters hearing 3/7 at 1 PM - **Senate** - Finance 3/14 at 1 PM	
HB 554	Lead Safe Income Tax Credit	Allowing an individual or a corporation to claim a credit against the State income tax for costs incurred for an approved lead hazard reduction project for qualifying property; providing for the calculation of the credit; providing for the submission of proposals for lead hazard reduction projects to the Department of Housing and Community Development for approval; limiting to $1,000,000 the total amount of credits that the Department may approve for any fiscal year; applying the Act to tax years beginning after December 31, 2011; etc.	Delegates Hogan, Boteler, Bromwell, Elliott, Glenn, Hough, Kach, Kaiser, Lafferty, McComas, McIntosh, Minnick, Mitchell, Otto, Ready, Schulz, Smigiel, Stocksdale, and Vitale - Fiscal and policy note available	**House** -Ways and Means hearing 2/21 at 1 PM - **Senate** - No Action	

2012 LEGISLATION

BILL NO.	TITLE	SUMMARY	REMARKS	HEARING DATE/ SPONSOR	SUPPORT, SUPPORT WITH AMENDMENTS, OPPOSE, NO POSITION
HB 644 /SB 947	Environment - Reducing the Incidence of Lead Poisoning	Altering the application of the Reduction of Lead Risk in Housing law to apply to specified property constructed before 1978; authorizing the Department of the Environment or a local health department to order lead abatement in any residential property under specified circumstances; establishing a specified rebuttable presumption that may be rebutted by clear and convincing evidence; increasing an annual registration fee for affected rental property from $15 to $30; etc.	Del Oaks and Niemann /Sen Gladden - No fiscal and policy note available	**House** - Environmental Matters hearing 3/7 at 1 PM - **Senate** - No Action	
HB 955	Lead Poisoning - Affected Property - Window Replacement	Requiring that owners of affected properties replace all windows that have lead-based paint with windows that are lead-free under specified circumstances and within a specified time frame; etc.	Del Rosenberg and Oaks - No fiscal or policy note available	**House** - Environmental Matters hearing 3/7 at 1 PM - **Senate** - No Action	
HB 977	Environment - Reduction of Lead Risk in Housing - Renovations and Repairs	Requiring, except for specified affected properties, that an activity that disturbs more than 3 square feet of painted surface in a specified building shall pass a test for lead-contaminated dust; authorizing the Department of the Environment to administer a renovation, repair, and painting program consistent with federal regulations; and requiring the Department to seek authorization to enforce the Environmental Protection Agency's Renovation, Repair and Painting Rule on or before March 31, 2013.	Del Rosenberg and Oaks - No fiscal or policy note available	**House** - Environmental Matters hearing 3/7 at 1 PM - **Senate** - No Action	
HB 1013	Environment - Lead Poisoning - Primary Prevention Fund	Establishing a Lead Poisoning Primary Prevention Fund in the Department of the Environment; providing for the administration of the Fund; requiring the Department to use Fund for specified purposes; requiring money distributed from the Fund to be in the form of a grant; exempting the Fund from § 7-302 of the State Finance and Procurement Article; requiring the Governor to include specified funding in the State budget for the Fund in specified fiscal years; etc.	Del Rosenberg and Oaks - No fiscal or policy note available	**House** - Environmental Matters hearing 3/7 at 1 PM - **Senate** - No Action	

2012 LEGISLATION

2/29/2012

BILL NO.	TITLE	SUMMARY	REMARKS	HEARING DATE/ SPONSOR	SUPPORT, SUPPORT WITH AMENDMENTS, OPPOSE, NO POSITION
HB 1134	Maryland Lead Poisoning Recovery Act	Requiring specified manufacturers of lead pigment to reimburse specified persons for damages caused by lead-based paint; establishing the types of damages caused by the presence of lead-based paint in residential buildings for which manufacturers of lead pigment are liable to specified persons; creating the Lead Paint Restitution Fund; etc.	Del Carter - No fiscal and policy note available	**House** -Judiciary hearing 3/15 at 1 PM - **Senate** -No Action	
HB 1268	Business Occupations and Professions - Plumbers - Lead-Free Materials	Altering the definition of "lead-free" to include a specified standard for individual plumbing fittings and fixtures; allowing for a stricter federal standard for lead-free plumbing fittings and fixtures and pipes and pipe fittings; and clarifying which pipes, pipe fittings, plumbing fittings, and fixtures are considered when calculating weighted average lead content.	Delegates Barnes, Davis, Feldman, Hershey, Impallaria, and W. Miller - No fiscal and policy note available	**House** - Environmental Matters hearing 3/14 at 1 PM - **Senate** - No Action	

THE GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

March 9, 2012

The Honorable Maggie L. McIntosh, Chairman
Environmental Matters Committee
House Office Building, Room 251
6 Bladen Street
Annapolis, MD 21401-1991

RE: House Bills 21, 472, 644, 955, 957 and 1013

Dear Chairman McIntosh:

The Lead Commission has reviewed the nine bills focusing on lead and childhood lead poisoning submitted so far this session, including seven bills to be heard by your committee. We understand that amendments are being submitted for many of the bills and that revisions are likely. Our comments pertain to the House Bills listed above.

In addition to the many budget shortfalls facing Maryland at the state and local levels, Maryland's federal funding from the Centers for Disease Control and Prevention (CDC) for lead poisoning prevention efforts is slated to be eliminated, starting in September of this year. Maryland has received funding from the CDC since 1991. The $600K for the current fiscal year funds MDE, Baltimore City and Wicomico County for healthy homes and lead poisoning prevention work.

The elimination of federal funding is coming at a time when there is widespread scientific understanding and recognition by CDC's Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP) that cognitive and other adverse health effects occur at blood lead levels well below the current level of concern of 10μg/dL. The ACCLPP has recommended a drop in the Federal blood lead level of concern to 5μg/dL. Based on these new recommendations, Maryland will be looking at a problem affecting more than 4,000 children (3.6% of Maryland children aged 0-72 months), instead of about 500 children (0.5%), based on MDE's Childhood Blood Lead Surveillance in Maryland Annual Report for 2010. This represents a potential increase in cases of 700%.

We have already seen the elimination of most state support for local health departments. The local health departments have provided case management services to families of children identified with elevated blood lead levels and have had key responsibilities for primary prevention outreach and education. In 2008, MDE provided funding for primary prevention outreach and education to 21 of 23 local jurisdictions and Baltimore City, but in 2012 MDE funding for local health departments is no longer available. Currently, eight local jurisdictions receive support from DHMH for lead poisoning prevention efforts.

Therefore, we feel that it is critical to pass legislation that will improve Maryland's focus on primary prevention and provide sufficient funding to address the on-going needs in our state. With that basic premise in mind, we recommend support for the following:

a) authority for MDE to administer the Renovation, Repair and Painting Rule, consistent with Federal standards;
b) recognition of any new Federal blood lead level of concern, consistent with Federal guidance;
c) requirements to improve housing stock in pre-1950 property including requirements for lead safety in owner-occupied properties;
d) incentives for lead hazard reduction in older rental and owner-occupied properties;
e) improved public access to lead safety information for rental properties;
f) authority for local health officers to order abatement of lead hazards in homes where a child has been identified with an Elevated Blood Lead Level; and
g) improved funding for primary prevention efforts at the state and local level.

We have made progress in Maryland. Having additional opportunities to protect Maryland children from exposure to lead and to ensure adequate funding of our public health infrastructure is critical if we are to complete the work began many years ago to eliminate childhood lead poisoning in Maryland.

Sincerely,

Patricia McLaine

Patricia McLaine, DrPH, MPH, RN
Chairman, Lead Commission

Lead Hazard Reduction Program Update

Baltimore City Department of Housing and Community Development

March 1, 2012

Prepared for the Governor's Lead Poisoning Prevention Commission

Ken Strong, Assistant Commissioner
Baltimore City HCD – Division of Green, Healthy and Sustainable Homes

And

Sheneka Frasier-Kyer
Lead Hazard Reduction Program Manager

I. HUD Application for Demonstration Grant Funds Submitted January 18th

A. Thanks to the Commission for its letter of support
B. Thanks also to the Coalition for its superb technical assistance
C. Features of the Grant Proposal:
    1. Seeks $2.9 million in federal funding over three years
    2. Includes $2 million in matching funds (State and CDBG)
    3. Funded partners include the Coalition and the Baltimore City Health Department ; joint home visits to at risk youth
    4. Emphasizes outreach to families with children testing 5 to 9 ebl
    5. Builds upon the progress of GHHI and the LIGHT program: innovative public-private partnerships – more comprehensive integrated, streamlined, and cost-effective.
    6. Includes HUD-recognized program manager

II. Introduction of Sheneka Frasier-Kyer

A. Background
B. Orientation – First Month
C. Challenges and Opportunities

III. Program Status

A. Production and Pipeline

1. 20 units completed this fiscal year by the end of February 2012
2. 21 units owned by non-profit organization in process
3. 8 units out to contractors
4. 12 units being settled or awaiting State check
5. 38 units in various stages of underwriting
5. 26 units in pre-underwriting stages

B. Innovative Developments and Initiatives

1. Joint Case Coordinator funded by City and Coalition in gear
2. Three contractors approved for weatherization/lead hazard reduction, first assignments
3. New bidding and contracts emphasize progressive policies for workforce development
4. Referral process and outreach to families with 5 to 9 ebl has begun and is improving
5. InterFACE program started for in-home applications lead-weatherization-rehabilitation and eligibility screening for 40 programs and benefits in partnership with Community Action Centers

APRIL 5, 2012

LEAD POISONING PREVENTION COMMISSION MEETING

MEMBERS

Governor's Lead Commission Meeting Attendance Sheet

4/5/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

Name/Signature	Representing	Telephone/Email
CONNOR, Patrick	Hazard ID Professional	
DWYER, M.D.Maura	Department of Health and Mental Hygiene	
HALL, Cheryl	Office of Child Care	
JENKINS, Melbourne	Property Owner Pre 1950	
LANDON, Edward	Dept. Housing and Community Dev.	
McLAINE, Patricia	Child Health/Youth Advocate	
MOORE, Barbara	Health Care Provider	
OAKS, Nathaniel (Delegate)	Maryland House of Delegates	
ROBERTS, Linda Lee	Property Owner Post 1949	
SNYDER-VOGEL, Mary	Child Advocate	
VACANT	Secretary of the Environment or Designee	
VACANT	Local Government	
VACANT	Parent of a Lead Poisoned Child	
VACANT	Financial Institution	
VACANT	Child Care Providers	
VACANT	Insurer	
VACANT	Property Owner Pre 1950 Outside Baltimore City	
VACANT	Maryland Insurance Administration	
VACANT	Maryland Senate	

GUESTS

Governor's Lead Commission Meeting Attendance Sheet

4/5/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

	Name	Representing	Address/Telephone/Email
✓	John Krupinsky	MDE	ext 3844
✓	Genevieve Birkby	BCHP	410-545-3409
✓	Andrea S Baker	OAG	x 3055
✓	Dana Schmidt	MMHA	410 825 6868
✓	Donna Messick	WCHD	via conf phone
✓	Ken Strong	Green Hlthy	Sustainable Homes
✓✓	RAN CECLP +	Shaketta Denson	
✓	Tracy Smith	MDE	
✓	Paula Montgomery	MDE	
✓	John OBrien	MDE	
✓	~~John Krupinsky~~	~~MDE~~	
✓	Horacio Tablada	MDE	

LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Thursday, April 5, 2012
9:30 AM - 11:30 AM

AERIS Conference Room – Front Lobby

AGENDA

I. Introductions

II. Approval of March 1, 2012 minutes

III. Future meeting dates:

The next Lead Commission meeting is scheduled for Thursday, May 3, 2012 at MDE in the AERIS Conference Room – Front Lobby, 9:30 am – 11:30 am.

IV. Update from 2010 Work Group Planning – **The next meeting – immediately following today's Commission meeting – AERIS Conference Room.**

V. Discussion:
A. Lower Shore Lead and Healthy Homes Primary Prevention Initiative
1. Donna Messick (Wicomico County) John Krupinsky(MDE)

B. Update 2012 Lead Legislation in Maryland General Assembly
1. Horacio Tablada (MDE), Ed Landon (DHCD), Ruth Ann Norton and Shaketta Denson (CECLP)

C. CDC Healthy Homes and Lead Poisoning Prevention Funding
1. Ruth Ann Norton (CECLP)

VI. Agency Updates
A. Maryland Department of the Environment
B. Department of Health and Mental Hygiene
C. Department of Housing and Community Development
D. Baltimore City Health Department
E. Office of Childcare
F. Maryland Insurance Administration
G. Other Agencies

VII. Public Comment

GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

April 5, 2012
APPROVED Minutes (5/3/12)

COMMISSIONERS IN ATTENDANCE

Dr. Maura Dwyer, Cheryl Hall, Edward Landon, Pat McLaine, and Barbara Moore.

COMMISSIONERS UNABLE TO ATTEND

Patrick Connor, Melbourne Jenkins, Delegate Nathaniel Oaks, Linda Roberts and Mary Snyder-Vogel.

GUESTS IN ATTENDANCE

Shaketta Denson – CECLP, Ruth Ann Norton – CECLP, Dana Schmidt -MMHA, Donna Messick – WCHD (via conference phone), Genevieve Birkby – BCHD, Ken Strong – Baltimore City HCD, Horacio Tablada – MDE, Andrea Baker – Attorney General, MDE, John O'Brien – MDE staff, John Krupinsky – MDE staff, Paula Montgomery – MDE staff, and Tracy Smith – MDE staff.

INTRODUCTIONS

Pat McLaine began the meeting at 9:41 am. Everybody present introduced themselves. Minutes from the previous meeting were approved.

FUTURE MEETING DATES

The next Lead Commission meeting will be on Thursday, May 3, 2012 at 9:30 am. A meeting for the 2010 work plan will be held immediately following today's meeting.

DISCUSSION

Lower Eastern Shore Healthy Homes Program

John Krupinsky (MDE) and Donna Messick (Wicomico Co. Hlth Dept) shared a Power Point presentation about Healthy Homes efforts on the lower Eastern shore, including community outreainspections with code enforcement officials, property owners, and tenants.

Since July 1, 2011, Donna and Pete Peterson performed home visits and assessments for Lead and Healthy Homes in four counties on the lower Eastern Shore – Worcester, Wicomico, Somerset and Dorchester. Support for this Lower Shore initiative was provided by a September 1, 2011 CDC grant, EPA funding and assessment tools, the Coalition and the National Center for Healthy Housing. DHCD provided support with lead hazard reduction grants.

Health Department nurses provided education on the prevention of lead exposure. Staff assessed four (4) areas: lead, asthma, home fire safety, and pest control. Donna Messick commented that their Healthy Homes web-site (wicomicohealth.org) was useful. Wicomico County Health Department and Housing staff were trained and may go back again for more training.

Both pre- and post-1950 homes were assessed in Wicomico County and Salisbury. The one or two day street sweeps made house by house visits to every house. Citations were issued for 11/50 properties that needed attention; fines and sanctions were issued. Fire, police and public works department staff were involved.

Some landlords stopped inspections and county staff were unable to complete approximately ½ of the inspections attempted.

Cheryl Hall inquired if any non-properties were inspected. Donna Messick stated that only residential properties in a five (5) street area in Salisbury had been inspected.

Pat McLaine inquired if the 11 properties had been corrected. Ed Landon inquired if building code officials had been involved, since they would normally review housing conditions. Donna confirmed that building code officials were involved and stated that concerns identified included gas lines, no smoke detectors, inoperable appliances, dead bolt locks on interior doors and lack of hallway lighting.

As of November 11, 2011, MDE has been involved in 2/50 properties that had been inspected in Salisbury. Lead was probable in 34/50 properties. 42/50 were rental, including 8 post-1950 construction and 34 pre-1950 construction. 40/50 houses did not have smoke detectors. Educational pamphlets were provided for blood lead levels between 5 and 9 and compliance for pre-1950 rental properties was assessed.

Donna reported that limited funds were available for smoke detectors and rodent/roach traps. Local hardware stores contributed many of these items as well as 10 sets of buckets and cleaning materials. The fire department waived fees for installing 36 smoke detectors.

Donna reported that their local Home Depot offered $5,000 mini grants for window replacement; Ruth Ann Norton noted that priority is given to veterans. Donna Messick confirmed when asked by Cheryl Hall that this funding was available at all Home Depot stores. In response to a question by Ken Strong, Donna Messick stated that the city of Salisbury became involved when roof and furnace problems were identified.
Donna Messick confirmed that all but 3/50 properties were in compliance for lead. She stated that one of the properties was registered but did not have certificates, one property owner was not aware of lead requirements, and one of the properties was mischaracterized as being owner-occupied.

Donna Messick stated that funding was available until the end of August, 2011. John Krupinsky said funding for this program has been eliminated.

Ken Strong inquired if state housing had creative solutions now that CDC funding is not available. Ruth Ann Norton inquired if there were appropriations for state funding and said that

there was nothing to preclude a rider to expand appropriations to build in more flexibility for funding.

When asked by Horacio Tablada, Ed Landon stated that $3 million was available from DHCD. Ed also questioned why the minimum livability code could not be used more effectively since it is a local problem. Ruth Ann Norton suggested state landlord licensing, Ed Landon identified where to get DHCD funding, and Ken Strong inquired what doesn't work.

Donna Messick confirmed when asked by Ed Landon that Salisbury had not provided feedback to DHCD about outcomes of the Salisbury street sweep. Ken Strong stated that similar efforts were underway in Baltimore City.

John Krupinsky commented that families on the Eastern shore either didn't qualify for a grant loan through DHCD or became lost in the application process. Donna Messick commented that not enough people were being certified. Ken Strong suggested that the funding application is a mismatch for emergency medical problems like lead. There is a provision in state regulation for a potential waiver of the rules and programs can submit an appeal to the Secretary.

Ruth Ann Norton suggested a $25,000 emergency grant program available through the Community Foundation in Easton. Donna indicated she had not applied for the Community of Easton foundation money.

Paula Montgomery asked who was unable to get funding. Ed Landon commented that money from the state is easier than money from the Federal government and that issues with private homes are generally complaint driven.

Andrea Baker commented that there is often no will to enforce requirements locally. Paula Montgomery commented that referrals to MDE don't have political pressures.

Donna indicated that Wicomico continues the sweeps, but the Health Department is no longer involved. Owners still put up a lot of pushback for this. Andrea Baker stated that landlords cannot prohibit renters from granting access for inspection or assessment. Donna Messick stated that five teams of people (including police) had been involved in the sweeps. Ed Landon suggested that the OAG could be useful in the future.

State Legislation

Horacio Tablada provided an update on legislation. Eleven lead bills (including one on plumbing) were proposed during the legislative session. Four bills were viable (time permitting), three bills had been pushed to the side, and four were either deemed unfavorable or withdrawn.

Elements of HB 644 has passed the House included changing the annual rental property registration fee from $15 – 30, providing health departments explicit authority to authorize lead abatements, authority for MDE to implement the RRP rule, changing the definition of an affected

property from 1950 to 1978 beginning on January 1, 2015, and reversing presumption of lead. The Senate has not moved or voted on this bill as of today.

MDE provided a letter of information for HB 21 that involved a court cases.

HB 472/ SB 873 involving potential compensation funding and liability protection passed the House, which may lay the ground work for a future bill next year after a work group to be administered by the Maryland Insurance Administration convenes this summer.

HB 1477 was introduced and heard and involved a revised qualified offer. A proposed bill involving income tax is sitting in committee. HB's 955, 977, 1013 were not passed and HB 1134 was withdrawn.

Ed Landon commented that HB 1268 (that altered the definition of lead-free plumbing) will pass.

Pat McLaine solicited comments with regards to the legislation. Ruth Ann Norton indicated that certification for bringing a suit was a hurdle for a lead-poisoned child. She expressed concerns with how HB 1477 was handled legislatively and with who would be on a committee for HB 472. Ruth Ann Norton stated that the Coalition was supporting HB 644 but preferred to have more clarity for MDE with regards to the RRP Rule and had concerns with rebuttable presumption. Ruth Ann Norton stated that the Coalition supported the Lead Safe Income Tax Credit bill but that HB 21 would not pass.

Ed Landon commented that too many bills may affect passage of legislation since there is no clear message. Pat McLaine noted that the Lead Commission had previously sent a letter with regards to legislation.

CDC Funding Cuts

Pat McLaine urged that the Commission take action with regards to the elimination of CDC Lead and Healthy Homes funding. Copies of letters of support for restoring CDC funding signed by four (4) Maryland congressmen and both Maryland senators to House and Senate Appropriations committee chairmen were distributed.. Funding in 35 states and localities are impacted, as well as the nation's blood lead surveillance system. In addition, lowering the blood lead level standard from 10 to 5ug/dL would result in an 8 fold increase in cases in Maryland. Pat McLaine inquired if 'gap funding' had been identified to cover program costs at MDE in the event that CDC funding is either eliminated or cut back.

Ruth Ann Norton stated that best case scenario, 'bridge funding' of $12.5 million could cover States until May, 2013. FY '14 budget would not pass until April at the earliest (the Senate has not passed a bill in three (3) years). Future funding would be more competitive. Ruth Ann Norton suggested sending a letter to Sen. Barbara Mikulski, who serves on the Appropriations Committee. Although the budget is unknown, there is the anticipation that there will be a 'de-coupling' of the program in FY '14. Many concerns were raised: families will be impacted,

children will not be tested, efforts will not be coordinated, and child advocates are not being heard at the White House.

It is likely that FY '13 funding will not change but it may be possible to restore funding for FY'14. Funding from a National Foundation like Robert Wood Johnson to a CDC foundation could restore funding for a year.

Pat McLaine noted that Maryland children are being impacted and that money lost would not be coming back (including a lead surveillance system.) National funding for lead programs disappeared about 30 years ago when categorical grants were replaced with block grants.

Pat McLaine suggested sending letters to both Maryland Senators and expressed the need to talk to both MDE and DHMH to continue programs. Ruth Ann Norton suggested on sending a letter to the Governor. Barbara inquired if a letter should be sent to Mayor Stephanie Rawlings-Blake. Ruth Ann Norton suggested that Mayor Rawlings-Blake should be the one to send the letter to David Agnew, the U.S. Conference of Mayors and that Maryland's Senators and Dr. Joshua Sharstein from DHMH may be helpful. A motion was approved by Barb (and seconded by Cheryl) to send a letter to the Governor, both Maryland Senators and all Maryland congressmen. Five (5) members were in support of a letter and Pat McLaine stated that people would be welcome to share the letter, including with agencies of Commission members.

AGENCY UPDATES:

MDE, Paula Montgomery - Stated that lead regulations have been finalized and will be published on April 10th.

DHMH – No updates.

Pat McLaine stated that the Commission was attempting to get a laboratory person to discuss detection levels/limits at the May 3, 2012 Lead Commission meeting.

DHCD, Ed Landon stated that the Green Code has been published and is in the process of being adopted. (This is not mandatory.)

Ed Landon stated that the livability code and rehab codes will be adopted. (There is no provision for lead in the 12 year old rehab code).

BCHD, Genevieve Birkby – reported that the City is preparing for the pending loss of $350,000 of CDC funding, which will severely impact current employees. However challenging, the Baltimore City Health Department will continue to serve families. The loss of employees is expected to include public health educators who monitor families. Position losses may be based on seniority level and union rules.

Five (5) Sanitarians will remain to perform XRF inspections. They will also be monitoring families and will attempt to bolster prevention. As of today, each Sanitarian has approximately 90 cases. Four (4) Public Health Inspectors (PHIs) may be moved over.

Baltimore City Housing - Ken Strong stated that Baltimore Housing had received $2.9 million dollars over 3 yrs, which included matching State funds of $2.1 million. (210 homes is the goal.) Ken Strong thanked the Commission for their efforts in this process.

The meeting adjourned at 11:44 a.m.

2012 LEGISLATION

4/5/2012

BILL NO.	TITLE	SUMMARY	REMARKS	HEARING DATE/ SPONSOR
HB 21	Certificate of a Qualified Expert - Lead Paint Poisoning Claim	Removing obsolete language in provisions relating to reduction of lead risk in rental housing; and making conforming changes.	Del McConkey - Fiscal and policy note available - First 8 1/2 pages were deleted.	**House passed 3/21 (131-0) - Senate hearing 4/3**
HB 472/ SB 873	Reduction of Lead Risk in Housing - Creation of Lead Poisoning Compensation Fund	Establishing the Lead Poisoning Compensation Fund; requiring specified owners of residential rental property to pay a Lead Poisoning Compensation fee; requiring the Fund to provide coverage to specified rental property owners for claims arising out of the alleged ingestion of lead; etc.	Del Mcintosh and Feldman/Sen Pugh - Fiscal and policy note available.	**House - 3/30 passed (115-23) - Senate -Finance 3/14 at 1 PM**
HB 554	Lead Safe Income Tax Credit	Allowing an individual or a corporation to claim a credit against the State income tax for costs incurred for an approved lead hazard reduction project for qualifying property; providing for the calculation of the credit; providing for the submission of proposals for lead hazard reduction projects to the Department of Housing and Community Development for approval; limiting to $1,000,000 the total amount of credits that the Department may approve for any fiscal year; applying the Act to tax years beginning after December 31, 2011; etc.	Delegates Hogan, Boteler, Bromwell, Elliott, Glenn, Hough, Kach, Kaiser, Lafferty, McComas, McIntosh, Minnick, Mitchell, Otto, Ready, Schulz, Smigiel, Stocksdale, and Vitale - Fiscal and policy note available.	**House** -Ways and Means hearing 2/21 at 1 PM - **Senate** - No Action

2012 LEGISLATION

BILL NO.	TITLE	SUMMARY	REMARKS	HEARING DATE/ SPONSOR
HB 644 /SB 947	Environment - Reducing the Incidence of Lead Poisoning	Altering the application of the Reduction of Lead Risk in Housing law to apply to specified property constructed before 1978; authorizing the Department of the Environment or a local health department to order lead abatement in any residential property under specified circumstances; establishing a specified rebuttable presumption that may be rebutted by clear and convincing evidence; increasing an annual registration fee for affected rental property from $15 to $30; etc.	Del Oaks and Niemann /Sen Gladden - Fiscal and policy note for House not for senate.	**House Passed (102-34) - Senate JPR Hearing 3/29**
HB 955	Lead Poisoning - Affected Property - Window Replacement	Requiring that owners of affected properties replace all windows that have lead-based paint with windows that are lead-free under specified circumstances and within a specified time frame; etc.	Del Rosenberg and Oaks - No fiscal or policy note available	**House - Unfavorable 3/14/12**
HB 977	Environment - Reduction of Lead Risk in Housing - Renovations and Repairs	Requiring, except for specified affected properties, that an activity that disturbs more than 3 square feet of painted surface in a specified building shall pass a test for lead-contaminated dust; authorizing the Department of the Environment to administer a renovation, repair, and painting program consistent with federal regulations; and requiring the Department to seek authorization to enforce the Environmental Protection Agency's Renovation, Repair and Painting Rule on or before March 31, 2013.	Del Rosenberg and Oaks - No fiscal or policy note available	**House - Unfavorable 3/14/12**
HB 1013	Environment - Lead Poisoning - Primary Prevention Fund	Establishing a Lead Poisoning Primary Prevention Fund in the Department of the Environment; providing for the administration of the Fund; requiring the Department to use Fund for specified purposes; requiring money distributed from the Fund to be in the form of a grant; exempting the Fund from § 7-302 of the State Finance and Procurement Article; requiring the Governor to include specified funding in the State budget for the Fund in specified fiscal years; etc.	Del Rosenberg and Oaks - No fiscal or policy note available	**House - Unfavorable 3/22/12**

2012 LEGISLATION

BILL NO.	TITLE	SUMMARY	REMARKS	HEARING DATE/ SPONSOR
HB 1134	**Maryland Lead Poisoning Recovery Act**	**Requiring specified manufacturers of lead pigment to reimburse specified persons for damages caused by lead-based paint; establishing the types of damages caused by the presence of lead-based paint in residential buildings for which manufacturers of lead pigment are liable to specified persons; creating the Lead Paint Restitution Fund; etc.**	**Del Carter - No fiscal and policy note available**	**House - Unfavorable 3/19/12 - withdrawn**
HB 1268	Business Occupations and Professions - Plumbers - Lead-Free Materials	Altering the definition of "lead-free" to include a specified standard for individual plumbing fittings and fixtures; allowing for a stricter federal standard for lead-free plumbing fittings and fixtures and pipes and pipe fittings; and clarifying which pipes, pipe fittings, plumbing fittings, and fixtures are considered when calculating weighted average lead content.	Delegates Barnes, Davis, Feldman, Hershey, Impallaria, and W. Miller - fiscal and policy note available	**House -passed (138-0) - Senate - Favorable report 4/4**
HB 1477	Environment - Reduction of Lead Risk in Housing - Qualified Offer	Requiring the Department of the Environment to create a specified formula for determining a payment amount for a qualified offer; requiring that the formula established for determining a payment amount for a qualified offer meet specified criteria; requiring the Department to adopt specified regulations; and declaring the intent of the General Assembly.	Delegates Niemann and McIntosh - Fiscal and Policy Note Available.	**House - Hearing 3/23/12 Senate - No Action**

Maryland—Impact Statement

In 2010, 531 children were found with an elevated blood lead level above 10 micrograms / deciliter, and 4,037 had a blood lead level above 5. The Maryland Lead Poisoning Prevention Program (MDLPPP) and county health department officials follow up on the cases of lead above the action level; inspect the homes, and order repairs to units with lead hazards. Scientific research indicates the need to start helping even more children with blood lead levels below the current action level of 10 micrograms / deciliter.

MDLPPP also maintains a surveillance system, the MD Childhood Lead Registry, (CLR) to capture and aggregate the results of blood tests for lead. CLR accumulated over 133,195 blood test records from 127,762 children in 2010. The surveillance data enables the MDLPPP to identify high-risk areas for lead poisoning and track patterns over time. The data is also shared with other health and environmental agencies and is matched with several other area programs. CLR utilizes the STELLAR system, and is migrating data over to the new CDC Healthy Housing and Lead Poisoning Surveillance System (HHLPSS).

MDLPPP is also responsible for enforcing EPA's Renovation, Repair, and Painting Rule, the most important legislation enacted by EPA in the last twenty years. MDLPPP conducts enforcement and conducts outreach to contractors and renovators, training them in lead-safe work practices. The program also does outreach to educate the general public about the dangers of lead-based paint and the importance of working lead-safe.

CDC funding enables this program to respond to emerging lead threats. For example, in some cases, multiple children in the same family may have elevated blood lead levels. The CDC-funded environmental health professional conducts an environmental inspection to identify a lead hazard in the home or child care facility.

MDLPPP received $890,000 in 2009 and $824,000 in 2010. The funding level was cut to $594,000 in 2011 which paid for state surveillance and testing, 6 full-time staff positions for public outreach in the high risk area of Baltimore City, and a program on the Eastern Shore of Maryland. The entire program could be in jeopardy after August of this year because of the severe cutbacks to the program in FY12 that will result in job loss and a reduction in vital services. Without the surveillance data, there will be no way to treat the existing threat or track a possible resurgence in blood lead levels.

United States Senate

March 29, 2012

The Honorable Patty Murray
Chairman
Subcommittee on Transportation, Housing and Urban Development, and Related Agencies
Committee on Appropriations
U.S. Senate
Washington, DC 20510

The Honorable Tom Harkin
Chairman
Subcommittee on Labor, HHS, Education, and Related Agencies
Committee on Appropriations
U.S. Senate
Washington, DC 20510

The Honorable Susan Collins
Ranking Member
Subcommittee on Transportation, Housing and Urban Development, and Related Agencies
Committee on Appropriations
U.S. Senate
Washington, DC 20510

The Honorable Richard Shelby
Ranking Member
Subcommittee on Labor, HHS, Education, and Related Agencies
Committee on Appropriations
U.S. Senate
Washington, DC 20510

Dear Chairmen Murray and Harkin and Ranking Members Collins and Shelby:

As you consider the fiscal year (FY) 2013 appropriations bills for the Departments of Transportation, Housing and Urban Development (HUD) and Labor, Health and Human Services and Education respectively, we urge your support for $120 million for HUD's Office of Healthy Homes and Lead Hazard Control, including $30 million for the healthy homes program, and $29 million to restore the Centers for Disease Control and Prevention (CDC) Healthy Homes and Lead Poisoning Prevention program.

Nearly 6 million families in America live in housing that rivals developing countries, with broken heating, inoperable plumbing, holes in walls, and leaking roofs. Millions more live in housing with serious health and safety hazards from mold, exposed wiring, and toxic chemicals. Over the past two decades, HUD's Office of Healthy Homes and Lead Hazard Control has developed programs to address these hazards and successfully treated 168,000 units for lead hazards, improved the lead safety of 185,000 units through enforcement actions, and upgraded 20,000 substandard housing units with healthy homes interventions. Providing the Office of Healthy Homes and Lead Hazard Control with $120 million in FY13 is critical to continuing this progress.

The CDC Healthy Homes and Lead Poisoning Prevention program is instrumental to the success of these HUD remediation programs. The CDC's funding has helped state and local health departments maintain a system for the collection and dissemination of data on lead poisoning, which helps HUD target resources for housing remediation. In addition, CDC grants have provided services to families with lead poisoned children, which have helped prevent costly emergency room and physician office visits for diseases and conditions like lead poisoning, asthma, and cancer. Restoring funding for this critical program will ensure the goals of HUD programs are met, as well improve the health and cognitive potential of children.

Addressing housing-related health hazards also makes economic sense, as every $1 spent to reduce home lead hazards there is a benefit of at least $17. We greatly appreciate your leadership and consideration of these requests.

Sincerely,

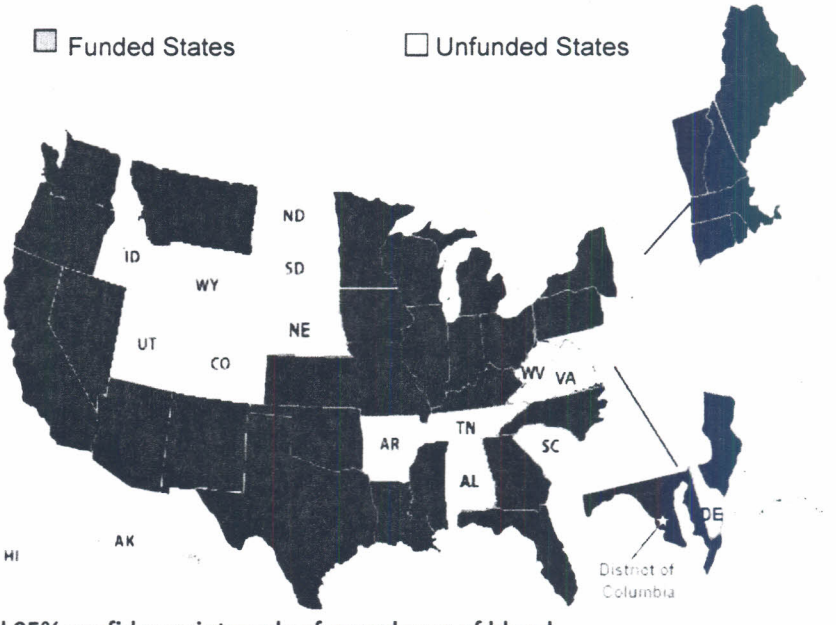
The CDC Healthy Homes/Childhood Lead Poisoning Prevention Program

- Funds states and localities to provide services to families with lead-poisoned children.
  - ✓ From 1997-2008, CDC's lead program served 850,000 children.
- Leads national lead poisoning *primary* prevention efforts.
  - ✓ Between 2008 and 2010, primary prevention efforts helped **reduce by 200,000 the number of children who have been exposed to lead**—saving $7.5 billion in lifetime productivity.
  - ✓ In 1990, only three states had state lead laws. As of 2009, 27 states had comprehensive laws enabling health departments to compel clean-up of hazardous homes.
- Maintains a system for the collection and dissemination of data on lead poisoning.
  - ✓ 46 states report data to CDC. These data are used to target grants from the U.S. Department of Housing and Urban Development for lead hazard control in housing.

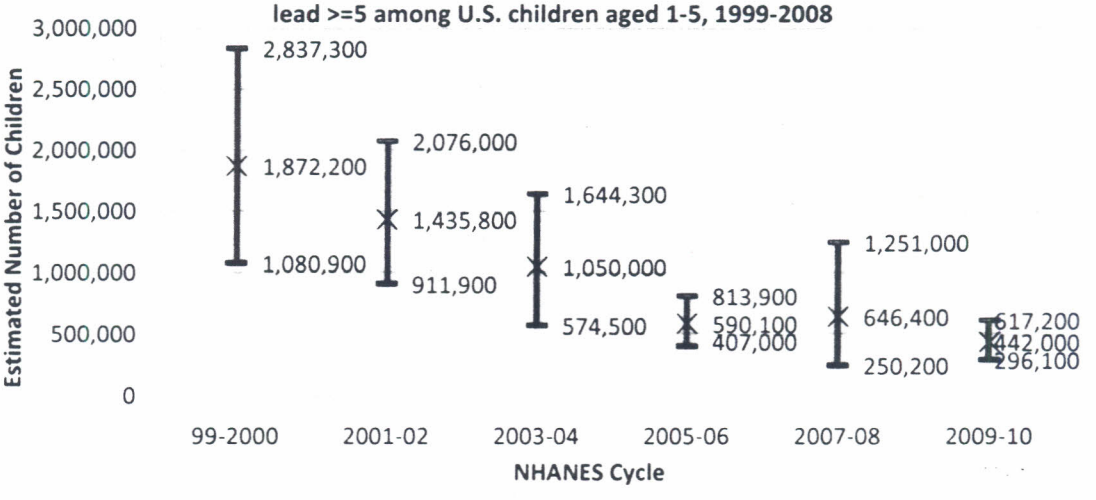
In FY 2011, CDC funded **35 states and localities** to:

- **Screen children** for lead poisoning.
- **Track** incidence and causes.
- **Inspect** the home **and remove** the environmental threat.
- **Connect with clinicians** to ensure that the child's health is protected through appropriate case management.
- **Provide education** to the public and health care providers.

Between 1976 and 2008, the **percentage of children aged 1 to 5 years with blood lead levels ≥ 10 µg/dL declined steeply, from 88.2% to 0.9%.** Despite our best efforts, **today nearly than 450,000 children need CDC-funded services to manage their exposures.**



NHANES estimates and 95% confidence intervals of prevalence of blood lead >=5 among U.S. children aged 1-5, 1999-2008



United States Senate

March 29, 2012

The Honorable Patty Murray
Chairman
Subcommittee on Transportation, Housing and Urban Development, and Related Agencies
Committee on Appropriations
U.S. Senate
Washington, DC 20510

The Honorable Tom Harkin
Chairman
Subcommittee on Labor, HHS, Education, and Related Agencies
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Washington, DC 20510

The Honorable Susan Collins
Ranking Member
Subcommittee on Transportation, Housing and Urban Development, and Related Agencies
Committee on Appropriations
U.S. Senate
Washington, DC 20510

The Honorable Richard Shelby
Ranking Member
Subcommittee on Labor, HHS, Education, and Related Agencies
Committee on Appropriations
U.S. Senate
Washington, DC 20510

Dear Chairmen Murray and Harkin and Ranking Members Collins and Shelby:

As you consider the fiscal year (FY) 2013 appropriations bills for the Departments of Transportation, Housing and Urban Development (HUD) and Labor, Health and Human Services and Education respectively, we urge your support for $120 million for HUD's Office of Healthy Homes and Lead Hazard Control, including $30 million for the healthy homes program, and $29 million to restore the Centers for Disease Control and Prevention (CDC) Healthy Homes and Lead Poisoning Prevention program.

Nearly 6 million families in America live in housing that rivals developing countries, with broken heating, inoperable plumbing, holes in walls, and leaking roofs. Millions more live in housing with serious health and safety hazards from mold, exposed wiring, and toxic chemicals. Over the past two decades, HUD's Office of Healthy Homes and Lead Hazard Control has developed programs to address these hazards and successfully treated 168,000 units for lead hazards, improved the lead safety of 185,000 units through enforcement actions, and upgraded 20,000 substandard housing units with healthy homes interventions. Providing the Office of Healthy Homes and Lead Hazard Control with $120 million in FY13 is critical to continuing this progress.

The CDC Healthy Homes and Lead Poisoning Prevention program is instrumental to the success of these HUD remediation programs. The CDC's funding has helped state and local health departments maintain a system for the collection and dissemination of data on lead poisoning, which helps HUD target resources for housing remediation. In addition, CDC grants have provided services to families with lead poisoned children, which have helped prevent costly emergency room and physician office visits for diseases and conditions like lead poisoning, asthma, and cancer. Restoring funding for this critical program will ensure the goals of HUD programs are met, as well improve the health and cognitive potential of children.

Congress of the United States
Washington, DC 20515

March 20, 2012

The Honorable Tom Latham
Chairman
Subcommittee on Transportation, Housing and Urban Development, and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

The Honorable Denny Rehberg
Chairman
Subcommittee on Labor, HHS, Education, and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

The Honorable John Olver
Ranking Member
Subcommittee on Transportation, Housing and Urban Development, and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

The Honorable Rosa DeLauro
Ranking Member
Subcommittee on Labor, HHS, Education, and Related Agencies
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen Latham and Rehberg, and Ranking Members Olver and DeLauro:

As you consider the Fiscal Year 2013 (FY 13) appropriations bills for the Departments of Transportation, Housing and Urban Development (HUD) and Labor, Health and Human Services (HHS) and Education, we respectfully request $120 million for HUD's Office of Healthy Homes and Lead Hazard Control, including $30 million for the Healthy Homes Program, and $29 million to restore the Centers for Disease Control and Prevention (CDC) Healthy Homes and Lead Poisoning Prevention program.

In 2009, the U.S. Surgeon General issued a call to action on healthy homes, stating that, "To improve the nation's overall health, we must improve the health of the nation's homes and ensure that safe, healthy, affordable, accessible, and environmentally friendly homes are available to everyone in the United States."

The number of children suffering from lead poisoning remains unacceptably high, with approximately 250,000 U.S. children aged 1-5 years of age having blood lead levels greater than 10 micrograms of lead per deciliter of blood, the level at which CDC recommends public health actions be initiated. New findings suggest that adverse health effects, including disruptive cognitive function as well as cardiovascular, immunological, and endocrine problems, occur at much lower levels of lead exposure than previously thought.

According to the American Healthy Homes Survey (AHHS), conducted by the U.S. Department of Housing and Urban Development, an estimated 37.1 million homes have lead-based paint somewhere in the building, of which 23.2 million have one or more lead-based paint hazard.

Poorer households have significantly higher rates of lead-based paint than more affluent households.

Over the past two decades, HUD's Office of Healthy Homes and Lead Hazard Control program has developed programs to address lead hazards in the home, successfully creating 165,000 lead-free units, ensuring that over 185,000 units are lead-safe, and upgrading 20,000 substandard housing units. Providing the Office of Healthy Homes and Lead Hazard Control with $120 million in FY 13 is critical to continuing this progress.

The CDC Healthy Homes and Lead Poisoning Prevention program is instrumental to the success of the HUD remediation programs. The CDC's funding has helped state and local health departments maintain a system for the collection and dissemination of data on lead poisoning, which helps HUD target resources for housing remediation. Between 1997-2008, CDC's lead program served 850,000 children with dangerous blood lead levels, tested more than four million children for lead, and conducted case management for nearly 30,000 children. CDC grants have provided services to families with lead poisoned children, which have helped prevent costly emergency room and physician office visits for diseases and conditions like lead poisoning, asthma, and cancer. Despite the innovation of the CDC Healthy Homes and Lead Poisoning Prevention program, its funding was drastically cut over the past two years. Restoring funding for this critical program will ensure the goals of HUD programs are met, as well improve the health and cognitive potential of children.

A cost-benefit analysis report showed substantial returns on investment in lead hazard control, particularly targeted at early intervention in communities most likely at risk. In 2006, for each dollar invested in lead hazard control there was a return of $17-$221, and a net savings of $181-269 billion. Maintaining funding for HUD's Office of Healthy Homes and Lead Hazard Control program and restoring the CDC Healthy Homes and Lead Poisoning Prevention program are both critically important, cost effective means of keeping Americans healthy, reducing unnecessary expense to the medical system, and strengthening our economy.

Thank you for your support of lead poisoning prevention and healthy housing. We greatly appreciate your leadership and consideration of these requests.

Sincerely,

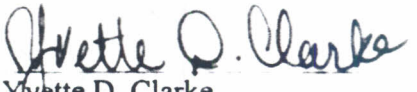
Louise M. Slaughter
Member of Congress

Leonard Boswell
Member of Congress

Robert A. Brady
Member of Congress

David Cicilline
Member of Congress

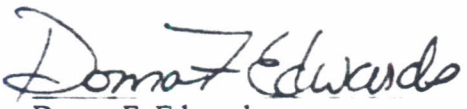
Hansen Clarke
Member of Congress



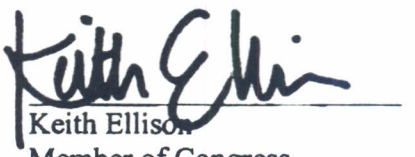
Yvette D. Clarke
Member of Congress

Steve Cohen
Member of Congress

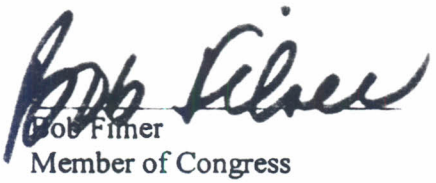
Elijah E. Cummings
Member of Congress



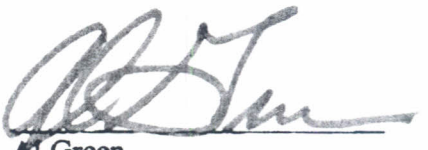
Donna F. Edwards
Member of Congress



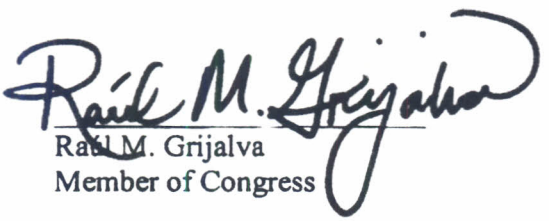
Keith Ellison
Member of Congress



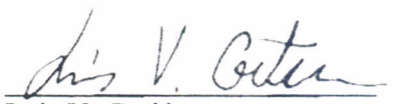
Bob Filner
Member of Congress



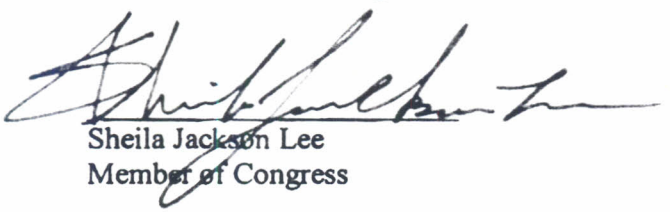
Al Green
Member of Congress



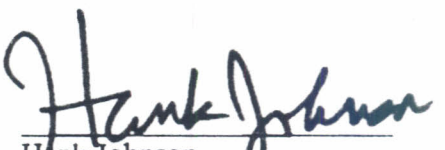
Raúl M. Grijalva
Member of Congress



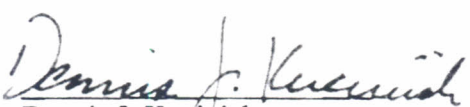
Luis V. Gutiérrez
Member of Congress



Sheila Jackson Lee
Member of Congress



Hank Johnson
Member of Congress



Dennis J. Kucinich
Member of Congress

Gwen Moore
Member of Congress

Jerrold Nadler
Member of Congress

Eleanor Holmes Norton
Member of Congress

Charles B. Rangel
Member of Congress

Jan Schakowsky
Member of Congress

C.A. Dutch Ruppersberger
Member of Congress

Maxine Waters
Member of Congress

Mel Watt
Member of Congress

Chaka Fattah
Member of Congress

Brad Miller
Member of Congress

Bruce Braley
Member of Congress

John Sarbanes
Member of Congress

National Safe and Healthy
Housing Coalition

FY 2013 Labor HHS Appropriations
CDC National Center for Environmental Health
Healthy Homes and Lead Poisoning Prevention Program

Program	Appropriation			President's Request	Coalition Request
	FY 10	FY 11	FY 12	FY 13	FY 13
Healthy Homes and Lead Poisoning Prevention	$34,805	$29,257	$1,995	$0	$29,257
Healthy Homes and Community Environments				$27,316 (with Asthma Program)	

Recommendation: Provide $29 million for the Healthy Homes and Lead Poisoning Prevention Program. Restoring the program to the FY 11 funding level will ensure protection of children at highest risk of lead poisoning.

Background: Lead poisoning remains a significant environmental public health threat. Although the prevalence of elevated blood levels has significantly declined from the 1970s, when 88% of children had excessive lead in their bodies, despite our best efforts, today nearly **450,000 children need CDC-funded services to reduce their exposures**.

Lead poisoning causes cognitive and behavioral problems, such as attention deficit hyperactivity disorder. Children with harmful blood lead levels will **lose 3 to 4 I.Q. points** on average, which can make the difference between a high D average and a low C. Children with a history of lead poisoning are **six times more likely to drop out of school**. Children with lead poisoning also have cardiovascular, immunological, and endocrine effects. Ultimately, lead exposure costs the nation more than **$50 billion in lost lifetime productivity**.

African American children are nearly **three times as likely to be lead poisoned** as Caucasian children and **children in low-income households are twice as likely** to be lead poisoned.

Justification: During the last two decades, CDC has delivered a cost-effective program to prevent lead poisoning and help children who have already been exposed. CDC is the only agency that houses the information about where, how, and when children are poisoned. Between 1997 and 2008, CDC's lead program served **850,000 children** with dangerous blood lead levels (greater than or equal to 10 µg/dL). In the most recent year, recipients of CDC grants tested more than **four million children** for lead and conducted **case management for nearly 30,000 children**. The services provided by health department staff (nurses, social workers, and environmental health professionals), include environmental assessments of the child's home to identify the source of exposure, enforcement of local health laws to clean-up of hazardous properties, and referrals of property owners to remediation resources (such as the HUD lead grant program). The health department programs also provide ongoing education and guidance to local officials, families, and health care providers to ensure that children receive appropriate screenings and, most importantly, prevent lead poisoning cases.

CDC's epidemiologists, blood lead laboratory proficiency program, and surveillance system are collectively poised to monitor the disease. Without these resources, children exposed will not be treated. It was CDC's program that identified lead-contaminated toys as a source of exposure, and CDC was first on the scene to address lead poisoning among refugee families. Internationally, CDC has been the lead organization to provide emergency response to the lead epidemic in Nigeria, where several hundred children have died from lead poisoning.

National Safe and Healthy Housing Coalition

FY 2013 Transportation HUD Appropriations
HUD's Office of Healthy Homes and Lead Hazard Control Program

Program	Appropriation			President's Request	Coalition Request
	FY 10	FY 11	FY 12	FY 13	FY 13
Lead Hazard Control and Demonstration Programs	$114,600	$94,110	$107,500	$86,000	$86,000
Healthy Homes Demonstration and Production Programs	***$20,000***	***$23,253***	***$10,000***	***$30,000***	***$30,000***
Lead Technical Studies and Regulatory Support	$4,000	$1,199	$2,500	$4,000	$4,000
HUD's Transformation Initiative	$1,400	$1,198	0	0	0
Total	$140,000	$119,800	$120,000	$120,000	$120,000

Ask: Level funding ($120 million) for HUD's Healthy Homes and Lead Hazard Control programs, and, **within that total, $30 million for healthy homes**. Continuing funding for this program at the FY 11 funding level will enable states and localities to address substandard housing conditions that cause disease and death among young children and the elderly. With respect to healthy homes, we are not asking for additional funding, only that of the $120 million in funding, $30 million of it would be used both for lead and for other healthy homes interventions, thus allowing Federal funds to more efficiently address life-threatening health hazards in homes.

Background: The **home is the most dangerous place for U.S. families**:

- Lead-based paint hazards in 24 million homes jeopardize the development and school success of millions of children.
- More than 6.4 million homes have dangerous levels of radon – a gas that causes 21,000 deaths from lung cancer each year, with associated annual costs of $2.3 billion.
- Carbon monoxide poisoning causes 20,000 emergency room visits and at least 400 deaths every year.
- Exposure to dampness and mold contributes to 21% of asthma cases, costing $3.5 billion, 10 million lost school days, and 2 million emergency room visits.

Justification: HUD's healthy homes program supplements the lead hazard control grants by enabling government agencies and nonprofit organizations to address other health and safety hazards. Healthy Homes grants are particularly critical because lead hazard control grants by law may only be used to fix lead paint hazards—a lead-safe home could still have a serious problem with carbon monoxide, radon, dry wall, mold, and more. The OHHLHC **healthy homes grants have made 20,000 units safe** from injury hazards and serious environmental hazards since 1999. **This program is highly over-subscribed with only one applicant receiving funding for every 11 qualified applications HUD receives.** Its interventions, costing $3,600 per unit, net savings such as $26,720 in unscheduled acute care services per 100 asthma cases.

The **lead hazard control grant** program has created over **165,000 lead-safe units** since 1993. The OHHLHC can only fund one out of every three qualified applications it receives due to its current budget. Since 1996, its lead disclosure rule **enforcement efforts** have resulted in owners making over **185,000 units lead safe.** The average cost for lead hazard control is $9,400. Each dollar invested in lead hazard control results in a return of at least $17 to $221.

Lead Poisoning Prevention and Healthy Homes Fact Sheet
State of Maryland

Funding Summary

HUD's Office of Healthy Homes and Lead Hazard Control (since 2007)

2011- Healthy Homes Production – Coalition to End Childhood Lead Poisoning - $930,000
2009- Healthy Homes Demonstration – Coalition to End Childhood Lead Poisoning - $875,000
2009- Lead Hazard Reduction Demonstration - Baltimore County - $4,000,000
2008- Lead Elimination Action Program – Coalition to End Childhood Lead Poisoning - $2,000,000
2007- Healthy Homes Demonstration – Coalition to End Childhood Lead Poisoning - $1,000,000
2007 - Lead Hazard Reduction Demonstration - Baltimore City - $3,897,094
2005 – Lead Hazard Control – Baltimore City - $2,740,000

CDC's Healthy Homes and Lead Poisoning Prevention Program

2013 --TBD
2012 – $0
2011 – $594,000
2010 - $824,000
2009 - $890,000

How are children in Maryland impacted by environmental health problems?

Statewide: 4,037 children have blood lead levels above 5 μg/dL.

Baltimore Housing Conditions: Compared to the national average, Baltimore-area homes are more likely to have deficiencies and safety hazards. Homes are more likely to have signs of pests, water infiltration, lead paint hazards, mold, poor energy performance, and roofing problems.

What services does the CDC lead and healthy homes program provide Maryland children?

The Maryland State Department of Environment (MDE):

- Encourages testing of children especially in the range of 0-72 months
- Assists families whose children have lead poisoning through case management, to help identify sources of lead poisoning and follow up with affected children and families.
- Collects and tracks alls lead screening data;
- Outreach, to educate citizens, contracts, and renovators about lead hazards and lead-safe work practices; and
- Targets other home hazards, such as carbon monoxide, asthma triggers, and safety hazards

What services does the HUD healthy homes program provide to Maryland children?

HUD lead hazard control grants are used to repair the homes that have caused children to have elevated blood lead levels or are highly likely to do so unless repairs are made. Under the Baltimore Health Department's most recent lead hazard control grant ($3.9 million), the city conducted testing and remediation of 220 homes. In the previous grant 150 units were remediated. The Coalition to End Childhood Lead Poisoning currently implements HUD Healthy Homes Demonstration and Production grants which provide asthma and other respiratory ailments trigger reduction and other healthy homes interventions where environmental conditions contribute to a child's illness or risk of injury. The program has remediated lead hazards in 704 homes and conducted Healthy Homes interventions in 513 homes since 2007. The Coalition also coordinates Baltimore's HUD-supported Green & Healthy Homes Initiative (GHHI)

MAY 3, 2012

LEAD POISONING PREVENTION COMMISSION MEETING

MEMBERS

Governor's Lead Commission Meeting Attendance Sheet

5/3/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

	Name/Signature	Representing	Telephone/Email
X	CONNOR, Patrick PTC	Hazard ID Professional	
	DWYER, M.D.Maura	Department of Health and Mental Hygiene	
	HALL, Cheryl	Office of Child Care	
	JENKINS, Melbourne	Property Owner Pre 1950	
	LANDON, Edward	Dept. Housing and Community Dev.	
	McLAINE, Patricia PM Laine	Child Health/Youth Advocate	
X	MOORE, Barbara	Health Care Provider	
X	OAKS, Nathaniel (Delegate)	Maryland House of Delegates	
	ROBERTS, Linda Lee	Property Owner Post 1949	
X	SNYDER-VOGEL, Mary	Child Advocate	
	VACANT	Secretary of the Environment or Designee	
	VACANT	Local Government	
	VACANT	Parent of a Lead Poisoned Child	
	VACANT	Financial Institution	
	VACANT	Child Care Providers	
	VACANT	Insurer	
	VACANT	Property Owner Pre 1950 Outside Baltimore City	
	VACANT	Maryland Insurance Administration	
	VACANT	Maryland Senate	

GUESTS

Governor's Lead Commission Meeting Attendance Sheet

5/3/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

Name	Representing	Address/Telephone/Email
JAN KRAJEWSKY	MDE	
JOHN O'BRIEN	"	1800 WASH BLVD BALTO MD 2123- (410)537-3825 JobRien@mde.state.md.us
ARTHUR D GRAY	BALTO DHCD	for KEN STRONG (kstrong@baltimore city.gov)
[redacted]		
Wes Stewart	CBCLP	2714 Hudson Street 21224 gwstewart@leadsafe.org
Shaketta Denson	CECLP	2714 Hudson St, 21224 sdenson@leadsafe.org
Kathy Howard	MMHA	11 E Fayette St Khoward@regionalmgmt.com
Horacio Tablada	MDE	1800 Washington Blvd Balto. MD 21230 410-537-3304 htablada@mde.state.md.us
Jim Carroll	MDE	1800 Washington Blvd, Baltimore MD 410-537-3432
Paula T. Montgomery	MDE	1800 Washington Blvd, md. 21090 - 410-537-3078
Dana Schmidt	MMHA	dschmidt@mmha online.org
X Donna Webster (did not call in)		
Margaret Schnitzer	BCHD	[redacted] 1800 N. Charles St, 5th fl 21201 443-984-2160
Hosanna Asfaw-Means	BCHD	" "

LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Thursday, May 3, 2012
9:30 AM - 11:30 AM

AQUA Conference Room – Front Lobby

AGENDA

I. Introductions

II. Approval of April 5, 2012 minutes

III. Future meeting dates:

The next Lead Commission meeting is scheduled for Thursday, June 7, 2012 at MDE in the PATUXENT Conference Room – 6th floor, 9:30 am – 11:30 am.

IV. Update from 2010 Work Group Planning – **The next meeting – May 17, 2012 – 9-11 AM, MDEStat Conference Room.**

V. Discussion:

A. Lead Smelters and Factories in Maryland – Jim Carroll, Program Manager, Land Restoration Program - MDE

B. Final summary of bills passed - 2012 Maryland General Assembly – Horacio Tablada

C. Blood lead laboratory issues – Dr. Maura Dwyer, DHMH

VI. Agency Updates

A. Maryland Department of the Environment
B. Department of Health and Mental Hygiene
C. Department of Housing and Community Development
D. Baltimore City Health Department
E. Office of Childcare
F. Maryland Insurance Administration
G. Other Agencies

VII. Public Comment

GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

APPROVED Minutes
May 3, 2012

Members in Attendance

Patrick Connor, Dr. Maura Dwyer, Cheryl Hall, Edward Landon, Pat McLaine, Delegate Nathaniel Oaks and Linda Roberts

Members not in Attendance

Melbourne Jenkins, Barbara Moore, and Mary Snyder-Vogel.

Guests in Attendance

Shaketta Denson – CECLP, Wes Stewart – CECLP, Dana Schmidt -MMHA, Margaret Schnitzer – BCHD, Hosanna Asfaw-Means – BCHD, Arthur Gray – Baltimore City/HCD(for Ken Strong), Kathy Howard – MMHA, James Carroll – MDE, Horacio Tablada – MDE, John O'Brien – MDE staff, John Krupinsky – MDE staff, Paula Montgomery – MDE staff, and Tracy Smith – MDE staff.

Introductions

Pat McLaine began the meeting at 9:33 am. Everybody present introduced themselves. Pat McLaine inquired if everyone had an agenda and had signed in. Future meetings are on the agenda.

Minutes from the April Commission meeting were approved by Ed Landon and seconded by Delegate Oaks after minor modifications.

Future Meeting Dates

The next Lead Commission meeting will be on Thursday, June 7, 2012 at 9:30 am in the PATUXENT conference room

Discussion

Mr. Jim Carroll, the Program Manager from MDE's Land Restoration Program, discussed lead smelters at several sites in Maryland. In 2001, a graduate student (Sanborn) did a thesis on lead smelters. A list of sites was distributed by EPA in 2005.

A reporter from USA Today contacted MDE last year and interviewed staff. No lead concerns were identified in Maryland, except for two sites (Dixie Metals and 108 E. Barney St in Baltimore) where additional information and data is needed and MDE will be performing preliminary assessments.

Pat McLaine commented about soil being a concern for lead poisoning in children. Paula Montgomery commented that soil testing from bare soil areas would be included in a risk assessment if soil is indicated on a questionnaire for a lead-poisoned child environmental investigation.

Paula Montgomery confirmed that a questionnaire for every lead poisoned child environmental investigation involves many elements including testing per Chapter 16 from the HUD Guidelines and Healthy Homes questions. Cheryl Hall commented that soil sampling is not standard for child care.

Although focus for lead is to remain on homes, there may be a future link on MDE's web-site related to lead smelters. Patrick Connor inquired if lead in soil was regulated at levels > 400 parts per million.

Jim Carroll explained that lead concerns for public parks could vary depending on the number of days (50 = low, 180 = medium, or 260 = high) that the parks are used. Nothing was represented to be an immediate need based on additional soil screening that MDE performed primarily at parks in Baltimore City. Paula Montgomery said lead could be a concern in the top 1 ½ inch of soil. Patrick Connor commented on lead in soil levels being different for factories (industrial) vs. residential properties.

Horacio Tablada discussed HB 472, HB 644, and HB 1268 (all of which passed during the legislative session.) HB 1268 does not involve the Land Management Administration since this bill involves plumbing (and MDE's drinking water supply program.)

Horacio Tablada will be MDE's representative for a Summer study work group that will be handled by the Maryland Insurance Administration (MIA) and may begin meeting in May. Nancy Egan, (410) 468-2488, is a point of contact with the MIA.

Horacio Tablada explained that HB 644 involves coordinating lead abatement orders with Health Directors and allowing MDE the authority to adopt EPA's RRP Rule. MDE will provide more updates in June, including possible meetings with property owner associations.

Paula Montgomery commented about a May 23rd meeting in Annapolis with the Historic Commission and the authority for ordering lead abatements.

Ed Landon commented about lead-free specific standards for pipe fittings and that HB 1268 will go into effect on October 1, 2012.

Horacio Tablada commented that Andrea Baker and Paula Montgomery will be meeting with regards to explicit authority for lead abatements, including for other counties besides Baltimore City. MDE meets monthly with Health Departments and 2 times/year with Health Commissioners.

Blood lead lab issues (including oversight of Maryland labs) were discussed. Lab oversight is in the Office of Health Care Quality @ DHMH. In order to assure accurate blood lead levels below 5µg/dL, the reporting laboratories' levels of detections (1, 3, or 5µg) are of concern as are the absence of spiked and blind samples.
Patrick Connor commented on the reliability of looking backwards at testing data (including from 2005.) Concerns with using wrong tube cap (lavender) colors and the loss of part of DHMH's blood lab program were discussed. A case where a child had been sent for chelation treatments based on an inaccurate lab result and other errors was discussed. Child blood lead level reports are sent to MDE and electronically recorded in Stellar.

Pat McLaine commented on approved letters for CDC funding and requested agency updates.

Horacio Tablada commented that an announcement for Alvin's vacant position on the Lead Commission, may be made by next month's Commission meeting.

Agency Updates

DHMH - Dr. Maura Dwyer - No updates

DHCD/Ed Landon - commented that DHCD has adopted Green and Livability Codes.

BCHD - The Baltimore City Health Department is working on a plan to address funding cuts. Sanitarians will be kept but the medical side could be affected after August 31, 2012.

Baltimore City Housing received $2.9 million in funding from HUD and will be hiring 3 or 4 people.

Office of Child Care/Cheryl Hall - No updates

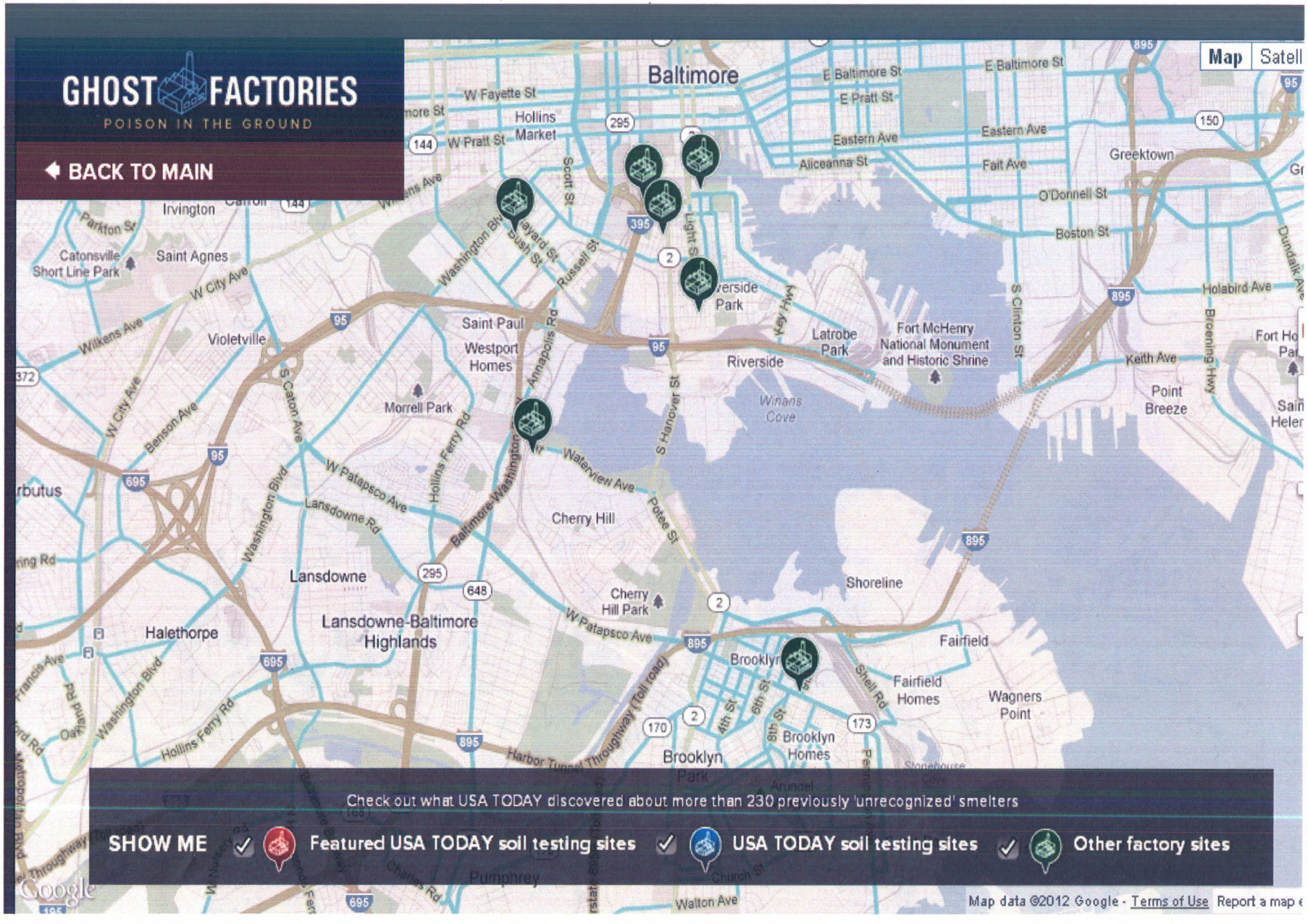
MIA – no representative

Delegate Oaks - No updates

CECLP/Wes Stewart - commented on the inflexibility for replacement wood windows (at a cost of $800 – 900/window) in historical areas. There was a comment with regards to concerns with the loss of tax credits for historic preservation. Surfaces (cornices, porches, etc.) can be treated but cannot be removed.

Paula Montgomery commented about replacing windows when meeting risk reduction standards for lead poisoned children but not in historical areas. Ed Landon commented that although windows can not be replaced in kind with wood, off-site paint stripping is worse.

After no further comments, the meeting adjourned at 11:44 am.


GHOST FACTORIES
POISON IN THE GROUND
BACK TO MAIN
Map
Satell
Baltimore
Hollins Market
Irvington
Catonsville Short Line Park
Saint Agnes
Violetville
Saint Paul
Westport Homes
Morrell Park
Riverside
Riverside Park
Latrobe Park
Fort McHenry National Monument and Historic Shrine
Winans Cove
Point Breeze
Greektown
Cherry Hill
Lansdowne
Lansdowne-Baltimore Highlands
Halethorpe
Cherry Hill Park
Shoreline
Fairfield
Fairfield Homes
Wagners Point
Brooklyn
Brooklyn Homes
Brooklyn Park
Pumphrey
Check out what USA TODAY discovered about more than 230 previously 'unrecognized' smelters
SHOW ME
Featured USA TODAY soil testing sites
USA TODAY soil testing sites
Other factory sites
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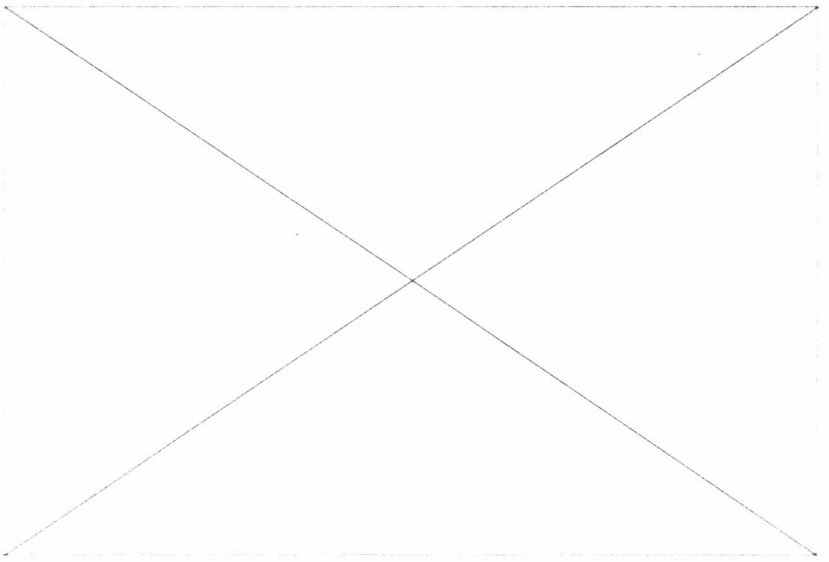
Report a map

USA TODAY INVESTIGATIVE REPORT

Poisons lurk where lead-smelting factories once stood

By Alison Young, USA TODAY

Updated 4d 22h ago



Ken Shefton is furious about what the government knew eight years ago and never told him — that the neighborhood where his five sons have been playing is contaminated with lead.

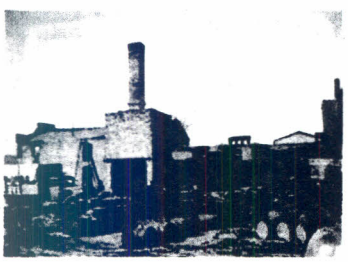
Their Cleveland home is a few blocks from a long-forgotten factory that spewed toxic lead dust for about 30 years.

The Environmental Protection Agency and state regulators clearly knew of the danger. They tested soil throughout the neighborhood and documented hazardous levels of contamination. They never did a cleanup. They didn't warn people living nearby that the tainted soil endangers their children.

INTERACTIVE: Explore more than 230 lead-factory sites
PHOTOS: Historical photos of forgotten lead factories
VIDEO: Ghost Factories: A failure to protect the public

"I needed to know that," Shefton said. "I've got a couple of kids that don't like to do nothing but roll around in the dirt."

More than a decade ago, government regulators received specific warnings that the soil in hundreds of U.S. neighborhoods might be contaminated with dangerous levels of lead from factories operating in the 1930s to 1960s, including the smelter near Shefton's house, Tyroler Metals, which closed around 1957.



Minnesota Historical Society

This 1940 photo shows Northwestern Smelting and Refining at 2522 Hiawatha Ave. in Minneapolis. State regulators told the EPA in 2002 they found no information that a smelter once operated at the site.

Despite warnings, federal and state officials repeatedly failed to find out just how bad the problems were. A 14-month USA TODAY investigation has found that the EPA and state regulators left thousands of families and children in harm's way, doing little to assess the danger around many of the more than 400 potential lead smelter locations on a list compiled by a researcher from old industry directories and given to the EPA in 2001.

In some cases, government officials failed to order cleanups when inspectors detected hazardous amounts of lead in local neighborhoods. People who live nearby — sometimes directly on top of — old smelters were not warned, left unaware in many cases of the factories' existence and the dangers that remain. Instead, they bought and sold homes and let their children play in contaminated yards.

PHOTOS: In the fallout zone: A Cleveland neighborhood

The USA TODAY investigation shows widespread government failures taking several forms:

•**A failure to look.** At dozens of sites, government officials performed cursory inquiries at best. In Minnesota, Indiana and Washington, state regulators told the EPA they could find no evidence that some smelters ever existed.

Yet in those states and others, reporters found the factories clearly documented in old insurance maps, town council minutes, city directories and telephone books — even in historical photos posted on the Web.

•**A failure to act.** In Pennsylvania, Maryland and Wisconsin, the EPA sent investigators to scores of sites from 2004 to 2006 after verifying a lead smelter once operated. The investigators recommended soil tests in the neighborhoods. Most of the tests were not done.

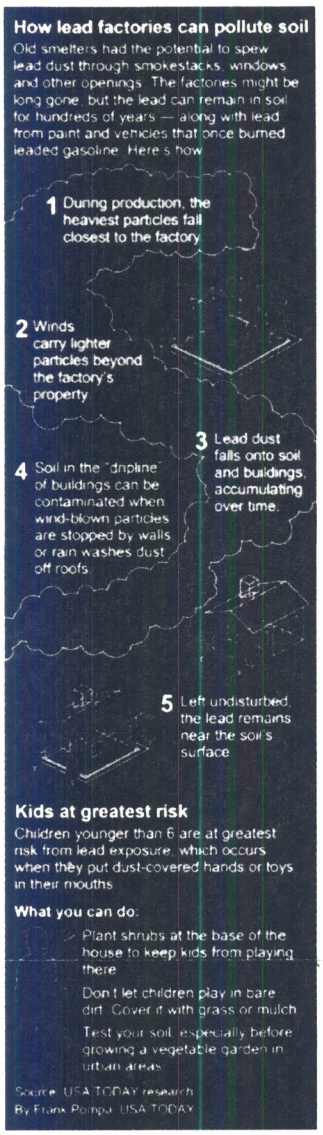
•**A failure to protect.** Even when state and federal regulators tested soil and found high levels of lead, as they did around sites in Philadelphia, Cleveland, Chicago and Portland, Ore., they failed for years to alert neighbors or order cleanups. Some kids who played in yards with heavily contaminated soil have dangerous levels of lead in their bodies, according to medical records obtained by USA TODAY.

Coming next

Day 2: [illegible]

Now: Review more than 230 old lead-factory sites nationwide.

In response to the investigation and USA TODAY's soil tests in 21 neighborhoods, government officials are taking action at old smelter sites in 14 states, ranging from reopening flawed investigations to testing soil to cleaning up contaminated property. In March, New York City officials closed four ball fields in a Brooklyn park after



learning from USA TODAY that the area was a former smelter site with elevated levels of lead.

"EPA and our state and local partners have overseen thousands of cleanups, through a variety of programs," said Mathy Stanislaus, an EPA assistant administrator. "Unfortunately, some of the sites USA TODAY identified have not yet been addressed or investigated by EPA. EPA will review USA TODAY's information to determine what steps can be taken to ensure Americans are not being exposed to dangerous levels of lead."

The EPA says it has worked with states to assess most of the sites on the 2001 list but that record-keeping is "incomplete" for many. Eighteen sites received some kind of cleanup but most weren't considered dangerous enough to qualify for federal action.

"I am convinced we have addressed the highest-risk sites," said Elizabeth Southerland, director of assessment and remediation for the EPA's Superfund program. "Absolutely and positively, we are open to reassessing sites that we now feel, based on your information, need another look."

EPA staff members said additional site reviews are underway, including checks of 48 sites the agency determined were never assessed. And the EPA said it will work with Ohio environmental regulators to re-examine the Cleveland neighborhood near Shefton's home to see whether a cleanup evaluation there is appropriate.

Ken Shefton and his family aren't waiting for the government to do a cleanup. His 6-year-old son, Jonathan, was diagnosed this spring with having an elevated level of lead in his body, Shefton said: "That was the last straw." He's in the process of selling his home. The family moved to another neighborhood last week. "Somebody needs to take care of this problem, or inform the people in this neighborhood," he said.

Concerns surfaced a decade ago

Most of the nation's lead factories — some huge manufacturing complexes and others tiny storefront melting shops — had been largely shuttered by the 1970s and 1980s. Often known as smelters, they emitted thousands of pounds of lead and other toxic metal particles into the air as they melted down batteries and other products containing lead.

The particles would land on nearby properties, potentially mixing with lead dust from automobile exhaust or paint chips — significant sources, says the government — to create a hazard. Children who play in lead-contaminated soil, sticking dust-covered hands or toys in their mouths, over time can suffer lost intelligence and other irreversible health problems.

Lead: The danger

In April 2001, environmental scientist William Eckel published a research article in the *American Journal of Public Health* warning about the dangers of old smelting factories. While working on his Ph.D. dissertation, Eckel had identified a historical smelting site unknown to federal and state regulators and wondered how many other sites had been forgotten over time, their buildings demolished or absorbed by other businesses.

What you can do

Create a barrier: Avoid letting children play in bare soil, especially in a city. Laying down a thick layer of sod, mulch or even a blanket can reduce their exposure to lead dust in soil. Consider replacing contaminated soil with clean dirt. Keep children's play areas and vegetable gardens away from the "dripline" around the base of homes or garages, where soil is more likely to be contaminated from airborne lead particles and flaking paint.

Wash up: Children are exposed to lead dust by putting dirty hands or toys in their mouths. Wash hands and toys frequently. For lead, there's no five-second rule. If you drop a lollipop in the dirt or window well, you can't put it back in your mouth. Either wash it off or throw it away," said Mary Jean Brown, chief of the Centers for Disease Control and Prevention's lead poisoning prevention branch.

Eat well: Good nutrition can protect children from the effects of lead exposure. "If you don't have enough calcium or iron, your body will absorb more lead," Brown said.

Get tested: Pediatricians and local health departments can test children's blood to measure lead levels. Local health departments can provide advice on how to test homes, yards and gardens for lead.

Keep surfaces clean: Household dust can be a major source of lead exposure for children. "Contaminated soils do come into people's homes and get incorporated into house dust," said Miriam Rotkin-Ellman, an environmental scientist with the Natural Resources Defense Council. Leave shoes at the door to avoid tracking contaminated soil inside. Wet-mop floors and wet-wipe surfaces — especially window ledges — every two to three weeks, the CDC advises.

By Alison Young

Eckel used old industry directories, which he cross-referenced with EPA databases, to come up with a list of more than 400 potential lead-smelting sites that appeared to be unknown to federal regulators.

Eckel confirmed that 20 of the sites' addresses were factories — and not just business offices — using Sanborn fire insurance maps, which detail the historical uses of individual pieces of property. An additional 86 sites were specifically listed in directories as "plant" locations. He paid to have soil samples tested from three sites in Baltimore and five in Philadelphia. All but one of the samples exceeded the EPA's residential hazard level for lead in areas where children play.

Eckel's article warned that the findings "should create some sense of urgency for the investigation of the other sites identified here because they may represent a significant source of exposure to lead in their local environments." The research indicates "a significant fraction" of the forgotten sites will require cleanups — likely at state and federal expense — because most of the companies went out of business long ago.

Buried by bureaucracy?

Eckel's research caught the attention of the EPA, which in 2001 asked him for a copy of his unpublished list, then shared it with EPA regional offices.

Records obtained under the Freedom of Information Act offer few details of the exact instructions the EPA gave to those receiving the list. Southerland, the EPA Superfund official, said the agency didn't provide regional offices any additional money or people to evaluate the old smelter locations. It asked only that the sites be put in their queues for possible assessment.

"We only have about 80 people and $20 million each year to do our site assessment program," Southerland said. About half of that money is sent by the EPA to state agencies.

Cleaning up contamination left by a smelter can be expensive. In Omaha, the EPA has cleaned up 10,000 residential yards and spent nearly $250 million addressing a former smelter there that wasn't on Eckel's list because it was already known to the agency. Many of the factories on Eckel's list were smaller operations.

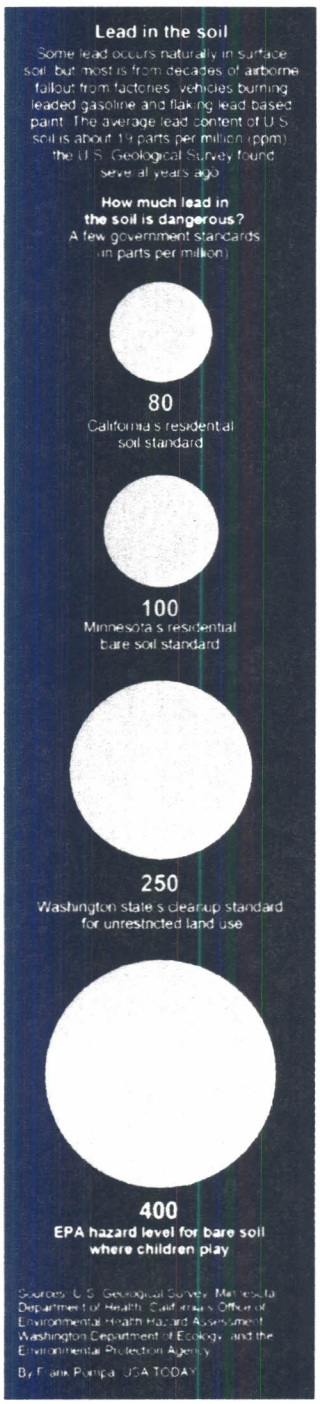
With limited resources and many contaminated sites, state and federal environmental officials have to prioritize assessing sites they consider of greatest risk, Southerland said, and drinking-water contamination tends to trump soil contamination.

In addition, Southerland said, the EPA is authorized to clean up contamination only if it can show it came from an industrial release. That can be tricky to determine in some urban areas, where the agency says it's not uncommon to find high levels of lead contamination in soil, "particularly in large cities ... due to historic gasoline emissions from vehicles, aerial deposition from industrial facilities, and lead paint," the EPA said in a statement.

The government's efforts to investigate the sites on Eckel's list varied widely, records show. Dozens were never investigated. Others received a cursory records review or a "windshield survey" — a drive-by type of visit. Soil was tested at some sites, but the testing in some cases was limited to the former smelter's property boundaries and ignored

where the wind might have carried airborne contamination; in other cases, testing was also done in nearby neighborhoods.

By 2005, concerned the list of 464 sites had been too large of a workload for the regions, officials at EPA headquarters launched their own assessment effort, Southerland said. The focus was on having regions examine a sampling of 31 sites from Eckel's list. They concluded many lacked evidence that they were ever smelters, according to a 2007 report obtained under FOIA marked "For Internal EPA Use Only." The report said only one of the sites determined to have been factories, Loewenthal Metals in Chicago, might qualify for a federal cleanup and the rest were being addressed by state regulators. Southerland said a North Carolina site ultimately received a federal cleanup.



Only six of EPA's 10 regional offices had undertaken some sort of smelter discovery initiative, according to the 2007 internal EPA report. Two of those initiatives — one by federal officials in Pennsylvania and Maryland, the other by EPA Region 5 and Michigan state officials — focused on sites from Eckel's list, the report said.

Michigan regulators took actions at some Detroit smelters after the *Detroit Free Press* in 2003 did historical research into 16 Detroit sites on Eckel's list and found smelting or foundry work at most of them. Only one site was being cleaned up at the time of the report. In 2006-07, cleanups occurred in two more neighborhoods, according to a state contractor's report.

But in scores of other cases, USA TODAY found government agencies didn't do much to protect families and children — even when their own tests showed dangerous levels of lead where people live.

Reporters scour 464 sites

The USA TODAY investigation set out to determine which sites remained unaddressed and to examine the depth and quality of any government assessments.

Reporters researched all 464 sites in 31 states that were on Eckel's list to determine how many were factories, rather than just business offices — and what, if anything, had been done to clean up those hazardous enough to threaten people living nearby.

Reporters spent weeks in the basement of the Library of Congress, researching its extensive collection of Sanborn maps. Maps showing smelting or factories were located for more than 160 sites — including many that regulators never looked for because they lacked exact street addresses. Reporters researched old phone books and city directories, archival photograph collections, old business directories, property records and corporation filings. They filed more than 140 federal, state and local public records requests with environmental, health and other government agencies to determine what, if any, assessments had been done of the sites and the risks posed to people nearby.

As a result, the investigation found evidence of smelting, foundries or lead manufacturing at more than 230 sites in 25 states on the list of forgotten factories.

The failure to protect

Ken Shefton, his wife and five boys lived until last week in a Cleveland neighborhood a few blocks northeast of the former site of the Tyroler Metals smelter. The area's two-story wood homes, mainly built around 1900, are flanked by factories, both operating and abandoned.

A smelter operated at the Tyroler site from about 1927 through 1957, according to the state's report. Smelting no longer occurs at the site, which is now a scrap yard with a different owner.

In 2002 and 2003, state regulators from the Ohio Environmental Protection Agency— working at the request of the federal EPA — tested 12 samples of soil around the old site and in the nearby neighborhood. All but one showed lead contamination above the EPA's residential hazard level of 400 parts per million (ppm) of lead in bare soil where children play. Nine of the samples had lead levels ranging from twice to five times the hazard level, according to the state's report.

The results indicated a possible "airborne depositional pattern or plume towards the northeast," the report said. In layman's terms: a fallout zone.

The state's research also identified that other smelters had been on adjacent properties dating to 1912, as well as a currently operating lead-manufacturing plant nearby. "A problem interfering with future investigation is attribution of lead contamination, due to multiple sources," the state's report said.

No matter the source, regulators never warned residents about what they found, and no cleanup occurred.

State regulators at the Ohio EPA said that without a specific polluter to blame — and force to pay for cleanup costs — there was nothing more they could do. "There are no Ohio EPA monies set aside and dedicated for this type of cleanup," the agency said in written responses to questions. "Our enforcement program focuses on responsible parties with the authority to legally compel them to fund cleanup."

Still, state regulators said that more than seven years ago they "recognized there could be potential for a health concern based on the sampling results." They said they fulfilled their duty by putting their findings about the neighborhood in a report and sending it to the EPA's regional office in Chicago. The state says it sent the report about Tyroler Metals, along with reports on eight other historical Cleveland smelter sites, to the director of the Cleveland Department of Public Health in June 2004.

Either agency could have followed up, the state said. Neither did.

Officials at the EPA regional office said that because the site didn't meet criteria for federal Superfund action, it was the state's responsibility. Federal and state officials now plan to review the site to see whether a cleanup evaluation is appropriate, the EPA said in a written statement.

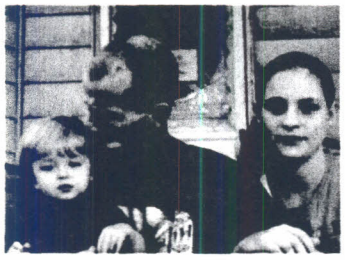
Current and former Cleveland health department officials — including Matt Carroll, who at the time was health director, and Wayne Slota, who at the time was in charge of the lead poisoning prevention division — said they don't remember receiving the state's letter and reports about Tyroler Metals.

The only smelter issue they remember involved a different site on Eckel's list: Atlas Metals, where a city park had been built atop the old smelter site and state investigators had observed children playing in dirt that tests showed was significantly contaminated.

Of the 17 Ohio sites on Eckel's list — in Cleveland, Cincinnati, Columbus and Toledo — Atlas Metals was the only one records indicate received a cleanup.

A neighborhood suffers

"I'm concerned. I really don't know what to do," said McKinley Woodby, as he held his then-15-month-old son, Damien, on his lap. "I'm just a renter. I'm on a fixed income, so it ain't like I can dig the front yard up and bring in new dirt."



By Alison Young, USA TODAY

McKinley Woodby holds Damien next to the boy's mother, Erin Fink, at their home near an old smelter site in Cleveland in October 2011. Damien played in the lead-laden soil.

"I'm not going to let (Damien) back in the yard, I know that," he said, sitting on the front steps of their home about four blocks from the Tyroler Metals site.

When USA TODAY tested soil in the family's yard where Damien played, the results showed potentially dangerous contamination in four of five samples, ranging from 577 to 1,035 ppm. Although the EPA uses 400 ppm as its residential hazard level, California's environmental health agency has set 80 ppm as the level it says will protect children who regularly play in the dirt from losing up to 1 IQ point over time.

Damien's blood was checked a few weeks before USA TODAY tested the yard. Health department records show he had a blood-lead level of 4. That's below the federal action level — set in 1991 — but current science indicates children with levels below 5 are at risk of having decreased academic achievement.

Blood test results filed with the Ohio Department of Health show that during 2007 through mid-2011 in the smelter's ZIP code about 350 kids under age 6 had reported blood-lead levels of 5 or higher. About the same number had blood-lead levels of 2 to 4. There is not a definitive way to know how prevalent lead poisoning is in the area because not all children are screened and some tests are less accurate than others.

How much the lead in the dirt is contributing to the children's blood-lead levels is unclear. But experts say that soil is an important component, along with deteriorating lead-based paint in older homes and contaminated house dust.

Bruce Lanphear, a leading expert on childhood lead poisoning, said his research has estimated that for the average child about 30% of the lead in the body comes from contaminated soil, about 30% from contaminated house dust — which includes particles of flaking paint — and about 20% from water.

"Those were the major sources, so they're all fairly important," said Lanphear, a professor of children's environmental health at Simon Fraser University in British Columbia.

A child's lead exposure can be very individualized, he said, depending on geography. For some children, it might be all about paint. "If you were to look at a community that's adjacent to a smelter, it might be that it's 80% soil, or 90% soil."

'Oh, my gosh, no, I didn't know'

Dig deeper

Explore more than 230 old lead-factory sites nationwide, historical maps, videos and photos.

In Chicago, officials have known for years about a neighborhood where contamination could pose a danger and have done little to address it. Walsh Elementary School in Pilsen is just down the block from the former site of Loewenthal Metals.

Delinda Collier said she had no idea the site used to be a lead smelter and was contaminated. There were no warning signs on the property. "Oh, my gosh, no, I didn't know," said Collier, 38, who rents an apartment across the street and lets her dog play on the vacant lot. "I'll bet nobody else does either."

Federal and state regulators knew.

Tests by the state in 2006 found the former smelter's vacant lot contaminated with up to 5,900 ppm of lead — more than 14 times the amount the EPA considers potentially hazardous in areas where children play.

"Since this site is in a residential area, the possibility of exposure is high," according to the report state officials sent to the EPA, which commissioned the work. But the site wasn't bad enough to qualify for its Superfund list, and the report was archived.

State regulators at the Illinois EPA said Loewenthal Metals was one of about 50 old smelter sites in Chicago they reviewed to varying degrees at the request of the U.S. EPA. The Loewenthal site had even been highlighted in the 2007 EPA headquarters report as the only site examined under its smelter initiative that might need a Superfund removal action.

Still, it fell through the cracks.

"We never got any follow-up instructions from them on what additional things to do with the reports we sent up to them," said Gary King, who was manager of the state agency's division of remediation management until he retired in December.

"Nonetheless, as a result, frankly, of the (open records) request that came in from USA TODAY and going back in and looking at this information ... we concluded that it would be best to send in what we call a 'removal action' referral," King said. That means the state is now formally asking the EPA to remove the contamination from the property.

The state also is formally asking the EPA to clean up a second Chicago site, Lake Calumet Smelting, where its tests in 2004 found high levels of lead — up to 768,000 ppm — on the former factory's property. The nearest homes are about a half-mile away, records show.

The failure to act

Even when officials did identify factory sites and nearby neighborhoods that could be contaminated, they failed to follow through.

The EPA's Philadelphia regional office developed one of the agency's most comprehensive smelter initiatives in response to Eckel's report. Officials there sent contractors in 2005-06 to visit most of the 71 factory sites listed in Pennsylvania, Maryland and Virginia.

The assessments confirmed dozens of the sites had had smelters, reports show, with 34 of them in troubling proximity to homes, parks and schools. As a result, EPA contractors recommended soils nearby be tested. Despite the passage of years, testing has been done at 10 sites, fewer than a third, records show.

The EPA now says the site assessment process is ongoing and the agency must prioritize its use of resources. In some cases, the EPA may not agree with its contractor's recommendations. Still, the EPA said it plans an additional assessment at several sites in late 2012 or early 2013. The "lead smelter sites at this time do not seem to pose the same threats we are encountering at other sites in the region," the EPA said.

The threat seemed serious to others in 2004.

At that time, state and federal health officials distributed a health alert to doctors with a map of the Pennsylvania locations on Eckel's list. The alert by the Pennsylvania Department of Health and the federal Agency for Toxic Substances and Disease Registry recommended doctors consider doing blood tests on children living near the sites to look for lead poisoning.

The EPA's Philadelphia regional office, however, says it sees no need to put out general warnings to neighbors of old smelter sites. "This type of approach would unnecessarily alarm residents and community members," it said. The office also said it saw no need to tell Maryland's state environmental agency about the 11 smelter sites in its state on Eckel's list. Nor did the EPA region alert the state agency that federal contractors had recommended soil testing around five of them.

USA TODAY provided Maryland officials the locations of the sites — and copies of the EPA's reports.

The EPA's failure to share such information is unusual, said Art O'Connell, chief of the Maryland Department of the Environment's state Superfund program. "I don't know what happened in this particular case, but it's certainly not the norm," he said.

As a result of the information provided by the newspaper, O'Connell said, the state recently examined the sites and determined that two former factories in Baltimore warrant further investigation: Industrial Metal Melting and Dixie Metal Co. The state has asked the EPA for funding to do soil testing and other investigation at the sites this year.

As for the three other factory sites where EPA's contractors recommended tests, O'Connell said his department believes they were small operations and had little impact on soil.

The failure to look very hard

Philadelphia-based officials started investigations; other EPA regions did far less.

Of the 120 sites on Eckel's list in New York and New Jersey, the EPA office responsible for those states sent inspectors to 14 locations. (USA TODAY found historical fire insurance maps and other documents showing evidence of smelting at 53 sites in those states.)

And even though the entire focus of Eckel's list involved smelters that had closed long ago, the EPA in 2002-03 inexplicably sent inspectors looking for active smelters at only nine of the locations.

"On each occasion, upon reaching the site where the smelter was supposedly operating, the inspector found the smelter had been closed down long ago," said Philip Flax, an EPA senior enforcement team leader, in a letter to USA TODAY that accompanied copies of some inspection reports.

In 2005-06, the EPA visited four more sites in New York and one in New Jersey.

The New Jersey Department of Environmental Protection had files on only five of the 31 sites listed in its state, according to the department's responses to 31 separate open records requests it required USA TODAY to file. Only two of the files showed evidence the sites were smelters or lead factories. Yet USA TODAY later found evidence that 12 additional sites were factories. The state is now working with EPA to investigate, DEP spokesman Lawrence Hajna said. He also now says the department has located case files on some sites it told USA TODAY it didn't have.

In 2002 and 2003, the New York Department of Environmental Conservation did an "informal investigation" at some of the 89 sites listed in the state, spokeswoman Emily DeSantis said.

Four sites were known to the department and undergoing cleanups. At the remaining sites, the department concluded there was "no evidence" of environmental impacts or "no apparent impact," according to information provided by DeSantis.

Yet the department provided records documenting staff visits to just 13 of those sites. Others were assessed by the department's regional offices, DeSantis said, but the department had no record of those evaluations. There was no soil testing at any of the sites, she said, but USA TODAY's findings will be reviewed for possible follow-up.

In other states, USA TODAY repeatedly located smelters that regulators said their extensive research found no evidence had existed.

The Indiana Department of Environmental Management told the EPA in 2002 they could not find the site of the former Chas. Braman & Sons factory in the north-central Indiana town of Plymouth. The list provided to them by the EPA had only a post office box as an address. "Numerous historical industrial directories, as well as Sanborn maps, were consulted without finding any reference to the site," the state said in a 2002 report sent to the EPA.

The newspaper found a street address for the plant listed in a 1959 edition of Plymouth's telephone directory. A call to Plymouth's City Hall produced council minutes beginning in 1954 showing that emissions from the plant were a source of citizen complaints. According to a 1956 article from a local newspaper that Plymouth's city attorney found in

the town's history museum, the Chas. Braman & Sons "smelting plant manufactured granular aluminum, solder and lead."

In response to USA TODAY's findings, state regulators sent staff to Plymouth and took 24 off-site soil samples from various locations near the former facility. Another six samples were taken on the factory site, which is now a granular aluminum company.

All the state's tests showed lead levels below federal guidelines; many did not detect any lead. "We did not see anything we were concerned about," said Mark Jaworski, a project manager in the state's site investigations section. The current owner of the aluminum company on the property, John Oliver Sr., said there has been no lead smelting since the Bramans' sold their factory around 1965.

Minnesota regulators told the EPA in a 2002 memo they were unable to confirm whether any of the seven sites in their state had been smelters. USA TODAY found evidence of historical smelting at two of them.

A state employee checked corporation records and did a drive-by of the former Hiawatha Avenue location of Northwestern Smelting & Refining in Minneapolis and noted a construction company and a bus line were among current businesses there. "No information available as to the operation of a smelter at this location," wrote Gary Krueger in his 2002 assessment.

The newspaper found photographs from the 1940s of the smelter in operation posted on the Minnesota Historical Society's website. A reporter located a historical Sanborn fire insurance map at the Library of Congress showing three smelters there at one time.

Krueger told the EPA in 2002 he couldn't find evidence of a National Lead smelter, which had been listed in St. Paul without a street address in old industry directories. "Additional use of state resources cannot be justified based solely on name of potential facility somewhere in St. Paul," says the state's report.

A reporter located the factory by searching through old indexes to Sanborn fire insurance maps. The map shows the National Lead plant was in a warehouse district near the Mississippi River and what is now Harriet Island Regional Park and describes it as a manufacturer of lead pipe, babbitt, solder and printers' metals; it also shows melting kettles.

After being given the photos and maps found by USA TODAY, Krueger recently visited the St. Paul site and made a second visit to the Minneapolis site. Krueger, a project manager in the state's Superfund program, noted the areas have undergone redevelopment.

"Quite honestly, it really doesn't change anything," he said. Without more proof of a danger, Krueger said, his department can't justify doing any soil sampling.

USA TODAY tested soil near the former National Lead site in St. Paul and found elevated levels in street-side public rights-of-way ranging up to 539 ppm. None of the three samples taken inside the park — which is in the river's flood plain — showed lead levels above 400 ppm, the EPA's hazard level for children's play areas. Near the Minneapolis smelter site, USA TODAY's tests found varying levels of lead.

•COMING NEXT: More tests, more contamination

Additional reporting by Peter Eisler. Contributing: Adam Kerlin, Brad Heath, Nicole Dao, Paul Monies and Barbara Hansen.

Questions Forwarded to:

- **Paul Celli, Coordinator for Laboratory Licensing and Surveying, Office of Health Care Quality, Maryland Department of Health and Mental Hygiene, and**
- **Robert Myers, PhD, Director, Maryland DHMH Laboratories Administration**

1. In light of the probable drop in the blood lead level of concern to 5µg/dL, proposed by CDC and currently under review by the US Department of Health and Human Services, we are most concerned about whether the labs currently performing analysis for Maryland residents will be able to meet new standards for level of detection. What percentage of the current blood lead testing workload is being analyzed by labs with levels of detection above 2µg/dL and what are the highest laboratory levels of detection among these labs at this time?

2. Our members also have concerns about the quality control and quality oversight of the labs, and have a number of questions about the extent to which DHMH monitors laboratory quality by the submission of spiked samples, which is common with environmental lead laboratories. Do you verify that the lab participates in one of the Proficiency Testing Programs (e.g. New York, Wisconsin)? Do you monitor results of these programs for labs performing analysis for Maryland residents? What oversight is DHMH currently providing when/if problems with blood lead analyses occur? How have past problems been identified and resolved?

Commission members have additional questions and we would prefer the opportunity to discuss these in person. Are you or one of your colleagues available for our meeting on May 3rd?

Response from Paul Celli, Coordinator for Laboratory Licensing and Surveying, Office of Health Care Quality, Maryland Department of Health and Mental Hygiene

Dr McLaine,

I was unaware that the state no longer performs lead analysis, I am surprised they eliminated this program.

Dr Myers responded to me with this information:
The DHMH Laboratory stopped performing blood lead testing on July 1, 2010. The testing program was eliminated due to budgetary constraints. At present blood lead testing in Maryland is performed by private clinical laboratories that I presume are licenced by OHCQ. The results of lead testing are reported to the MD Lead Registry database that is maintained by MDA so it is possible that they could provide you with a statistical breakdown of current blood lead detection levels. There is a long-term plan to migrate the lead registry to DHMH. Dr. Cliff Mitchell of IDEHA is charge of environment health programs for the state so he could also be resource for current information regarding blood lead testing.
I spoke to Tina Wiegand who was the head of the DHMH Lead Lab for many years regarding the PT questions . There are at least three national blood lead PT programs that she was aware of. They are; CAP, Pennsylvania and Wisconsin that runs a CDC sponsored PT program. In the past the DHMH Lead Lab was a reference/referee for all three of these PT programs. I would assume the results of these PT programs are either sent to your office directly or are available for review during your lab inspections. As you know each lab could also choose to run an internal PT program of blinded specimens . I have copied Tina on this e-mail she would be a good source for further technical details regarding blood lead testing should you need them.

Dr Myers is accurate that OHCQ does review these PT results for lab inspections. There are currently only 13 CLIA (certificate of compliance) labs that we inspect biennially, that are performing lead testing, there may be additional Certificate of Waiver labs, using the Lead care II or other waived kits, but these are not routinely inspected or monitored. I am sorry I do not have any more information for you at this time. Unfortunately with the large number of labs we inspect, we do not offer consulting services to identify problems and offer solutions if these labs are having problems with lead analyses. We hold them to be in compliance with CLIA and state regulations, and rely on the test kit manufacturers to provide technical support.

Sincerely,

Paul Celli
Coordinator for Laboratory Licensing and Surveying
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Phone:(410)402-8022
Fax:(410)402-8213
Email: pcelli@dhmh.state.md.us
Website: www.dhmh.state.md.us/ohcq

Response from Robert Myers, PhD, Director, Maryland DHMH Laboratories Administration

Dr. Dwyer,

I do not believe I can offer any significant insights in the current status of blood lead testing Maryland to the Governor's Lead Poisoning Prevention Commission and my attendance at your meeting on May 3rd. would not be informative to the Commission . The DHMH Laboratory stopped performing blood lead testing on July 1, 2010 due to budgetary constraints. At present blood lead testing in Maryland is performed by private clinical laboratories that are licensed by the DHMH Office of Health Care Quality (OHCQ). The Laboratories Administration has no regulatory oversight of the private testing laboratories and we are currently unaware of the state-of-the art in blood lead testing.

I can offer the following in response to your questions based on our past experiences. With regard to question concerning the lower limit detection level, the results of lead testing are reported to the Maryland Lead Registry database that is maintained by MDA so it is possible that they could provide you with a statistical breakdown of current blood lead detection levels. To respond to your second question concerning the quality assurance and oversight of blood lead testing, licensed clinical laboratories performing blood lead testing are required to be enrolled in a recognized proficiency testing (PT) program. They are also required to submit the results of their performance of proficiency testing panels to OHCQ and to document corrective actions undertaken if they obtain incorrect results on any of the PT panel specimens. Additionally, documentation of proficiency testing, performance and PT corrective actions (if needed) must be available for two years for review during a clinical laboratory licensing inspection. If a laboratory consistently fails PT for any regulated analyte they can be decertified to test for that analyte. OHCQ should have records of the PT performance of the clinical laboratories they license for blood lead testing in Maryland. Each clinical testing laboratory could also choose to run an additional internal PT program of blinded specimens. For details regarding the clinical laboratory regulatory process I would recommend that you contact OHCQ. I hope this has helped to address your concerns.

Best regards,

Bob Myers

Robert A. Myers Ph.D.
Director
Maryland DHMH Laboratories Administration
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Phone (410) 767-6100 FAX (410) 333-5312
E-mail: myersr@dhmh.state.md.us

JUNE 7, 2012

LEAD POISONING PREVENTION COMMISSION MEETING

MEMBERS

Governor's Lead Commission Meeting Attendance Sheet

6/7/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

Name/Signature	Representing	Telephone/Email
CONNOR, Patrick	Hazard ID Professional	
DWYER, M.D.Maura	Department of Health and Mental Hygiene	
HALL, Cheryl	Office of Child Care	
JENKINS, Melbourne	Property Owner Pre 1950	
LANDON, Edward	Dept. Housing and Community Dev.	
McLAINE, Patricia	Child Health/Youth Advocate	
MOORE, Barbara	Health Care Provider	
OAKS, Nathaniel (Delegate)	Maryland House of Delegates	
ROBERTS, Linda Lee	Property Owner Post 1949	
SNYDER-VOGEL, Mary	Child Advocate	
VACANT	Secretary of the Environment or Designee	
VACANT	Local Government	
VACANT	Parent of a Lead Poisoned Child	
VACANT	Financial Institution	
VACANT	Child Care Providers	
VACANT	Insurer	
VACANT	Property Owner Pre 1950 Outside Baltimore City	
VACANT	Maryland Insurance Administration	
VACANT	Maryland Senate	

GUESTS

Governor's Lead Commission Meeting Attendance Sheet

6/7/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

Name	Representing	Address/Telephone/Email
Shalétta Denson	CECLP	2714 Hudson St., 4105346447 sdenson@leadsafe.org
[illegible]	-	MDE
JOHN O'BRIEN	MDE	1800 WASHINGTON BLVD, SUITE 630, BALTIMORE, MD 21230
Mary Kathryn Page	MMHA	
Ken Strong	HCD	KEN.STRONG@baltimorecity.gov
Horacio Tablada	MDE	
Paula Montgomery		

GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Approved Minutes (7/12/12)
June 7, 2012

Members in Attendance

Patrick Connor, Melbourne Jenkins, Edward Landon, Pat McLaine, Barbara Moore, and Delegate Nathaniel Oaks.

Members not in Attendance

Dr. Maura Dwyer, Cheryl Hall, Linda Roberts, and Mary Snyder-Vogel.

Guests in Attendance

Shaketta Denson – CECLP, Mary Katherine Pnre – MMHA, Ken Strong – HCD, Horacio Tablada – MDE, Ezatollah Keyvan – MDE staff, John O'Brien – MDE staff, Paula Montgomery – MDE staff, and Tracy Smith – MDE staff.

Introductions

Pat McLaine began the meeting at 9:40 am. Everybody present introduced themselves. Pat McLaine inquired if everyone had an agenda and had signed in. Future meetings are on the agenda.

Motion to accept the draft minutes from the May Commission meeting by Ed Landon and seconded by Patrick Connor and approved.

Future Meeting Dates

The next Lead Commission meeting is scheduled for Thursday, July 5, 2012 at 9:30 am –BUT possibly reschedule for July 12 due to the holiday. Tracy will send out an email when reschedule date is confirmed.

Discussion

Discussions about CDC accepting the Advisory Committee's recommendations for lowering the target blood lead level to 5µg/dL included concerns with funding and unclear guidance/standards for implementing the recommendations.

Since January in Baltimore City, children with blood lead levels between 5-9 µg/deciliters have been referred to Baltimore Housing. The Baltimore City Health Department will continue primary prevention efforts for children and will provide additional data with regards to the number of children at the next meeting.

Ken Strong from Baltimore Housing commented that their new HUD grant that begins on July 1st includes a strategy for reaching out to children with blood lead levels between 5-10 µg/deciliters, with the Baltimore City Health Department and the Coalition providing assistance to identify 150 families.

Concerns were raised about reaching people who are difficult to reach since this is not a mandate and is voluntary at lower blood lead levels. Protocols for follow-up are similar to Baltimore City Health Department protocols already in place at levels of 10µg/dL.

Pat McLaine commented that there is no Federal guidance for blood lead levels between 5-9 µg/deciliters, that this is currently voluntary, and though it includes primary prevention it does not include the same degree of case management.

Comments about what Maryland's reference value would be if, according to NHHANES, 97.5 % of blood lead levels nationwide were < 5 µg/deciliter. Based on 2010 CLR data, Maryland appears to have 8 times as many children with blood lead levels in the 5-9µg/dL range as the national NHANES estimates would suggest. NHHANES data may not be representative of blood lead levels in Maryland. According to the Coalition, Maryland ranks 11/35 for children that are above 10 µg/deciliter for States that are in the CDC program.

Pat McLaine stated that the Commission did send out letters about our concerns with budgets @ the Federal level. The U.S. Senate kept HUD's funding at $ 120 million, including $ 30 million for Healthy Homes programs ($10 million for Healthy Homes had been allocated by the House of Representatives).

An elimination of $ 2 million from the CDC budget will be discussed next week by the Senate. $27 million to be split up amongst 15 states (including for asthma). Two years ago, 35 states were involved. The goal is to restore funding to FY 2011 levels for 35 states. Differences between the Senate and the House are to be reconciled in committee.
Bridge funding will be ending on September 1st this year.

Dr. Keyvan made a presentation to the Commission on current analytical methods that are used for blood lead testing and included costs and detection limits. Tests with higher levels of accuracy generally cost more.

Proficiency testing programs are based on the complexity of the method that is used to conduct the blood lead measurement. Most commercial labs participate in Wisconsin's proficiency testing program. CLIA requirements for proficiency testing have been in place since 1988 and include 3 test events/year and 5 challenges/event.

Assessing lab performances was discussed, which included what happens when a test is failed and whether a failure would impact previous test analyses or might affect other labs in Maryland from the same company. Pat McLaine commented that every site with an instrument has to participate in

proficiency testing. New Jersey labs that are licensed in Maryland are required to participate in proficiency testing.

Dr. Keyvan discussed laboratory registration/licensing requirements. The six page application form includes the CLIA #, qualifications of the lab director and technical supervisor, and documentation of accreditation.

A lead study group that was created in 1984 under DHMH included the reporting of diseases by lab and not doctors. Lead reporting is included in COMAR 26.16.01 and was amended in 2001 and 2002. Minimum information includes dates of birth, sex, race, street name, address (street name, apt, #, city, zip code, and state), sample type, and blood lead level.

A total of 125,877 tests were reported in calendar year 2011, from 36 laboratories. Different methods of reporting include faxing, mailing, a secured werb-site, and and MDE FTP site. All blood levels > or = to 15 µg/deciliter are faxed to MDE; some are faxed to MDE @ 10 µg/deciliter. 10 % of the laboratories that analyze blood lead samples are in the state of Maryland; 90 % of the laboratories that analyze blood lead samples are from outside the state of Maryland.

Most (80%) samples in Marylandare analyzed by graphite furnace atomic absorption spectrometry, with a limit of detection of about 1µg/dL. Three Anodic Stripping Voltammetry (ASV) methods (used for 6.3% of samples), including both Lead Care devices, have limits of detection between 2 and 3 µg/dL. MDE performs semi-annual and annual checks of blood lead reports by laboratories and matches the names of labs that report to MDE with DHMH's list of registered and licensed labs..

Manufactures provides the list of laboratories that are using Lead Care II analyzers to MDE. Concerns were raised with regards to following up a positive Lead Care II sample with a venous result and whether it was practical to measure blood lead levels at 5 µg/deciliter using the Lead Care II analyzer.

The distribution of blood lead levels in Maryland has changed significantly:

- 18 % of blood lead levels in 1995 were > 10 µg/deciliter; in 2010 0.5 % were >10 µg/deciliter.
- < 50 % of blood lead levels in 1995 were < 4 µg/deciliter; in 2010, 97 % were < 4 µg/deciliter.
- 3.2 % of blood lead levels in 1995 were > or = 20 µg/deciliter; in 2010, 0.1 % were > or = 20 µg/deciliter.
- The geometric (average) mean blood lead level in 1995 was 4.24 µg/deciliter; in 2010 it was 1.45 µg/deciliter.

Quality concerns with specimen collection include which tube is used, who draws, where the blood is drawn, and whether the lab phlebotomist is an employee of the lab or the provider, or draws samples for different labs. The lower the blood lead levels, the greater the chance of specimen collection error affecting the result.

Ed Landon asked whether CDC is addressing the question of an increase in legal cases.
Pat McLaine suggested that independent submittal of spiked and blinded samples would be useful.

Horacio Tablada commented that (annual) rental fees in Maryland increased from $15 to $30 as of June 1st. At the end of CDC's grant year, MDE will continue to support the Baltimore City and Wicomico County lead poisoning prevention work previously funded by CDC. MDE continues to work on implementing regulations for RRP in Maryland. Paula Montgomery has been named as the Environmental Program Manager for the Lead Program. A work group has been formed with the Maryland Insurance Administration (pursuant to HB 472 and there will be a meeting later this month in Annapolis.

AGENCY UPDATES:
DHMH – not in attendance
DHCD – HB 472 meeting
Baltimore City – Funding committee
MIA – no representative
Office of Child Care – not in attendance
Baltimore Housing – Received $2.9 million from HUD that were matched with $2.3 million from State and local funding. Will be hiring after July 1st. Goal is to abate 210 houses in 3 yrs, targeting children with blood lead levels between 5-9 µg/deciliter.

Comments included concerns about behavioral problems in schools for children with blood lead levels between 5-9 µg/deciliter and that no one is prepared to provide educational, rehabilitative, and psychological services for these levels.

Pat McLaine commented about the educational costs on the effects of lead at low levels (including with reading readiness and 3rd grade math scores). Pat McLaine referenced her study in Providence where 1/5 children had blood lead levels of 10 and above µg/deciliter. Pat McLaine commented that the problem of lead is not over and that we are not done with our work to prevent childhood lead poisoning.

The meeting adjourned @ 11:40 A.M.

CDC Response to Advisory Committee on Childhood Lead Poisoning Prevention Recommendations in "*Low Level Lead Exposure Harms Children: A Renewed Call of Primary Prevention*"

BACKGROUND

In late 2010, the Centers for Disease Control and Prevention's (CDC) Advisory Committee for Childhood Lead Poisoning Prevention (ACCLPP) formed a workgroup to evaluate new approaches, terminology, and strategies for defining elevated blood-lead levels (BLLs) among children. ACCLPP established the ad hoc Blood Lead Level workgroup on November 10, 2010. The charge of this workgroup was to:

1. Recommend how to best replace the term, 'level of concern,' regarding accumulating scientific evidence of adverse effects of BLLs at < 10 µg/dL in children.
2. Consider laboratory capability for measuring BLLs in establishing new guidance on childhood BLLs.
3. Advise ACCLPP on how CDC should communicate advisories to groups affected by policy changes concerning:
    a. Interpretation of childhood BLLs and trends in childhood BLLs over time;
    b. Screening and follow-up screening intervals;
    c. Requirements and procedures for notifying parents or guardians concerning BLL test results; and,
    d. Interventions known to control or eliminate lead exposure.

On November 16–17, 2011, the ACCLPP met and deliberated on the ad hoc workgroup draft report. On January 4, 2012, the ACCLPP met and a majority approved the report, including the recommendations.

In brief, the ACCLPP recommendations include:

- Elimination of the use of the term "blood lead level of concern" based on the compelling evidence that low BLLs are associated with IQ deficits, attention-related behaviors, and poor academic achievement. The absence of an identified BLL without deleterious effects, combined with the evidence that these effects appear to be irreversible, underscores the critical importance of primary prevention. This strategy emphasizes preventing lead exposure rather than responding after the exposure has taken place. ACCLPP recommends specific actions that CDC and other local, state, and federal agencies should take to shift priorities to primary prevention and provides guidance to respond to BLLs < 10 µg/dL in children. The ACCLPP recommends that CDC collaborate with these and other stakeholders, and provide advice and guidance. ACCLPP also recommends using a reference value based on the 97.5th percentile of the BLL distribution among children 1–5 years old in the United States (currently 5 µg/dL) to identify children with elevated BLLs using data generated by the National Health and Nutrition Examination Survey (NHANES). Approximately 450,000 children in the United States have BLLs higher than this reference value.
- Additional research is needed to develop and evaluate interventions that effectively maintain BLLs below the reference value in children. Other research priorities should include efforts that better use data from screening programs; develop next-generation,

point-of-care lead analyzers; and improve the understanding of epigenetic mechanisms of lead action.

Herein we describe CDC's response to each of the ACCLPP recommendations. The proposed methods to address recommendations are contingent on the availability of resources. In FY 2012, funding for CDC's Childhood Lead Poisoning Prevention activities was reduced significantly from FY 2011. As a result, funding is not available for state and local Childhood Lead Poisoning Prevention Programs (CLPPPs). In many instances, these reductions limit CDC's ability to fully implement many of these recommendations in the short term. This draft response was prepared by CDC's National Center for Environmental Health (NCEH).

For the purpose of these responses:

Concur – We agree, and we have the funding, staff, and control over the means to implement the recommendation. The response provides potential strategies which are achievable within current FY 2012 or proposed FY 2013 resources.

Concur in principle – We agree, but we do not have the funding, staff, or control over the means to implement the recommendation. The response highlights strategies that have been shown to be effective, however a commitment to implement actions cannot be made due to our lack of control over available resources.

Nonconcur – We disagree with the recommendations and provide the reasons for the disagreement.

CDC concurred or concurred in principle with all of the recommendations approved by the ACCLPP.

RECOMMENDATIONS

I. Recommendation: ***Based on the scientific evidence, the ACCLPP recommends that (a) the term, "level of concern", be eliminated from all future agency policies, guidance documents, and other CDC publications, and (b) current recommendations based on the "level of concern" be updated according to the recommendations contained in this report.***

Concur

Specific Means to Address or Implement

a. CDC will emphasize that the best way to end childhood lead poisoning is to prevent, control or eliminate lead exposures. Since no safe blood lead level in children has been identified, a blood lead "level of concern" cannot be used to define individuals in need of intervention.

b. In FY2012, CDC will discontinue using the term 'level of concern' in future publications and replace it with the reference value and the date of the NHANES that was used to calculate the reference value. CDC also will make this standard language available to operating divisions across CDC and use the cross-clearance procedure to ensure that authors adopt this language.

c. Publications on the Web site (www.cdc.gov/nceh/lead) will use the terminology in place at the time of their publication. The CDC Lead statement 1975–1991 includes

an asterisked note that "these documents are being kept on this website for historical purposes and are no longer in print." In FY2012, CDC will add the asterisk to the 2005 statement and the footnote will be edited to include the words "These documents refer to various blood-lead thresholds and levels of concern for adverse health outcomes in children. This terminology is outdated and readers are referred to the ACCLPP recommendations of 2012." A similar note will be applied to the document, "Managing Elevated Blood Lead Levels Among Children" (CDC, 2002) that states: "This document refers to a blood-lead level of 10 µg/dL as the CDC level of concern for adverse health outcomes in children. This terminology is outdated and readers are referred to the ACCLPP recommendations of 2012. However, the 2012 document does not recommend changes to the guidelines for the evaluation and treatment of children requiring chelation (BLLs ≥ 45 µg/dL) published here."

Status: The statement will be placed on www.cdc.gov/nceh/lead no later than two weeks following agency clearance. A joint publication summarizing the ACCLPP recommendations and CDC's response will be submitted jointly to the *Morbidity Mortality Weekly Review* and the journal, *Pediatrics*, no later than May 2012.

II. Recommendation: ***CDC should use a childhood BLL reference value based on the 97.5th percentile of the population BLL in children aged 1–5 years (currently 5 µg/dL) to identify children living or staying for long periods in environments that expose them to lead hazards. Additionally, the reference value should be updated by CDC every 4 years based on the most recent population-based–blood-lead surveys conducted among children.***

Concur in principle

Specific Means to Address or Implement

In FY12, CDC will:

a. Use the reference value in recommendations that involve follow-up evaluation of children after BLL testing.

b. Use the reference value as defined to identify high-risk childhood populations and geographic areas most in need of primary prevention.

c. Provide this information, including specific high-risk areas, to a wide variety of federal, state, and local government agencies and nongovernment organizations interested in lead-poisoning prevention.

In addition, CDC will update the value every 4 years using the two most recent NHANES surveys. The updated reference value will be posted at www.cdc.gov/nceh/lead and widely distributed through various Web-based LISTSERV sites, pediatric associations, and partners at the federal, state, and local level. Updated reference values will be reported in the National Report on Human Exposures to Environmental Chemicals and other relevant journals.

Status: CDC's National Center for Health Statistics (NCHS) will continue to monitor BLLs in the United States and make data tapes available on its Web site for public use at 2-year intervals.

CDC publications will use the reference value to provide guidance to clinical health care providers and others as these publications are prepared. Broader dissemination through Web sites, notices to clinical pediatric care providers, and the MMWR will be considered by CDC in the future.

III. Recommendation: ***CDC should develop and help implement a nationwide primary-prevention policy to ensure that no children in the United States live or spend significant time in homes, buildings, or other environments that expose them to lead hazards.***

Concur in Principle

Specific Means to Address or Implement

CDC recognizes the value of primary prevention. As feasible, CDC will develop strategies and guidelines for primary prevention. Implementation of primary-prevention programs is not currently practicable.

Status: CDC may examine the possibilities of working with the U.S. Department of Housing and Urban Development (HUD), the Health Resources and Services Administration (HRSA), state and local governments, and philanthropic organizations to identify opportunities for collaboration on primary prevention in the future.

IV. Recommendation: ***Clinicians should be a reliable source of information on lead hazards and take the primary role in educating families about preventing lead exposures. This includes***

recommending environmental assessments PRIOR to blood lead screening of children at risk for lead exposure.

Concur in Principle

Specific Means to Address or Implement

Although this recommendation is directed to clinicians, CDC may play a supportive role in enhancing the recommendation by working with providers to provide educational material. Some currently available resources can be used to update CDC/ATSDR documents to reflect the primacy of clinical health care providers in educating families about preventing lead exposure. For example, revisions to the ATSDR Lead Toxicity Case Study (available at http://www.atsdr.cdc.gov/csem/csem.html) are scheduled for 2012, and these changes can be incorporated.

Status: Full implementation contingent on funding

V. Recommendation: ***Clinicians should monitor the health status of all children with a confirmed BLL ≥ 5 µg/dL for subsequent changes in BLL until all recommended environmental investigations and mitigation strategies have been completed. Clinicians also should provide BLL test results to the families of all affected children in a timely and appropriate manner.***

Concur in Principle

Specific Means to Address or Implement

Although this recommendation is directed to clinicians, CDC may play a supportive role in enhancing the recommendation by working with clinical care providers and professional organizations to achieve this goal. Ensuring that children with BLLs > 5 µg/dL can be retested is feasible within the current resources because these tests are covered by Medicaid and many private health care insurance providers. As discussed earlier, some provider training will be conducted.

Status: Full implementation contingent on funding

VI. Recommendation: ***Clinicians should ensure that BLL values at or higher than the reference value are reported to local and state health or housing departments if no mandatory laboratory reporting exists. Clinicians also should collaborate with these agencies to ensure that the appropriate services and resources provided to children and their families.***

Concur in Principle

Specific Means to Address or Implement

Although this recommendation is directed to clinicians, CDC may play a supportive role in enhancing the recommendation through CDC's continued work with testing laboratories, point-of-care instrument manufacturers, and clinical health care providers to ensure the availability of high-caliber laboratory services. In addition, most of the state CLPPPs funded by CDC have

mandatory reporting laws in place, and those that do not are required to implement such laws during this year of funding.

Status: Full implementation contingent on funding

VII. Recommendation: ***Educate families, service providers, advocates, and public officials on the primary prevention of lead exposure in homes and other child-occupied facilities to ensure that lead hazards are eliminated before children are exposed.***

Concur in Principle

Specific Means to Address or Implement

In FY12, CDC will provide available educational materials through its Web site, and seek the assistance of partner agencies and organizations to implement this recommendation. In FY 2012, funding is not available for state and local CLPPPs.

Status: Implementation contingent on funding

VIII. Recommendation: ***CDC should encourage local, state, and other federal agencies to: (a) facilitate data-sharing between health and housing agencies, (b) develop and enforce preventive lead-safe housing standards for rental and owner-occupied housing, (c) identify financing for lead hazard remediation, and (d) provide families with the information they need to protect their children from hazards in the home.***

Concur in Principle (a.-c.)

Specific Means to Address or Implement

a. In FY12, CDC will continue to recommend that health and housing agencies share data that can be used to identify geographic areas where lead-exposure risk is high. In the future, CDC can explore strategies to facilitate data sharing between health and housing agencies. If funds for CLPPPs become available, CDC will require data sharing between CLPPPs and housing agencies in all CLPPP grant programs.

b. CDC has developed guidelines for lead-safe housing and in FY2012 will encourage local, state, and federal agencies to enforce these standards.

c. HUD Lead Hazard Control Program provides approximately $100 million annually and is the most easily identifiable and largest source of federal funding for lead-hazard remediation. Many CLPPPs help property owners complete the HUD application process, help to identify alternative funding sources, and negotiate with local banks. In FY 2012, however, funding is not available for state and local CLPPPs.

Concur (d.)

Specific Means to Address or Implement

d. These materials currently exist and are distributed through a wide variety of networks. Future development of new materials could be considered by CDC in the future.

Status: Implementation contingent on funding

IX. Recommendation: ***Elected officials and the leaders of health, housing, and code enforcement agencies can help protect the children in their jurisdictions from lead exposure in their homes through many activities. CDC should work with officials to ensure adoption of a suite of preventive policies.***

Concur in Principle

Specific Means to Address or Implement

In the future, CDC could consider educating state and local elected officials about the importance of primary prevention and evidenced-based strategies at a national level. In FY 2012, funding is not available for state and local CLPPPs.

Status: Full implementation contingent on funding

X. Recommendation: ***CDC should (a) emphasize the importance of environmental assessments to identify and mitigate lead hazards before children demonstrate BLLs at or higher than the***

reference value and (b) adopt prevention strategies to reduce environmental lead exposures in soil, dust, paint, and water before children are exposed.

Concur (a.)

Specific Means to Address or Implement

a. For more than 20 years CDC has emphasized the importance of environmental assessment and mitigation of lead hazards before children are exposed (before their BLLs are at or higher than the reference value) through policies, cooperative agreements, interagency agreements, and publications. CDC will continue these efforts.

Status: Ongoing

Concur in Principle (b.)

Specific Means to Address or Implement

b. In FY12 and FY13, CDC will work with federal agencies that may also be affected by these recommendations including, but not limited to, HUD and the Environmental Protection Agency (EPA). The goal of the summit will be to develop primary prevention strategies. In FY 2012, funding is not available for state and local CLPPPs.

Status: Full implementation contingent on funding

XI. Recommendation: ***If a lead hazard that requires a response is found in any unit in a multi-family housing complex, the same response must be applied to all similar untested units in the complex. However, if a previous risk assessment demonstrated that no lead hazards are present in the other units; they do not need to be retested.***

Concur in Principle

Specific Means to Address or Implement

CDC concurs with the evidence that a building that houses one child with lead poisoning is an indication that other children in that building are likely at risk. In the future, CDC may explore implementing recommendations for increased inspections.

Status: Implementation contingent on funding

XII. Recommendation: ***CDC should encourage additional research directed towards developing interventions capable of maintaining children's BLLs lower than the reference value.***

Concur in Principle

Specific Means to Address or Implement

CDC will work with the National Institute of Environmental Health Sciences (NIEHS) and academic partners to encourage research. This research will be designed to develop and evaluate effective, broadly useful interventions that are effective in the complex lead-exposure situations that are commonly encountered. In the future, CDC may explore strategies to support additional research.

Status: NIEHS is working with other partners to foster collaboration on developing a research agenda that will address the spirit of the recommendation. In the future, CDC may explore strategies to support additional research.

XIII. Recommendation: ***Additional research priorities should include improving the use of data from screening programs, developing next generation point-of-care lead analyzers, and improving the understanding of epigenetic mechanisms of lead action.***

Concur

Specific Means to Address or Implement

As funding permits, CDC will work with NIEHS, academic partners, and laboratory instrument manufacturers to encourage research in these important areas.

Status: There is ongoing interaction with NIEHS and others to foster collaboration on developing a research agenda.

MDE

MARYLAND DEPARTMENT OF THE ENVIRONMENT

Lead Poisoning Prevention Program

Childhood Blood Lead Surveillance in Maryland

A Review of Current Methods for Blood Lead Testing And The State of State Childhood Blood Lead Reporting

June, 2012

Current Analytical Methods for Blood Lead Measurements

Method	Detection Limit	Cost ($)	Automation
Graphite furnace (Electrothermal) Atomic Absorption Spectrometry (GFAAS/ETAAS)	≈ 1 µg/dL	30K- 50K	Automated
Anodic Stripping Votammetry (ASV)	≈ 2-3 µg/dL	10K – 15K	Non-automated
Inductively Coupled Plasma-Mass Spectrometry (ICP-MS)	≈0.05 µg/dL	180K – 250K	automated
Lead Care I (ASV-hand held)	≈2 µg/dL	2K – 3K	Non-automated
Lead Care II (ASV-hand held)	≈3 µg/dL	2K – 3K	Non-automated

Assessing Laboratory Performance

On individual sample

- "Satisfactory" if the reported concentration is within acceptable range (i.e., ± 4 µg/dL or ± 10%)

On one PT Test Event (5 samples)

- "Pass" if satisfactory performance on 80% of samples (i.e., 4 out of 5)

Overall PT performance

- "Unsuccessful" if Fail 2 consecutive PT events.
- "Unsuccessful" if Fail 2 of 3 PT events.

Pass	Pass	Fail	Pass	Pass	Fail	(OK)
Pass	Fail	Fail	(Unsuccessful)			
Fail	Pass	Fail	(Unsuccessful)			

Laboratory Registration and Licensing in Maryland

The Coordinator for Laboratory Licensing and Surveying at Maryland Department of Health and Mental Hygiene, Office of Health Care Quality is in-charge of registration and licensing of laboratories (in and out of state) that do business in Maryland.

Registration/Licensing Requirements

- Completed six-page application form
- Documentation of qualification of lab director and technical supervisor
- CLIA number (application form, CMS 116)
- Documentation of accreditation by at least one of the accrediting agencies (CAP, AOA, AABB, ASHI, The Joint Commission)

State of the State Blood Lead Testing Report and Registry

LEAD POISONING

STRATEGIES for PREVENTION

A REPORT TO THE MARYLAND GENERAL ASSEMBLY

Lead Poisoning
Strategies for Prevention

Report to the Maryland General Assembly

Prepared by the
Science and Health Advisory Group
Maryland Department of Health and Mental Hygiene
with the assistance of
The Lead Study Group
Co-Chaired by
Max Eisenberg, Ph.D.
and
Katherine Farrell, M.D., M.P.H.

William M. Eichbaum
Assistant Secretary
Office of Environmental Programs

December, 1984

Blood Lead Laboratory Reporting Requirements

The amended law and regulations of 2001 and 2002 require, among other things, that:

The following child's demographic data should be included in each blood lead test reported:

- **Date of Birth**
- **Sex**
- **Race**
- **Address (street name & number, Apt. #, city, zipcode, state)**
- **Test date**
- **Sample type**
- **Blood lead level**

The Registry makes attempt to have the street address rather than P.O. Box address.

Method of Report by Reporting Laboratories (Calendar Year 2011)*

Method of Reporting		Number of Laboratories	Volume of Report	
			Number	Percent
Electronic	Lab Secure Website	7	111,255	88.4
	MDE Secure FTP site	1	2,475	1.9
Hard copy	Mail	16	4,722	3.8
	Fax	12	7,425	5.9
Total		36	125,877	100.0

* Preliminary numbers. NOT FOR DISTRIBUTION

All blood lead tests >= 15 (10) µg/dL are faxed

Method of Blood Lead Measurement by Reporting Laboratory (Calendar Year 2011*)

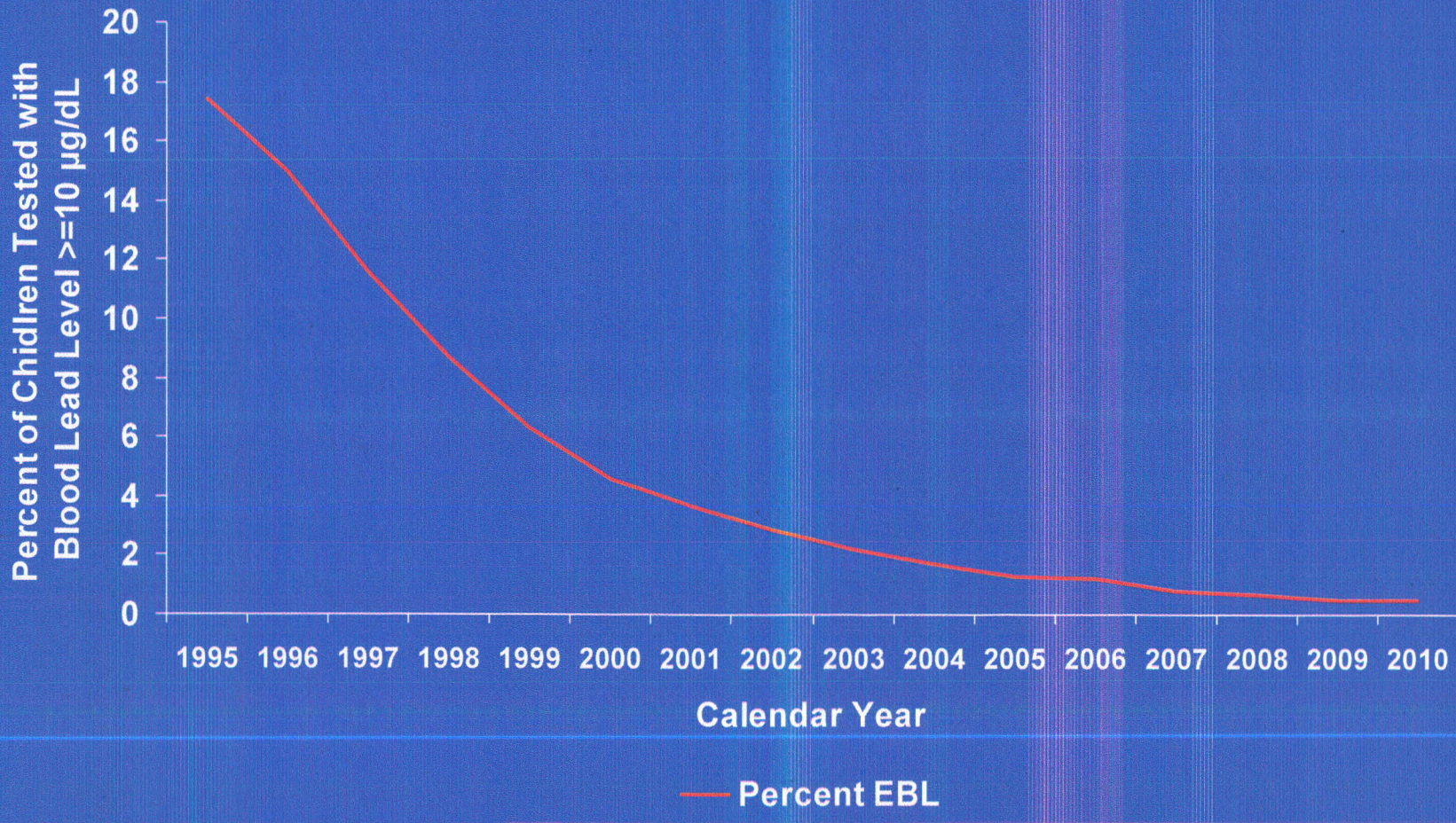
Method	Number of Lab	Number of Reports	Percent of Reports
Graphite furnace Atomic Absorption Spectrometry (GFAAS)	12	101,069	80.3
Anodic Stripping Votammetry (ASV)	2	2,590	2.1
Inductively Coupled Plasma-Mass Spectrometry (ICP-MS)	3	15,915	12.7
Lead Care I (ASV-hand held)	6	2,566	2.0
Lead Care II (ASV-hand held)	11	2,754	2.2
Unknown	2	983	0.7
Total	36	125,877	100.0

* Preliminary numbers. NOT FOR DISTRIBUTION

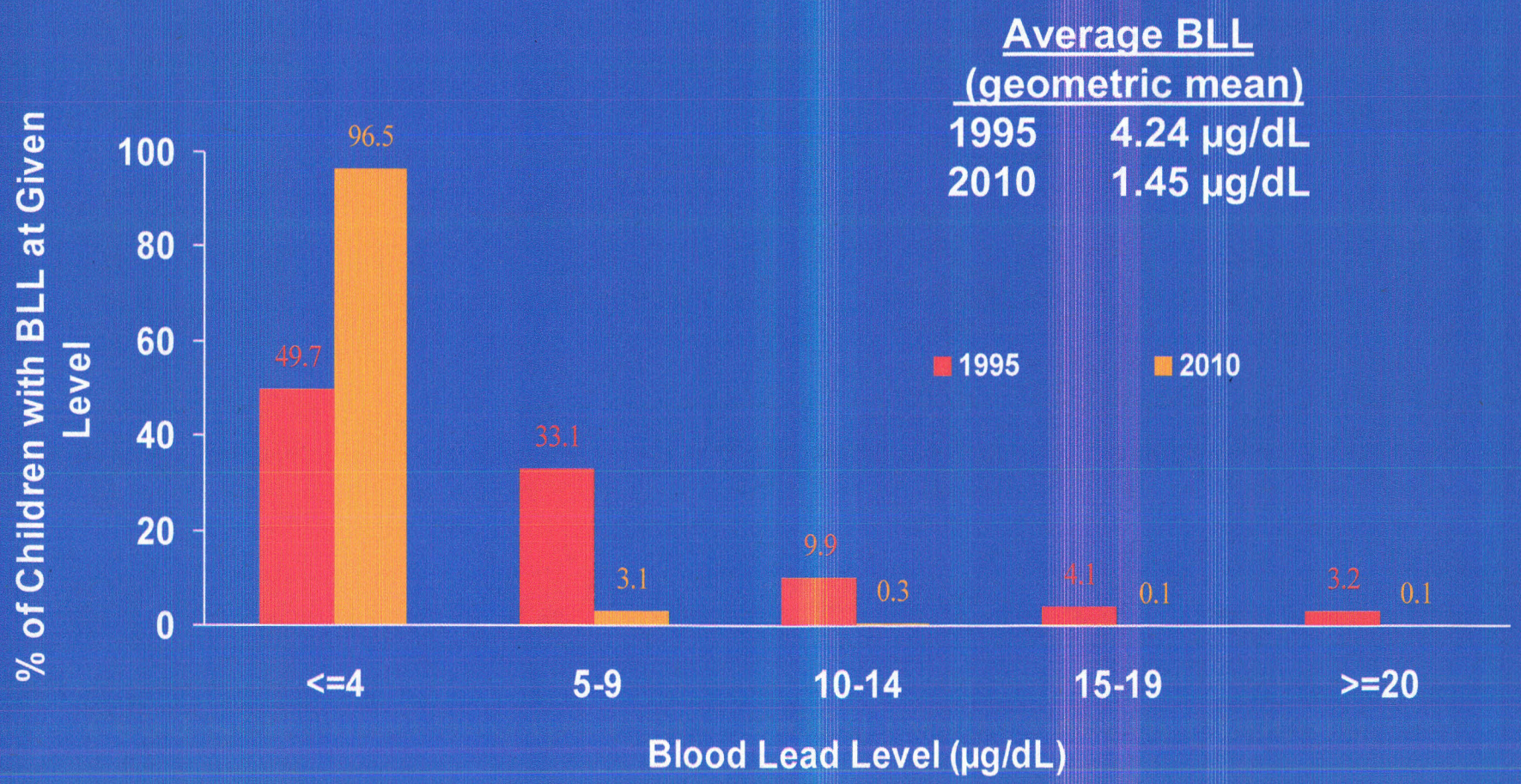
Tracking Laboratories for Blood Lead Measurement

- Semi-annual and annual check of blood lead reports by laboratories.
- Receiving monthly list of health care clinics/facilities that start doing in-house blood lead testing using hand-held LeadCare II lead analyzer (The list is provided by the manufacturer).
- Annual matching of Registry list of reporting laboratories with the list of laboratories registered with and licensed by the DHMH to do blood lead measurement on Maryland residents.
- Casual report of EBL by health care provider.

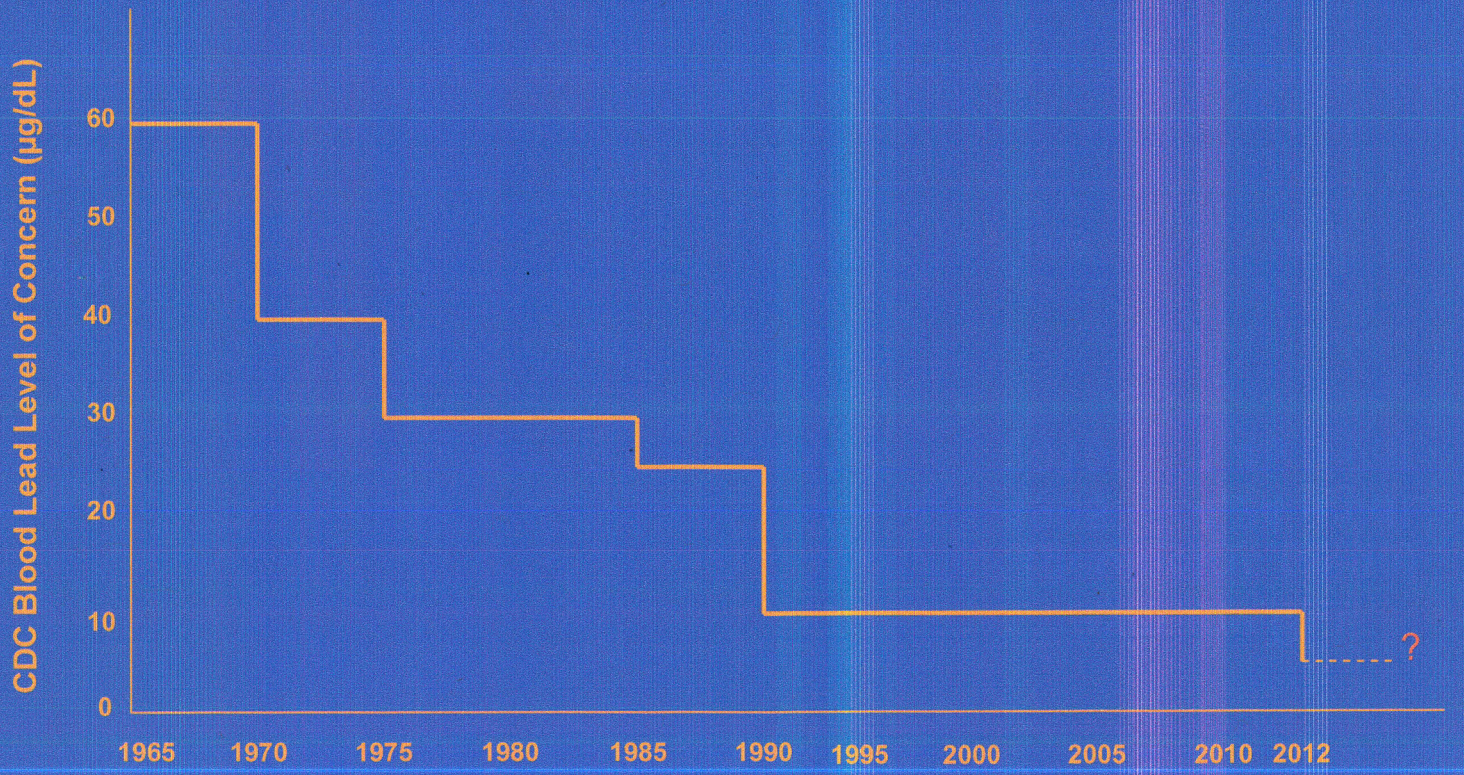
Statewide Drop in the Extent of Blood Lead Exposure



Statewide Drop in the Severity of Blood Lead Exposure



Lead Poisoning and the CDC "Blood Lead Level of Concern"



Problem with specimen collection

Instruction on specimen collection

Pediatric II		**0979-5**
CBC with Differential and Platelets, Chem 24, Lead, F.E.P., Sickle Cell (Does not contain HDL/LDL)	**1 spun barrier tube 1 lavender top tube 1 green top tube**	

Lead, Blood (Pediatric), Synonyms: Pb, Blood	
Test Number: 717009 CPT Code: 83655	
Related Information:	Lead and Protoporphyrin (FEP/ZPP), Blood (Pediatric) •Lead, Blood (Adult)
Specimen:	**Whole blood**
Volume:	**0.5 mL (capillary) or 3 mL (venous)**
Container:	**Royal blue-top (EDTA) tube or tan-top lead-free tube; submit original tube.**
Collection:	**Mix blood thoroughly to avoid clotting.**
Storage Instructions:	**Maintain specimen at room temperature.**
Patient Preparation:	**Caution: Microtainer™ results may be artificially elevated due to skin surface contamination. Venipuncture is preferred. For capillary puncture, wash skin surface thoroughly to minimize contamination.**
Causes for Rejection:	**Clotted specimen**

Problem with specimen collection

Who Draws Blood?/Where blood is drawn?

Independent phlebotomist

- Draw site operates under independent phlebotomist. The site may have contract with different laboratories. Neither Labs nor providers have any control on draw site operations.

Laboratory phlebotomist

- Draw site is under control and supervision of a given laboratory.

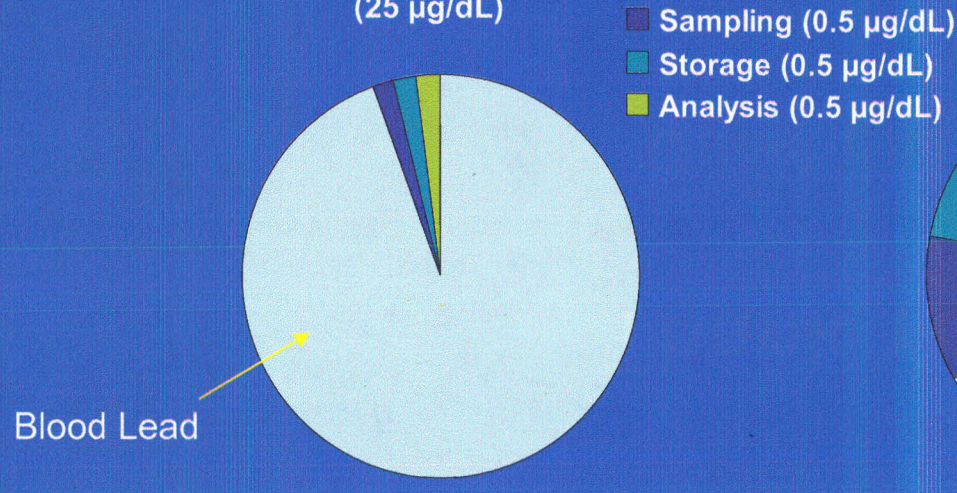
Provider phlebotomist

- Draw site is part of the health care provider's office. Phlebotomist works with the provider.

Relative problem of contamination and error in analysis of high and low blood lead concentration

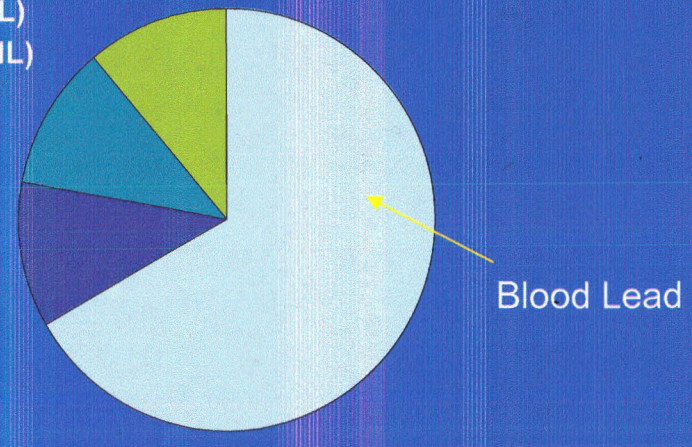
Error in Blood Lead Reporting	
Source	Magnitude
Sampling/Collection	0.5 µg/dL
Storage/Transportation	0.5 µg/dL
Analysis	0.5 µg/dL

High Blood Lead Concentration
(25 µg/dL)



Blood lead level reported 26.5 µg/dL.
≈ (94%) blood lead, (6%) error

Low Blood Lead Concentration
(3 µg/dL)



Blood lead level reported 4.5 µg/dL.
≈ (67%) blood lead, (33%) error.

Adapted from Flegal and Smith, 1992

Thank You

Questions?

National Center for Healthy Housing

CDC Response to the Advisory Committee on Childhood Lead Poisoning Prevention (ACLPP) Recommendations on Low Level Lead Exposure and Primary Prevention of Lead Poisoning

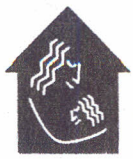
	ACLPP Recommendation	CDC Response	Status
I.	Based on the scientific evidence, the ACCLPP recommends that (a) the term, "level of concern", be eliminated from all future agency policies, guidance documents, and other CDC publications, and (b) current recommendations based on the "level of concern" be updated according to the recommendations contained in this report.	Concur	The statement will be placed on www.cdc.gov/nceh/lead no later than two weeks following agency clearance. A joint publication summarizing the ACCLPP recommendations and CDC's response will be submitted jointly to the *Morbidity Mortality Weekly Review* and the journal, *Pediatrics*, no later than May 2012.
II.	CDC should use a childhood blood lead level (BLL) reference value based on the 97.5th percentile of the population BLL in children aged 1–5 years (currently 5 µg/dL) to identify children living or staying for long periods in environments that expose them to lead hazards. Additionally, the reference value should be updated by CDC every 4 years based on the most recent population-based–blood-lead surveys conducted among children.	Concur in principle	CDC's National Center for Health Statistics (NCHS) will continue to monitor BLLs in the United States. CDC publications will use the reference value to provide guidance to health care providers.
III.	CDC should develop and help implement a nationwide primary-prevention policy to ensure that no children in the United States live or spend significant time in homes, buildings, or other environments that expose them to lead hazards.	Concur in principle	CDC may examine the possibilities of working with the U.S. Department of Housing and Urban Development (HUD), the Health Resources and Services Administration (HRSA), state and local governments, and philanthropic organizations to identify opportunities for collaboration on primary prevention in the future.

National Center for Healthy Housing

ACLPP Recommendation		CDC Response	Status
IV.	Clinicians should be a reliable source of information on lead hazards and take the primary role in educating families about preventing lead exposures. This includes recommending environmental assessments PRIOR to blood lead screening of children at risk for lead exposure.	Concur in principle	Full implementation contingent on funding
V.	Clinicians should monitor the health status of all children with a confirmed BLL ≥ 5 µg/dL for subsequent changes in BLL until all recommended environmental investigations and mitigation strategies have been completed. Clinicians also should provide BLL test results to the families of all affected children in a timely and appropriate manner.	Concur in principle	Full implementation contingent on funding
VI.	Clinicians should ensure that BLL values at or higher than the reference value are reported to local and state health or housing departments if no mandatory laboratory reporting exists. Clinicians also should collaborate with these agencies to ensure that the appropriate services and resources provided to children and their families.	Concur in principle	Full implementation contingent on funding
VII.	Educate families, service providers, advocates, and public officials on the primary prevention of lead exposure in homes and other child-occupied facilities to ensure that lead hazards are eliminated before children are exposed.	Concur in principle	Implementation contingent on funding
VIII.	CDC should encourage local, state, and other federal agencies to: (a) facilitate data-sharing between health and housing agencies, (b) develop and enforce preventive lead-safe housing standards for rental and owner-occupied housing, (c) identify financing for lead hazard	Concur in principle (a.-c.) Concur (d.)	Implementation contingent on funding

National Center for Healthy Housing

	ACLPP Recommendation	CDC Response	Status
	remediation, and (d) provide families with the information they need to protect their children from hazards in the home.		
IX.	Elected officials and the leaders of health, housing, and code enforcement agencies can help protect the children in their jurisdictions from lead exposure in their homes through many activities. CDC should work with officials to ensure adoption of a suite of preventive policies.	Concur in principle	Full implementation contingent on funding
X.	CDC should (a) emphasize the importance of environmental assessments to identify and mitigate lead hazards before children demonstrate BLLs at or higher than the reference value and (b) adopt prevention strategies to reduce environmental lead exposures in soil, dust, paint, and water before children are exposed.	Concur (a.) Concur in principle (b.)	Ongoing (a.) Full implementation contingent on funding (b.)
XI.	If a lead hazard that requires a response is found in any unit in a multifamily housing complex, the same response must be applied to all similar untested units in the complex. However, if a previous risk assessment demonstrated that no lead hazards are present in the other units; they do not need to be retested.	Concur in principle	Implementation contingent on funding
XII.	CDC should encourage additional research directed towards developing interventions capable of maintaining children's BLLs lower than the reference value.	Concur in principle	The National Institute of Environmental Health Sciences (NIEHS) is working with other partners to foster collaboration on developing a research agenda that will address the spirit of the recommendation. In the future, CDC may explore strategies to support additional research.



National Center for Healthy Housing

	ACLPP Recommendation	CDC Response	Status
XIII.	Additional research priorities should include improving the use of data from screening programs, developing next generation point-of-care lead analyzers, and improving the understanding of epigenetic mechanisms of lead action.	Concur	There is ongoing interaction with NIEHS and others to foster collaboration on developing a research agenda.

From: Paul Celli [pcelli@dhmh.state.md.us]
Sent: Wednesday, June 06, 2012 3:40 PM
To: McLaine, Pat
Cc: Renee Webster
Subject: Renee Forwarded Questions

Dr McLaine,

Renee forwarded me the following questions. I believe Dr Myers and myself have tried to answer the first four previously. I will try to answer the last three as well.
If anyone has additional questions regarding a regulatory issue regarding lead testing, I will do my best to answer.

1. Does OHCQ monitor lab quality through the submission of spiked samples, which is common with environmental lead laboratories? **No**

2. Does OHCQ verify that labs participate in one of the Proficiency Testing Programs? **There are currently only 13 CLIA (certificate of compliance) labs that we inspect biennially, that are performing lead testing, there may be additional Certificate of Waiver labs, using the Lead care II or other waived kits, but these are not routinely inspected or monitored.Only a random 2% of CLIA waived labs are surveyed each year.**

3. Does OHCQ monitor results of the Proficiency Testing Programs? **Yes**

4. What oversight does OHCQ provide when/if problems with blood lead analyses occur?

Unfortunately with the large number of labs we inspect, we do not offer consulting services to identify problems and offer solutions if these labs are having problems with lead analyses. We hold them to be in compliance with CLIA and state regulations, and rely on the test kit manufacturers to provide technical support.

5. How have past problems been identified and resolved? **Lab's practices that do not meet CLIA and State of MD standards for all testing not only Lead are identified on inspection and resolved by the OHCQ accepting the labs plan of correction.**

6. Can a summary report of the Proficiency Testing performance of Maryland labs be made available to the Lead Commission?**I can share that information, but I would need specific laboratory information. We do not collect this data by specific test, but by CLIA location.**

7. Does OHCQ have a written statement prohibiting the use of Lavender Top tubes for samples related to lead in blood determination, and that blood lead results known to have been collected in Lavender Top tubes shall not be relied upon and that re-testing is required?
There is no statement regarding this in the COMAR laboratory regulations. In my clinical experience most manufacturer vendors share this information with the labs when setting up their instrument.

Sincerely,

Paul Celli
Coordinator for Laboratory Licensing and Surveying
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Phone:(410)402-8022
Fax:(410)402-8213
Email: pcelli@dhmh.state.md.us
Website: www.dhmh.state.md.us/ohcq

THE GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

May 30, 2012

The Honorable Donna F. Edwards
House of Representatives
318 Cannon House Office Building
Washington, DC 20515

Dear Congresswoman Edwards:

As you know, FY 2012 funding has been cut for CDC's Healthy Homes and Lead Poisoning Prevention Program, and the program is slated for consolidation and further cuts in FY2013. We appreciate your leadership and support for the National Safe and Healthy Housing Coalition's recommendation to provide $29 million for the Healthy Homes and Lead Poisoning Prevention Program in FY2013. Restoring the program to the FY 11 funding level will ensure protection of children at highest risk of lead poisoning.

How are children in Maryland impacted? The majority of Maryland homes were built before lead paint was banned for residential use in 1978, with nearly 19% built before 1950.[1] In Maryland, the number of poisoned children (blood lead level of 10μg/dL or higher) has dropped from about 3,402 children in 2000 to 531 children in 2010. However, based on our 2010 Maryland data, we estimate that the recent federal lowering of the blood lead level of concern from 10 to 5μg/dL would result in an eight-fold increase in the number of identified at-risk children. Concerned parents are already calling local and state programs to find out what they can do to protect their children.

For many years, CDC funding has supported essential activities across the state of Maryland to prevent children from being exposed to environmental sources of lead. Maryland received $824,000 in CDC funding in 2010. The budget was reduced to $594,000 in 2011, which included funding for our state surveillance system personnel at MDE, 6 full-time positions for outreach and case management of more than 200 new cases in Baltimore City, and a prevention program targeting the lower Eastern Shore of Maryland. These federal funds are slated to be eliminated in August 2012, placing the entire state prevention program in jeopardy. State and local resources are limited. If nothing is done, these federal cuts could result in further loss of Maryland jobs and a reduction in vital services to at-risk Maryland families.

Solving lead poisoning, a major public health problem, requires continued CDC leadership. Lead poisoning remains a significant environmental public health threat. The continued cost to

our nation is staggering: childhood lead poisoning in 2008 alone will cost the nation an estimated $50 billion in lost lifetime economic productivity.[ii]

We respectfully request your continued support for this effort to make children a priority in the FY 13 Labor-HHS bill next month by fully funding lead poisoning prevention and healthy homes programs. Now is not the time to dismantle CDC's Healthy Homes and Lead Poisoning Prevention Program. Instead we need a separate $29 million program, one that is not merged with CDC's asthma control program or blended with HRSA's home visiting program, to continue the job of preventing lead poisoning.

Thank you for your continued support and leadership on this critical public health matter.

Sincerely,

Pat McLaine, RN, DrPH, MPH
Chair

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[i] Source: US Census Bureau, American Community Survey, 2005-2009 American Community Survey 5-Year Estimates

[ii] Trasande, L. and Liu, Y., Reducing The Staggering Costs Of Environmental Disease In Children, Estimated At $76.6 Billion in 2008, *Health Affairs 30*, No. 5 (2011)

THE GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

May 30, 2012

The Honorable Elijah E. Cummings
House of Representatives
2235 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Cummings:

As you know, FY 2012 funding has been cut for CDC's Healthy Homes and Lead Poisoning Prevention Program, and the program is slated for consolidation and further cuts in FY2013. We appreciate your leadership and support for the National Safe and Healthy Housing Coalition's recommendation to provide $29 million for the Healthy Homes and Lead Poisoning Prevention Program in FY2013. Restoring the program to the FY 11 funding level will ensure protection of children at highest risk of lead poisoning.

How are children in Maryland impacted? The majority of Maryland homes were built before lead paint was banned for residential use in 1978, with nearly 19% built before 1950.[i] In Maryland, the number of poisoned children (blood lead level of 10µg/dL or higher) has dropped from about 3,402 children in 2000 to 531 children in 2010. However, based on our 2010 Maryland data, we estimate that the recent federal lowering of the blood lead level of concern from 10 to 5µg/dL would result in an eight-fold increase in the number of identified at-risk children. Concerned parents are already calling local and state programs to find out what they can do to protect their children.

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THE GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

May 30, 2012

The Honorable John P. Sarbanes
House of Representatives
2444 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Sarbanes:

As you know, FY 2012 funding has been cut for CDC's Healthy Homes and Lead Poisoning Prevention Program, and the program is slated for consolidation and further cuts in FY2013. We appreciate your leadership and support for the National Safe and Healthy Housing Coalition's recommendation to provide $29 million for the Healthy Homes and Lead Poisoning Prevention Program in FY2013. Restoring the program to the FY 11 funding level will ensure protection of children at highest risk of lead poisoning.

How are children in Maryland impacted? The majority of Maryland homes were built before lead paint was banned for residential use in 1978, with nearly 19% built before 1950.[i] In Maryland, the number of poisoned children (blood lead level of 10µg/dL or higher) has dropped from about 3,402 children in 2000 to 531 children in 2010. However, based on our 2010 Maryland data, we estimate that the recent federal lowering of the blood lead level of concern from 10 to 5µg/dL would result in an eight-fold increase in the number of identified at-risk children. Concerned parents are already calling local and state programs to find out what they can do to protect their children.

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THE GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

May 30, 2012

The Honorable C. A. Dutch Ruppersberger, III
House of Representatives
2453 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Ruppersberger:

As you know, FY 2012 funding has been cut for CDC's Healthy Homes and Lead Poisoning Prevention Program, and the program is slated for consolidation and further cuts in FY2013. We appreciate your leadership and support for the National Safe and Healthy Housing Coalition's recommendation to provide $29 million for the Healthy Homes and Lead Poisoning Prevention Program in FY2013. Restoring the program to the FY 11 funding level will ensure protection of children at highest risk of lead poisoning.

How are children in Maryland impacted? The majority of Maryland homes were built before lead paint was banned for residential use in 1978, with nearly 19% built before 1950.[1] In Maryland, the number of poisoned children (blood lead level of 10µg/dL or higher) has dropped from about 3,402 children in 2000 to 531 children in 2010. However, based on our 2010 Maryland data, we estimate that the recent federal lowering of the blood lead level of concern from 10 to 5µg/dL would result in an eight-fold increase in the number of identified at-risk children. Concerned parents are already calling local and state programs to find out what they can do to protect their children.

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Pat McLaine, RN, DrPH, MPH
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THE GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

May 30, 2012

The Honorable Andrew P. Harris
House of Representatives
506 Cannon House Office Building
Washington, DC 20515

Dear Congressman Harris:

As you know, FY 2012 funding has been cut for CDC's Healthy Homes and Lead Poisoning Prevention Program, and the program is slated for consolidation and further cuts in FY2013. We need your support for the National Safe and Healthy Housing Coalition's recommendation to provide $29 million for the Healthy Homes and Lead Poisoning Prevention Program in FY2013. Restoring the program to the FY 11 funding level will ensure protection of children at highest risk of lead poisoning.

How are children in Maryland impacted? The majority of Maryland homes were built before lead paint was banned for residential use in 1978, with nearly 19% built before 1950.[i] In Maryland, the number of poisoned children (blood lead level of 10µg/dL or higher) has dropped from about 3,402 children in 2000 to 531 children in 2010. However, based on our 2010 Maryland data, we estimate that the recent federal lowering of the blood lead level of concern from 10 to 5µg/dL would result in an eight-fold increase in the number of identified at-risk children. Concerned parents are already calling local and state programs to find out what they can do to protect their children.

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We respectfully request that you ensure that Representatives Denny Rehberg and Rosa DiLauro, Chair and Ranking Member for the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, make children a priority in the FY 13 Labor-HHS bill next month by fully funding lead poisoning prevention and healthy homes programs. Now is not the time to dismantle CDC's Healthy Homes and Lead Poisoning Prevention Program. Instead we need a separate $29 million program, one that is not merged with CDC's asthma control program or blended with HRSA's home visiting program, to continue the job of preventing lead poisoning.

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THE GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

May 30, 2012

The Honorable Christopher Van Hollen, Jr.
House of Representatives
1707 Longworth House Office Building
Washington, DC 20515

Dear Congressman Hollen:

As you know, FY 2012 funding has been cut for CDC's Healthy Homes and Lead Poisoning Prevention Program, and the program is slated for consolidation and further cuts in FY2013. We need your support for the National Safe and Healthy Housing Coalition's recommendation to provide $29 million for the Healthy Homes and Lead Poisoning Prevention Program in FY2013. Restoring the program to the FY 11 funding level will ensure protection of children at highest risk of lead poisoning.

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Pat McLaine, RN, DrPH, MPH
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THE GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

May 30, 2012

The Honorable Joseph Bartlett
House of Representatives
2412 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Bartlett:

As you know, FY 2012 funding has been cut for CDC's Healthy Homes and Lead Poisoning Prevention Program, and the program is slated for consolidation and further cuts in FY2013. We need your support for the National Safe and Healthy Housing Coalition's recommendation to provide $29 million for the Healthy Homes and Lead Poisoning Prevention Program in FY2013. Restoring the program to the FY 11 funding level will ensure protection of children at highest risk of lead poisoning.

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THE GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

May 30, 2012

The Honorable Steny H. Hoyer
House of Representatives
1705 Longworth House Office Building
Washington, DC 20515

Dear Congressman Hoyer:

As you know, FY 2012 funding has been cut for CDC's Healthy Homes and Lead Poisoning Prevention Program, and the program is slated for consolidation and further cuts in FY2013. We need your support for the National Safe and Healthy Housing Coalition's recommendation to provide $29 million for the Healthy Homes and Lead Poisoning Prevention Program in FY2013. Restoring the program to the FY 11 funding level will ensure protection of children at highest risk of lead poisoning.

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THE GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

May 30, 2012

The Honorable Barbara A. Mikulski
Senate of Maryland
503 Hart Senate Office Building
Washington, DC 20510

Dear Senator Mikulski:

As you know, FY 2012 funding has been cut for CDC's Healthy Homes and Lead Poisoning Prevention Program, and the program is slated for consolidation and further cuts in FY2013. We appreciate your leadership and support for the National Safe and Healthy Housing Coalition's recommendation to provide $29 million for the Healthy Homes and Lead Poisoning Prevention Program in FY2013. Restoring the program to the FY 11 funding level will ensure protection of children at highest risk of lead poisoning.

How will children in Maryland be impacted? The majority of Maryland homes were built before lead paint was banned for residential use in 1978, with nearly 19% built before 1950.[i] In Maryland, the number of poisoned children (blood lead level of 10μg/dL or higher) has dropped from about 3,402 children in 2000 to 531 children in 2010. However, based on our 2010 Maryland data, we estimate that the recent federal lowering of the blood lead level of concern from 10 to 5μg/dL would result in an eight-fold increase in the number of identified children. Concerned parents are already calling local and state programs to find out what they can do to protect their children.

For many years, CDC funding has supported essential activities across the state of Maryland to prevent children from being exposed to environmental sources of lead. Maryland received $824,000 in CDC funding in 2010. The budget was reduced to $594,000 in 2011, which included funding for our state surveillance system personnel at MDE, 6 full-time positions for outreach and case management of more than 200 new cases in Baltimore City, and a prevention program targeting the lower Eastern Shore of Maryland. These federal funds are slated to be eliminated in August 2012, placing the entire state prevention program in jeopardy. State and local resources are limited. If nothing is done, these federal cuts could result in further loss of Maryland jobs and a reduction in vital services to at-risk Maryland families.

Solving lead poisoning, a major public health problem, requires continued CDC leadership. Lead poisoning remains a significant environmental public health threat. The continued cost to our nation is staggering: childhood lead poisoning in 2008 alone will cost the nation an estimated $50 billion in lost lifetime economic productivity.[ii]

We respectfully request that you ensure that Senator Tom Harkin, Chairman of the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, makes children a priority in the FY 13 Labor-HHS bill by fully funding lead poisoning prevention and healthy homes programs. Now is not the time to dismantle CDC's Healthy Homes and Lead Poisoning Prevention Program. Instead we need a separate program, funded at least at 2011 levels ($29 million) to continue the job of preventing and eliminating lead poisoning. Merging the program with CDC's asthma control program or blending it with HRSA's home visiting program would weaken the effort needed to reach this important goal.

Thank you for your continued support and leadership on this critical public health matter.

Sincerely,

Pat McLaine, RN, DrPH, MPH
Chair

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[i] Source: US Census Bureau, American Community Survey, 2005-2009 American Community Survey 5-Year Estimates

[ii] Trasande, L. and Liu, Y., Reducing The Staggering Costs Of Environmental Disease In Children, Estimated At $76.6 Billion in 2008, *Health Affairs* 30, No. 5 (2011)

THE GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

May 30, 2012

The Honorable Benjamin L. Cardin
Senate of Maryland
509 Hart Senate Office Building
Washington, DC 20510

Dear Senator Cardin:

As you know, FY 2012 funding has been cut for CDC's Healthy Homes and Lead Poisoning Prevention Program, and the program is slated for consolidation and further cuts in FY2013. We appreciate your leadership and support for the National Safe and Healthy Housing Coalition's recommendation to provide $29 million for the Healthy Homes and Lead Poisoning Prevention Program in FY2013. Restoring the program to the FY 11 funding level will ensure protection of children at highest risk of lead poisoning.

How will children in Maryland be impacted? The majority of Maryland homes were built before lead paint was banned for residential use in 1978, with nearly 19% built before 1950.[i] In Maryland, the number of poisoned children (blood lead level of 10µg/dL or higher) has dropped from about 3,402 children in 2000 to 531 children in 2010. However, based on our 2010 Maryland data, we estimate that the recent federal lowering of the blood lead level of concern from 10 to 5µg/dL would result in an eight-fold increase in the number of identified children. Concerned parents are already calling local and state programs to find out what they can do to protect their children.

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Pat McLaine, RN, DrPH, MPH
Chair

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[ii] Trasande, L. and Liu, Y., Reducing The Staggering Costs Of Environmental Disease In Children, Estimated At $76.6 Billion in 2008, *Health Affairs* 30, No. 5 (2011)

JULY 12, 2012

LEAD POISONING PREVENTION COMMISSION MEETING

MEMBERS

Governor's Lead Commission Meeting Attendance Sheet

7/12/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

Name/Signature	Representing	Telephone/Email
CONNOR, Patrick	Hazard ID Professional	
DWYER, M.D.Maura	Department of Health and Mental Hygiene	
HALL, Cheryl	Office of Child Care	
JENKINS, Melbourne	Property Owner Pre 1950	
LANDON, Edward	Dept. Housing and Community Dev.	
McLAINE, Patricia	Child Health/Youth Advocate	
MOORE, Barbara	Health Care Provider	
OAKS, Nathaniel (Delegate)	Maryland House of Delegates	
ROBERTS, Linda Lee	Property Owner Post 1949	
SNYDER-VOGEL, Mary	Child Advocate	
VACANT	Secretary of the Environment or Designee	
VACANT	Local Government	
VACANT	Parent of a Lead Poisoned Child	
VACANT	Financial Institution	
VACANT	Child Care Providers	
VACANT	Insurer	
VACANT	Property Owner Pre 1950 Outside Baltimore City	
VACANT	Maryland Insurance Administration	
VACANT	Maryland Senate	

GUESTS

Governor's Lead Commission Meeting Attendance Sheet
7/12/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

Name	Representing	Address/Telephone/Email
D. G. Johnson	Health Dept	1800 N. Charles St. (21201) denise.g.johnson@baltimorecity.gov
Hosanna Afaw-Means	BCHD	1800 N. Charles St. Hosanna.afaw-means@baltimorecity.gov
Genevieve Birkby	BCHD	1800 N. Charles St genevieve.birkby@baltimorecity.gov
Shanetta Denson	CECLP	2714 Hudson St sdenson@leadsafe.org
JOHN C. O'BRIEN	MDE	1800 WASHINGTON BLVD. BALTO MD 21230 (410) 537-3925 jobrien@mde.state.md.us
JOHN KENAWSKY	MDE	1800 WASHINGTON BLVD. BALTO, MD 410-537-3844 JKENAWSKY@MDE.STATE.MD.US
TRACY SMITH	MDE	
Heather Barthel	MDE	HBarthel@mde.state.md.us
Geraldine Woodson	BCHD	1800 N. Charles St, 5th Flr. Balto. MD 4439842491
Lisa Nissley	MDE	lnissley@mde.state.md.us
Horacio Tablada	MDE	
Paula Montagnet	MDE	
Clifford Mitchell	DHMH	

LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Thursday, July 12, 2012
9:30 AM - 11:30 AM

AERIS Conference Room

AGENDA

I. Introductions

II. Approval of June 7, 2012 minutes

III. Future meeting dates:

The next Lead Commission meeting is scheduled for Thursday, August 2, 2012 at MDE in the AERIS Conference Room – Front Lobby, 9:30 am – 11:30 am.

IV. Update from 2010 Work Group Planning – Evaluation of 2010 State Plan to Eliminate Childhood Lead Poisoning – draft of Work Group's Key Points
Upcoming meetings: to be determined

V. Discussion:
A. Work Group Key Points

B. Follow-up laboratory issues discussion

C. DHMH Plan for new CDC Recommendations

VI. Agency Updates
A. Maryland Department of the Environment
B. Department of Health and Mental Hygiene
C. Department of Housing and Community Development
D. Baltimore City Health Department
E. Office of Childcare
F. Maryland Insurance Administration
G. Other Agencies

VII. Public Comment

GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Approved Minutes **(10/4/12)**
July 12, 2012

Members in Attendance
Patrick Connor, Cheryl Hall, Melbourne Jenkins, Ed Landon, Pat McLaine, Barbara Moore, and Linda Roberts.

Members not in Attendance
Dr. Maura Dwyer, Delegate Nathaniel Oaks, and Mary Snyder-Vogel.

Guests in Attendance
Shaketta Denson – CECLP, D. G. Johnson – BCHD, Hosanna Asfaw-Means, Genevieve Birkby, Geraldine Woodson – BCHD, Clifford Mitchell – DHMH, Horacio Tablada – MDE, Heather Barthel – MDE, Lisa Nissley – MDE, John O'Brien – MDE staff, Paula Montgomery – MDE staff, John Krupinsky – MDE staff, and Tracy Smith – MDE staff, by phone Renee Webster, DHMH Office of Health Care Quality.

Introductions
Pat McLaine called the meeting to order at 9:38 a.m. Attendees introduced themselves. Motion to accept the draft minutes from the June Commission meeting by Ed Landon and seconded by Patrick Connor; minutes were approved.

Future Meeting Dates
The next Lead Commission meeting is scheduled for Thursday, August 2, 2012 at 9:30 am in the Aeris conference room.

Discussion
Updates to the work plan were discussed. The work plan has met four (4) times since the June meeting. A July 13, 2012 draft of take home points from the task force executive summary was provided to attendees and discussed.

A question was raised with regards to a significant drop in the number of registered affected properties. MDE is working with Maryland Environmental Services for cleaning up data, including linking the inspection certificate data base with registration.

MDE is adding resources this year to link registrations with fee payments and information from Department of Assessment and Taxation. This will provide much better data.

Discussion included concerns about Baltimore City being unable to obtain Medicaid reimbursements for environmental investigations. Dr. Clifford Mitchell from DHMH indicated that he has met with the Baltimore City Health Department about this concern. The rate for inspections is $333; issues with reimbursement include paper submissions (and not electronic billing) for reimbursement processing.

With regards to loss of Federal dollars for lead poisoning prevention efforts, Commissioners were reminded that the Commission sent letters to our elected Federal congressional and senate representatives requesting their support for federal funding. MDE staff indicated that future property registration fees will probably be in the range of $8-9 million/year, but agreed in principle with a task force suggestion that one third of resources could be used to fund primary prevention efforts. Pat McLaine thanked the task force for their work. The Commission is looking forward to reading their report.

A discussion of laboratory issues raised at the presentation by Dr. Keyvan at the June 7, 2012 meeting followed. There are more tests than children (some of whom are tested multiple times.) Errors increase at lower blood lead levels. Purple (lavender) top tubes do not provide reliable results, should not be used, and can lead to faulty data/levels. Errors in blood lead analysis recently led to a child being admitted and chelation started unnecessarily.

There are currently 13 accredited laboratories. A concern was raised with oversight of draw stations. Submittal of blind/spiked samples to laboratories was also discussed. Concerns with reporting results as venous or capillary was discussed.

DHMH's plan for new CDC recommendations was discussed. DHMH is working with MDE. Letters have been sent out to health care providers informing them of CDC's new recommendations. The recommendations included dropping the term "level of concern", and using the term "reference value".

There is no change in current recommendations with regards to who should be tested. However, DHMH has started a review of more recent Maryland data on blood lead data as the first step in revising the 2004 targeting plan. The goal is to revise the targeting plan by early next year, after reviewing current data, and seeking public comments and recommendations in light of the new recommendations and the goal of eliminating lead exposure.

Critical questions moving forward include:

a.) How should health departments manage children with BLLs in the 5 – 9µg/dL range, particularly with respect to environmental assessments and clinical recommendations?
b.) What are the DHMH recommendations for clinical management of children with historical blood lead levels of5 -9 µg/dL? And how far back should the recommendations apply?
c.) Lab quality and procedures.

DHMH is requesting public comments, after which DHMH/MDE will review and present results to the Lead Commission at our October meeting. The Commission meeting would include a public discussion of concerns by key stakeholders and full discussion of recommendations by the Commission.

John Krupinsky noted that regional lead meetings will be held in September, providing an opportunity for further discussion of this topic. Although there is concern for children who tested 5-9µg/dL years ago, our focus should be on follow through with children tested this year.

Agency Updates:

MDE – working on databases, the RRP (EPA) rule, the MIA study group, and helping DHMH. 2011 blood lead screening report should be available by early August and there may possibly be a media event. Ms. Karen Stakem Hornig is the new insurance commission member.
A presentation about lead was made recently to Health Officers. A current case involves the first abatement order in a post-1949 rental property.

DHMH – There has been a re-organization. Lead surveillance stats will be available for the August meeting. DHMH personnel may be attending future meetings on a rotating basis. (There is a goal to centralize.)

HCD – No report.

Baltimore City Health Department – Funding issues continue. BCHD staff have had internal discussions for handling/responding to children with levels between 5 and 9µg/dL.

Baltimore Housing – Not represented.

Child Care – The Office of Child Care is no longer funding inspectors for Baltimore City.

Maryland Insurance Administration – Not represented.

Barb Moore reported that there have been cases of dogs exposed to lead in dog toys, including rawhide toys and ropes from China. One company, Petsmart, has their own inspectors who test these items for lead prior to packaging.

The meeting adjourned at 11:17 a.m.

Take Home Points – for Task Force executive summary (July 13 2012 draft)

A. Blood Lead Screening

1. Screening has improved but is still insufficient.

   - In 2010, 32.7% of Maryland children aged 0-36 months was screened. At-risk jurisdiction Caroline County had the highest screening rate of 56.2%.
   - In 2010, the overall Medicaid screening rate was 66%, with variation by MCO, race, gender and age
   - In 2010, approximately 88% of Maryland children were tested before school entry.
   - Some efforts have been successful in increasing screening including:
     - County efforts to track and test more children at school entry
     - A WIC pilot program in Wicomico County
     - The annual match of Medicaid and CLR data, a valuable QC tool

2. CDC's establishment of a population-based reference value to target children with blood lead levels above the 97.5th percentile, currently a blood lead level of 5µg/dL, will require a new assessment of geographic risks and new targeting plan by DHMH.

3. CDC's new recommendations will require additional effort to ensure laboratory quality for blood lead testing of Maryland's children, including more attention to selection of testing supplies and laboratory methods.

B. Rental Property Registration

1. The US Census 2010 American Community Survey estimates that Maryland has 128,284 pre-1950 rental housing units. MDE reports 43,000 of these units are LBP- free. The remaining 85,284 are classified as Affected Properties.

2. The number of registered Affected Properties has dropped significantly from 90.5 thousand in 2007 to 70.9 thousand in 2011. This drop has occurred without a significant increase in the number of LBP-free units. MDE currently reports only 39.4 thousand registered Affected Properties for 2012. Using the 2007 registration numbers as the base, this has resulted in a potential reduction of revenue to MDE for registration fees of $1.16 million over a four year period through 2011.

3. Based on industry projections of an annual turnover rate of 40%, compliance rate for risk reduction for registered properties over the last several years appears to be around 73%. This means that one out of four registered rentals is not in compliance with on-going risk reduction requirements.

4. MDE's on-line registration system, effective November 2011, has the potential to improve record-keeping system for registration and communication with regulated property owners. However, it has been utilized by only 11.4% of owners who have registered properties for 2012. In addition, the system lacks the ability to interface with the Inspection Certificate (i.e. Risk Reduction) system. This disconnect prevents real time monitoring of the on-going Risk Reduction requirements.

5. Former House Bill 644 (2012 session), effective June 1, 2012, regulates residential rental dwelling units constructed between 1950 and 1978. This population of 313,000 units will increase demands on the existing system by over 365%. Expansion of the on-line data collection and management system is necessary to support effective management and enforcement efforts. Preliminary estimates suggest that 40,000 of these properties have been certified as Lead-based Paint free; however these inspection certificates may no longer be valid due to changes in Lead-based Paint inspection protocols in March 2000.

C. Case Management

1. The drop in BLL for targeting to 5ug/dL could increase the caseload 8-fold, based on the 2010 CLR Report. However, CDC has not yet established the extent of case management needed for BLLs of 5-9ug/dL.

2. Dedicated funding is needed for case management efforts by local health departments. In all jurisdictions except Baltimore City, case management has been done by community public health nurses.

3. Although reimbursement for environmental investigation, a part of case management, was approved by Maryland Medicaid in 2010, Baltimore City Health Department has been the **only** jurisdiction to seek reimbursement. As of July 2012, despite submitting claims for 223 inspections with a reimbursement value of $74,324, BCHD has only received payment of $75 from Maryland Medicaid.

4. The Section 8 Voucher program in Baltimore City has been successful in ensuring long term family stability in lead safe housing. With supportive services, 98 percent of families have remained in lead safe housing at least one year after placement.

5. Unlike the 1990s, when the majority of cases were living in rental property, in 2010 about 42% of Maryland's new lead cases (10ug/dL and higher) lived in owner-occupied housing. This shift has been occurring over the last decade. Although 2012 legislation has increased the capacity of Health Officers to respond to these cases, few requirements for primary prevention actions are in place.

6. The shift in demographics for lead poisoned children to immigrant populations, seen in Prince Georges and Montgomery Counties, has made outreach, follow-up testing, and public health follow-up more difficult due to trust and communication barriers.

7. The lack of safe, affordable housing and transportation are major barriers to relocation. Outside Baltimore, relocation appears to be easier.

D. Education and outreach

1. Physician understanding of lead poisoning appears to be inadequate. With the lowering of CDC's reference standard to 5µg/dL, a much larger emphasis on education and outreach of the health care provider community is needed.

2. With MDE taking on enforcement of the Renovation, Repair and Painting (RRP) program, education/outreach and enforcement targeting the contractor community should improve. QC checks on compliance at the worksite and enforcement will be needed.

3. MDE's successful 2006 campaign targeting pre-1950 rental property owners, local housing rental registries and enforcement offices, had a large impact on registration of rental properties state-wide.

4. Except for Baltimore City and Wicomico County, local jurisdictions in Maryland are not currently funded for primary prevention efforts.

5. Based on the projected expansion of Lead Risk Reduction in Housing law in 2014/2015, additional targeting of property owners, tenants and county enforcement offices (including local housing inspectors, rental registry personnel) will be needed to ensure compliance with registration.

E. **Resources**

1. Resources for Maryland's childhood lead poisoning prevention program increased from 2005 to 2009, but dropped sharply in 2010 and decreased again in 2011.

2. CDC-CLPPP resources, representing a significant portion of the funding for lead poisoning prevention programs in Maryland, are slated to end in August 2012. Although MDE has pledged to support BCHD, Wicomico and MDE's effort using Departmental funds, this loss of Federal dollars is of concern.

3. Based on additional registration of pre-1978 properties by 2015, MDE stands to collect more than $12 million per year in property registration fees. We recommend that one third of these resources be used to fund primary prevention programs in local health departments, with allocation based on the number of affected properties and local compliance with MDE registration.

AUGUST - 2010

NO MEETING SCHEDULED

SEPTEMBER 6, 2012

LEAD POISONING PREVENTION COMMISSION MEETING

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Thursday, September 6, 2012
9:30 AM - 11:30 AM

PATUXENT Conference Room
6th floor
AGENDA

I. Introductions

II. Approval of July 12, 2012 minutes

III. Future meeting dates:

The next Lead Commission meeting is scheduled for Thursday, October 4, 2012 at MDE in the AERIS Conference Room – Front Lobby, 9:30 am – 11:30 am.

IV. Update from 2010 Work Group Planning – Evaluation of 2010 State Plan to Eliminate Childhood Lead Poisoning – upcoming meetings to be determined

V. Old Business
   A. Follow-up laboratory issues discussion

   B. DHMH Plan for new CDC Recommendations

VI. Agency Updates
   A. Maryland Department of the Environment
   B. Department of Health and Mental Hygiene
   C. Department of Housing and Community Development
   D. Baltimore City Health Department
   E. Office of Childcare
   F. Maryland Insurance Administration
   G. Other Agencies

VII. Public Comment

GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Approved Minutes (10/6/12)
September 6, 2012

Members in Attendance

Dr. Maura Dwyer, Cheryl Hall, Karen Stakem Hornig, Ed Landon, Pat McLaine, Barbara Moore, and Delegate Nathaniel Oaks.

Members not in Attendance

Patrick Connor, Mel Jenkins, Linda Roberts, and Mary Snyder-Vogel.

Guests in Attendance

Shaketta Denson – CECLP, Hosanna Asfaw-Means, Arthur Gray – DHCD, Geraldine Woodson – BCHD, Rita AuYeung – UMB student, Horacio Tablada – MDE, Heather Barthel – MDE, John O'Brien – MDE staff, Paula Montgomery – MDE staff, John Krupinsky – MDE staff, and Tracy Smith – MDE staff.

Introductions

Pat McLaine started the meeting at 9:51 a.m. Everybody introduced themselves. Minutes from the previous meeting will be sent out after today's meeting and approved at the next meeting. The evaluation of the 2010 Plan to Eliminate Childhood Lead Poisoning may be ready for review by the next meeting.

Future Meeting Dates

The next Lead Commission meeting is scheduled for Thursday, October 4, 2012 at 9:30 am in the Aeris conference room.

Old Business

Laboratory quality issues that had been discussed during June's meeting (that included a presentation by Dr. Keyvan) were raised. Issues include tubes and supplies, oversight of lab quality, including DHMH standard protocols for evaluation of lab performance, and use of blind/spike samples. These issues are more important given our focus on blood lead levels between 5 – 9 µg/dl. Maura Dwyer will try to set up a meeting between Commissioners and the Office of Health Care Quality to follow-up these concerns. MDE will re-send the powerpoint from June's meeting to Commissioners.

DHMH's plan for new CDC recommendations will be discussed at a future meeting. The Commission will host a hearing on DHMH's proposed changes for follow-up. Commissioners requested that details of DHMH's plan and the hearing be sent out to Commissioners.

Baltimore City Health Department (BCHD) – Hosanna Asfaw-Means reported that BCHD is working collaboratively with both DHMH and MDE in a thoughtful, strategic way to adopt best practices to address blood levels between 5–9µg/dL. 2,130 children were identified as having first-time BLLs of 5-9µg/dL in 2011. Last year, BCHD targeted 5-9µ/dLs jointly with Baltimore City Housing. It was difficult getting into homes but the City has targeted specific groups and areas for marketing the program. The community has been interested in available services. Completing Notice of Defects has empowered citizens to take ownership of this problem. Shakeeta Denson noted that the Coalition also gets into homes, works on EA-6 compliance and prevention issues and helps identify cases for legal follow-up.

Baltimore City Housing – Arthur Gray reported that the program is making referrals on pre-1950 housing and that the Green and Healthy Homes Division is having a task force meeting on November 7th.

Office of Childcare – Cheryl Hall reported that asthma friendly child care initiative will be part of OCC's new quality rating system.

Maryland Insurance Administration (MIA) – Karen Stakem Hornig reported that MIA has been meeting since June with members of the workgroup established as a result of HB472. The workgroup will evaluate and make recommendations about lead liability protection for owners of rental properties. From a small landlord's perspective (owner of 1-4 units), pollution insurance is unaffordable. Assuming that owners would pass underwriter's criteria, the premium would exceed rent. Setting up a state fund would involve a large initial liability reserve, estimated to be $4.2 billion for BLLs of 10µg/dL only. The Committee has determined that to establish a fund, every pre-78 landlord would need to contribute $2500-500 per unit for start up costs. Other options would include risk retention groups. Public comment period is until the end of October 2012. A final report is due in December.

A comment was made that primary prevention is needed to (further) reduce the incidence of childhood lead poisoning. A comment was made that more targeted enforcement may be needed. Challenges include potential lead exposure for families fixing up owner occupied properties and for future enforcement of the Renovation, Repair, and Painting (RRP) Rule.

Comments were made about what to do in pre-1978 properties, waiting for CDC to provide recommendations for levels between 5-9, expenses for providing relocations in housing with lead-based paint, and concerns that not as much has been done with regards to reducing/eliminating (lead) hazards nationwide. Some properties have had multiple lead poisoned children. A comment was made with regards to innovative ideas/approaches to prevent blood lead levels from going to a 10µg/dL. A comment was made with regards to proper eating and cleaning habits.

BALTIMORE

PRESS RELEASE

STEPHANIE RAWLINGS-BLAKE, MAYOR

PAUL T. GRAZIANO, COMMISSIONER

Office of Communications • Cheron Porter • 417 East Fayette Street • Baltimore, MD 21202 • 410-396-4709

DATE: For Immediate Release

CONTACT: Cheron Porter
410-396-4709 (office)
410-428-7689 (cell)

HABC Makes Payment in Largest Lead Paint Claim

Successfully Pursues Bankrupt Insurance Company to Pay Lead Claim

(Baltimore, MD – August 6, 2012) The Housing Authority of Baltimore City (HABC) has made the largest payment to date toward a lead paint case in the amount of $3.675 million. The funding to pay for the judgment came after HABC successfully pursued an insurance claim for this case.

HABC had a general liability insurance policy with Integrity Insurance Company from 1981 through 1985, which covered lead paint claims for occurrences during those years. In 1987, a New Jersey court declared Integrity Insurance insolvent. For several years, HABC aggressively pursued a claim against Integrity Insurance to honor its policy coverage. This case represents the largest judgment facing the federally-funded agency; however, the payment did not require the Department of Housing and Urban Development (HUD) approval as it involved no federal funds.

"This has been a long hard road to say the least and we are glad to find some level of resolution for what this plaintiff has suffered," said Baltimore Housing Commissioner Paul T. Graziano. "HABC will continue to work hard to resolve lead paint judgments in a fair and responsible way while protecting public funds needed for the thousands of vulnerable low income housing families."

To date HABC has paid nearly $4.6 million associated with four judgments. The agency is currently faced with eight unresolved judgments with two of those on appeal. It should be noted that while these cases were filed in recent years, they involve incidents that occurred prior to the implementation of Maryland's lead law in 1996. HABC has been fully compliant with this law and is providing lead safe housing to all its families. In addition to trying to resolve these matters, HABC has the great responsibility of providing housing assistance for approximately 25,000 very low-income households throughout Baltimore City, while confronted with severe federal funding constraints and facing extensive unfunded requirements. HABC currently faces over $900 million in claims to date with an open-ended timeframe for additional claims to be filed.

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OCTOBER 4, 2012

LEAD POISONING PREVENTION COMMISSION MEETING

MEMBERS

Governor's Lead Commission Meeting Attendance Sheet

10/4/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

	Name/Signature	Representing	Telephone/Email
X	CONNOR, Patrick	Hazard ID Professional	
✓	DWYER, M.D.Maura	Department of Health and Mental Hygiene	
✓	HALL, Cheryl	Office of Child Care	
✓	HORNIG, Karen Stakem	Maryland Insurance Administration	
✓	JENKINS, Melbourne	Property Owner Pre 1950	
✓	LANDON, Edward	Dept. Housing and Community Dev.	
✓	McLAINE, Patricia	Child Health/Youth Advocate	
✓	MOORE, Barbara	Health Care Provider	
✓	OAKS, Nathaniel (Delegate)	Maryland House of Delegates	
X	ROBERTS, Linda Lee	Property Owner Post 1949	
✓	SNYDER-VOGEL, Mary	Child Advocate	
	VACANT	Secretary of the Environment or Designee	
	VACANT	Local Government	
	VACANT	Parent of a Lead Poisoned Child	
	VACANT	Financial Institution	
	VACANT	Child Care Providers	
	VACANT	Insurer	
	VACANT	Property Owner Pre 1950 Outside Baltimore City	
	VACANT	Maryland Senate	

GUESTS

Governor's Lead Commission Meeting Attendance Sheet
10/4/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

Commission Member	Name	Representing	Address/Telephone/Email
	KAREN STAKEM HORNIG	MIA	200 ST PAUL PLACE, STE 2700, 21202 khornig@mdinsurance.
✓	RON WINEHOLT	AOBA	86 STATE CIRCLE ANNAPOLIS, MD 21401 State.md.us
			rwineholt@aoba-metro.org
✓	Lesa Hoover	AOBA	lhoover@aoba-metro.org
✓	JOHN O'BRIEN	MDE	1800 WASH. BLVD, BALTO. (410)537-3825
✓	JOHN KRZOWSKY	MDE	" "
✓	Horacio Tablada	MDE	
✓	Hosanna Abu-Means	BCHD	1800 N. Charles, 5th floor hosanna.gsplaw@baltimorecity.gov
✓	Molly Call	CCLD	
✓	Shaketta Denson	CECLD	
✓	Kathy Howard	MMHA	11 E Fayette St Balt 21202 khoward@regionalmgmt.com
✓	Paula Montgomery		
✓	Donna Webster	– conf phone	
✓	Rita Awuku	UMB	
✓	Tracy Smith		

LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Thursday, October 4, 2012
9:30 AM - 11:30 AM

AERIS Conference Room
1st floor Main Lobby
AGENDA

I. Introductions

II. Approval of July 12 (9/6/12 minutes not available at this time)

III. Future meeting dates:

The next Lead Commission meeting is scheduled for Thursday, November 8, 2012 at MDE in the AQUA Conference Room – Front Lobby, 9:30 am – 11:30 am.

IV. Review of 2011 Annual Report - Horacio

V. Update from 2010 Work Group Planning – Evaluation of 2010 State Plan to Eliminate Childhood Lead Poisoning – draft of Work Group's Key Points
Upcoming meetings: to be determined

VI. DHMH Plan for new CDC Recommendations

VII. Agency Updates
- A. Maryland Department of the Environment
- B. Department of Health and Mental Hygiene
- C. Department of Housing and Community Development
- D. Baltimore City Health Department
- E. Office of Childcare
- F. Maryland Insurance Administration
- G. Other Agencies

VIII. Public Comment

GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Approved Minutes
October 4, 2012

Members in Attendance

Cheryl Hall, Karen Stakem Hornig, Mel Jenkins, Ed Landon, Pat McLaine, Barbara Moore, and Delegate Nathaniel Oaks.

Members not in Attendance

Patrick Connor, Dr. Maura Dwyer, Linda Roberts., and Mary Snyder-Vogel.

Guests in Attendance

Shaketta Denson – CECLP, Hosanna Asfaw-Means, Rita AuYeung – UMB student, Ron Wineholt – AOBA, Lesa Hoover – AOBA, Molly Call – CECLP, Kathy Howard, MMHA, Donna Webster – WCHD (via phone), Horacio Tablada – MDE, John O'Brien – MDE staff, Paula Montgomery – MDE staff, John Krupinsky – MDE staff, and Tracy Smith – MDE staff.

Introductions

Pat McLaine started the meeting at 9:39 a.m. Everyone introduced themselves. July minutes were approved.

Future Meeting Dates

Next month's meeting will be on November 8th at MDE. Commission meeting will be brief (9:30 a.m. – 10:00 a.m.). Hearings (Cliff Mitchell) will begin at 10 a.m. on new CDC recommendations. Participants in the hearing will have 5 minutes to talk and should bring 20 copies of testimony.

Discussion

2011 Childhood Lead Registry Report - Horacio Tablada reviewed the 2011 Childhood Blood Lead Surveillance in Maryland Annual Report. The report will be posted on MDE's web-site and released via social media and a press release. At request of commissioners, copies of this report were provided during the meeting and will be e-mailed to Commission Members. The numbers of Maryland children 0-72 months of age tested was 109,534, a decrease of 5,295 compared to 2010. In Baltimore, the number of children tested increased by 2,317. State-wide, the number of children with first time BLLs 10µg/dL and above continued to decrease, from 399 in 2010 to 342.

State-wide, 60% of new cases were in non-affected properties (rental properties built between 1950 and 1978 and owner-occupied). In Baltimore City, 37% of new cases were living in affected properties, with 5% in post-1950 rental and 32% in owner-occupied properties. In

Maryland Counties, 21% of new cases were living in affected properties, with 41% in post-1950 rental and 38% in owner-occupied properties.

The 2011 report identified 2,129 children with first time BLLs between 5 and 9µg/dL (newly identified in 5-9 µg/dL range). Previous reports had reported all children with BLLs in this range. Additional emphasis will be placed on blood lead tests @ lower levels the next Annual report.

With regards to the decrease in the number of children screened, MDE suggested that difficulty in matching Medicaid records, results reported as "zero" and data entry into the Stellar dB could account for some of the decrease in the number of children that were tested. Pat McLaine commented that blood lead levels of zeros need further investigation, since this may represent levels below a limit of detection of one and is a lab reporting issue. The failure to report all BLL testing to MDE is also a reporting issue.
Cliff Mitchell noted that DHMH has started a comprehensive Medicaid discussion to improve testing results, including revising targeting plan, linking reporting and better matching.

Ken Strong commented about the quality of data from providers. Issues in data quality for 2011 are also of concern: although 100% of reports had complete name and date of birth, race was missing in over 50%, guardian's name in 36%, type of sample in 13% and address in 10% of samples. These issues become more important with the decrease in BLL of concern to 5µg/dL. Pat McLaine commented that information on race was commonly missing in other states, although it is required by regulation. DHMH is responsible for enforcement and additional enforcement is needed to correct these problems. MDE staff indicated that children with levels of 10 µg/dL and above are being followed on a 1 on 1 basis with case management. Additional data completeness is needed to assure quality at lower BLLs. Commissioners were asked to review the report and send questions to Tracy Smith with cc to Pat McLaine; Dr. Keyvan can address these issues at a future meeting.

2010 Evaluation - The Work Group has met once or twice since the last Commission meeting and is currently fine tuning the 2010 Work Plan. Ed Landon requested information for incoming funds for a chart. Pat McLaine commented that the purpose is the big picture of resources since the Federal picture has changed dramatically.

DHMH Request for Comment on Management of Childhood Lead Exposure - Pat McLaine noted that the Commission will hold a hearing about follow-up of Maryland children based on the new CDC recommendations at our November meeting on November 8th. A copy of the request for comment was distributed. It includes a summary of changes by CDC and questions being considered by DHMH and was sent out to physicians.

Cliff Mitchell reported that seven or eight comments have been received thus far. Case management by Health Departments @ 5-9µg/dL and what to do about historic cases of children with BLLs in the 5-9 µg/dL range. Cliff Mitchell will summarize all comments and provide them the the Chair as background for the Commissioners. Commissioners were urged to send names of any individuals or groups (including providers, advocates, housing officials, local health departments) who should be invited to the hearing to Cliff Mitchell. DHMH hopes that the Commission will have comments to Secretary Sharfstein before the end of the year. Tracy Smith will request all Commissioners to provide names to Cliff Mitchell.

Cliff Mitchell reported that DHMH has been reorganized and that the Environmentl Health Bureau is now part of the Prevention and Health Promotion Divison. The Office of Healthy Homes and Communities includes lead, asthma, swimming pools, and other environmental concerns.

Cliff Mitchell reported on a quality improvement project with RWJ to improve the WIC referral process for children not tested for lead that would involve giving the mother a referral to return to the child's provider for testing; no communication would be needed between WIC and the provider. DHMH hopes that this project will have an impact on increasing screening among the most vulnerable and at- risk children and improving testing rates of children covered by Medicaid. Cliff Mitchell indicated that he was looking into improving the reimbursement process for the Baltimore City Health Department. DHMH is also working with MDE to improve lead testing and with migrating data from Stellar into the new HELPS system.

A comment was made about the lack of money that is available from CDC for case management. MDE has picked up previous loss of funding for this year. Going from 10 to 5 µg/dL will at least triple the number of affected children. A comment was made about what the appropriate clinical public health response should be due to limited resources.

A question was raised about whether sources are the same @ 5 -9 µg/dL; concerns were raised that there may be no obvious source (lead in water in schools, previous residence, etc.)

With regards to the November hearing, DHMH's Secretary has requested comments from the Commission by the end of 2012. Ideas/suggestions for procedures/process/format for the November hearing were discussed. The hearing will start after the minutes have been approved. Assuming a large number of individuals plan to testify, individuals will be given 3 minutes and asked to bring written copies of their comments. Most other States are waiting for further direction/guidance from CDC. Pat McLaine commented that CDC had recommended that programs focus on primary prevention activities and not take the same approach they had taken at levels of 10 µg/dL and above (case management, a secondary prevention approach).

Pat McLaine indicated that additional information was available from an August presentation on the new CDC guidelines at Johns Hopkins School of Public Health.

DHMH sent the notice about the hearing to Med Chi; it was not sent to nurse practitioners, PAs or to Mount Washington Pediatrics. Cliff Mitchell indicated that he would ensure that these groups were informed about the hearing and individual Commission members were encouraged to also invite interested groups and individuals. The November 8th hearing may assist in the 2013 target plan revision. Ultimate goal at DHMH is to have lead testing rates comparable to immunization rates.

Agency Updates

MDE – Paula Montgomery

MDE is working on implementation of HB 644 with current staff (which includes owner occupied properties, rentals built before 1978, and day care facilities). HB 644 also includes the Renovation, Repair, and Painting (RRP) Rule and is aimed at primary prevention. MDE may be responsible for the enforcement of any work that is performed.

MDE has performed outreach with current lead training providers and other government agencies and partners. MDE will seek self-authorization from EPA after writing regulations. HB 644 extends the universe of properties to pre-1978 rental, owner-occupied and child care facilities. There are currently 2,500 EPA certified RRP firms. MDE is seeking a January 1, 2014 implementation date, which is one (1) year before new law changes. MDE needs to decide between adopting the current Federal program as is or (modifying) the current accreditation program. MDE may have additional ideas/suggestions for the Commission next Spring. MDE's requirements minimally must be as stringent as EPA. Comments included looking @ permits issued and working with local code officials. A comment was made about requiring dust wipe clearance sampling for government supported programs.

MDE is improving the lead rental registry database. There is a current IT project linking inspection certifications with registrations. MDE is also looking at the issue of all units being uniquely registered. 15,000 letters were mailed out last week to property owners, indicating that they may be out of compliance and could owe MDE money. This is expected to further improve gaps in registration and help clean up the database before the next annual mail-out. 5,000 such letters were previously mailed. MDE's system continues to move toward more automation and on-line registrations.

DHCD - Ed Landon

There will be a Governor's Housing Conference on October 16th at the Baltimore Hilton. Emphasis will be on foreclosures, and other housing issues.

Baltimore City Health Department - Hosanna Asfaw-Means
The lead program is working with senior leadership for a thoughtful and collaborative approach/strategies to children with BLLs 5-9 µg/dL . BCHD had lots of success last year with gatherings and meetings about Healthy Homes. BCHD is looking at the possibility of doing filter paper testing because the lack of follow-up testing is a big issue for many Baltimore children. Lead screening was conducted previously on site and at Health Fairs.

Office of Child Care – Cheryl Hall
Nothing to report with regards to lead.

Maryland Insurance Administration - Karen Stakem Hornig
Work of the Lead Liability Protection Workgroup has been completed and the report is due December 1, 2012. This will be discussed at the December meeting.

Baltimore City Housing – Ken Strong
Work plan presented. Four (4) new people will be hired. The policy and procedural manual has been completed. Work will start on January 1, 2013 with 210 homes to be completed in 2.5 years. MOUs are needed with the Health Department and Coalition. A grant was received from Able Foundation to do eligibility screening in the home with laptop computers and to identify other services for which clients may be eligible. Ken noted a concern about the Special Loans Program requirements that treat everyone as a "borrower" with underwriting required even though a grant is provided. Ed Landon asked about using a consolidated consistent checklist to include all basic housing items and recommended using a good home inspection report for all properties. Ken Strong indicated that lead abatement and weatherization will be the common scope of work. Commissioners were requested to send any comments to Ken Strong.

Public Comment
Molly Call from The Coalition to End Childhood Lead Poisoning reported that Lead Poisoning Prevention Week is from October 21 - 27. Cliff Mitchell asked about providing publicity for the November 8th Hearing during these activities.

The meeting adjourned at 11:42 a.m. The next meeting is scheduled for November 8th, at 9:30 at MDE.

MARYLAND
Department of the Environment

Childhood Blood Lead Surveillance in Maryland

Annual Report 2011

Lead Poisoning Prevention Program

MARYLAND DEPARTMENT OF THE ENVIRONMENT
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Martin O'Malley, Governor | Anthony G. Brown, Lt. Governor | Robert Summers, Ph.D., Secretary

MDE

MARYLAND CHILDHOOD LEAD REGISTRY

ANNUAL SURVEILLANCE REPORT 2011

EXECUTIVE SUMMARY

The Maryland Department of the Environment's statewide Childhood Lead Registry (CLR) performs childhood blood lead surveillance for Maryland. The CLR receives the reports of all blood lead tests done on Maryland children 0-18 years of age, and the CLR provides blood lead test results to the Department of Health and Mental Hygiene including Medicaid and local health departments as needed for case management and planning.

Since 1995, the CLR has released a comprehensive annual report on statewide childhood blood lead testing. This current report presents the childhood blood lead test results for calendar year (CY) 2011. All numbers are based on blood lead testing (venous or capillary) on children. The CLR does not receive any reports on lead screening based on the lead risk assessment questionnaire. With few exceptions all numbers referred to children 0-72 months of age.

Maryland CY 2011 Surveillance Highlights:

- In 2011 a total of 126,554 blood lead tests from 121,524 children 0-18 years were received and processed by the CLR, of which 114,121 tests were from 109,534 children 0-72 months.

- Of those 109,534 children, 452 (0.4%) were identified with a blood lead level ≥10 µg/dL (prevalence). Of those 452 children 342 were indentified with their first venous or capillary blood lead level ≥ 10 µg/dL (incidence).

- Of the 342 incident cases statewide, a total of 292 met the criteria for medical and environmental case management. There were a total of 130 incident cases in Baltimore City and a total of 162 incident cases in the remaining Maryland Counties.

- The highest testing rates for children 0-72 months were found in jurisdictions that require testing of all children at age 1 and 2 years. These include: Baltimore City (34.2%) Somerset County (31.5%), Allegany County (28.5%), and Worcester County (26.6%).

- The testing rate statewide for children 0-72 months was 21.9%. Not all children in Maryland are required to be blood lead tested. Based on Maryland's "Targeting Plan for Areas at Risk for Childhood Lead Poisoning", children are required to have a blood lead test at ages 1 and 2 years if they meet any of the following criteria; (a) Live in an identified "at-risk" zip code, (b) Participate in Maryland's "Medicaid" EPSTD Program, (c) Positive response to "Risk Assessment Questionnaire" conducted on children up to age six years of age, as required.

- In Baltimore City, 130 children with the first venous blood lead level ≥ 10 µg/dL received medical and environmental case management. In approximately 82 (63%) of

these cases children were living in a pre-1950 residential rental dwelling "Affected Property". In the remaining 48 cases, 6 (5%) children were living in a post 1949 residential rental dwelling and 42 (32%) were living in owner occupied properties ("Non-Affected").

- In Maryland Counties, 162 children with the first venous blood lead level ≥ 10 µg/dL received medical and environmental case management. In approximately 34 (21%) of these cases children were living in a pre-1950 residential rental dwelling ("Affected Property"). In the remaining 128 cases, 66 (41%) children were living in a post 1949 residential rental dwelling and 62 (38%) were living in owner occupied properties ("Non-Affected").

- In 2011, CLR received blood lead reports from 36 laboratories nationwide. Number of reports for the whole year varied from as low as 2 from one laboratory to more than 68,000 from another laboratory. More than 85% of reports however are from three major laboratories. These and five other laboratories sent their reports electronically (91.3%). The average reporting time, from the time sample is drawn to the time the result enters the CLR database is about 6 days. The average time for elevated blood lead results (≥10 µg/dL) is approximately 30 hours.

News for 2011

Exposure to lead is still the most significant and widespread environmental hazards for children in Maryland. Children are at the greatest risk from birth to age six while their neurological systems are being developed. Exposure to lead can cause long-term neurological damage that may be associated with learning and behavioral problems and with decreased intelligence.

There is no evidence of a blood lead level below which there are no health effects. The Centers for Disease Control and Prevention (CDC) concurs that the evidence shows that there is no threshold level for blood lead that can be considered "safe". Since 1990 CDC maintained the blood lead level of 10µg/dL as level of concern.

In March 2012, based on recommendation of the CDC's Advisory Committee on Childhood Lead Poisoning Prevention, CDC dropped the concept of a blood lead level of 10µg/dL as the "Level of Concern" and adopts the blood lead level of 5µg/dL as the new "Reference Level". The new criteria is based on NHANES data which shows 97.5% of children aged 1-5 years have blood lead level at or below 5 µg/dL. CDC will update the "Reference Value" every four years based on the most recent population-based-blood-surveys conducted among children.

Sources of Childhood Lead Exposure

Lead paint dust from deteriorated lead paint or from renovation is the major source of exposure for children in Maryland. Out of estimated of 2,127,439 occupied residential houses in Maryland 358,068 (16.8%) were built before 1950 and 853,743 (40.1%) between 1950-1979. (Source: US Census Bureau, 2010 American Community Survey, 1-Year Estimates) A significant number of pre-1950 and 1950-1979 residential rental units have been made lead free. Untreated units in those groupings are highly likely and likely to have lead based paint respectively.

Water, air, and soil, may provide low-level, "background" exposure, but rarely may cause childhood lead poisoning.

Imported products, parental

- See Appendix C for a breakdown by jurisdiction on the number of children tested for the first time in 2011 with a blood lead level between 5-9 µg/dL.

Primary Prevention Efforts

House Bill 644: Reducing the Incidence of Lead Poisoning

In May of 2012, Governor Martin O'Malley singed House Bill 644 that was passed during the 2012 legislative session in Maryland. House Bill 644 was introduced in repose to a report of findings of a study group designed to evaluate processes to further reduce the incidence of lead poisoning in Maryland. House Bill 644 has various components that relate to lead poisoning. The bill amends provisions of the Environment Article, Title 6, Subtitle 8, Reduction of Lead Risk in Housing Act ("Act) as well as Title 6, Subtitle 10, Accreditation of Lead Paint Abatement Services. Below is an overview of the components of HB 644 targeted at primary prevention HB 644:

- Expanding the Definition of Affected Property
  The initial portion of HB 644 seeks to further reduce the incidence of childhood lead poisoning in Maryland by expanding the universe of Affected Properties under the Act to also include residential rental dwelling units built 1950-1978. Because the residential use of lead based paint was not banned until 1978, the bill seeks to expand the primary prevention aspects of the Act that previously only mandated compliance for rental dwelling units built prior to 1950. Phase in-compliance will go into affect January 1, 2015.

- Issuance of Abatement Orders
  This portion of HB 644 provides the Department, health departments or other local jurisdictions the authority to order abatements in response to an investigation report of a lead poisoned person at risk. Abatements may be ordered in any residential building, including owner-occupied, rentals, child care facilities or pre-school facilities. The Department may enforce the provisions of the order. This becomes effective on June 1, 2012.

- Federal Renovation Rule
  The remaining portion of HB 644 amends the Environment Article Title 6, Subtitle 10, Accreditation of Lead Paint Abatement Services, to expand the definition of Abatement to include renovation, repair and painting (RRP) of lead-containing substances in a residential, public or commercial building built before 1978. It also gives the Department the authority to adopt regulations to carry out the provisions, including the accreditation of lead paint contractors and inspectors. This becomes affective on June 1, 2012. The Department will have to seek authorization from the EPA in order to enforce the RRP.

Statistical Report

In calendar year 2011, a total of 114,121 children 0-72 months were tested for lead exposure statewide. Table One provides a summary of statewide statistics of blood lead testing in 2011.

Table One
Calendar Year (CY) 2011 Statistical Report[1]

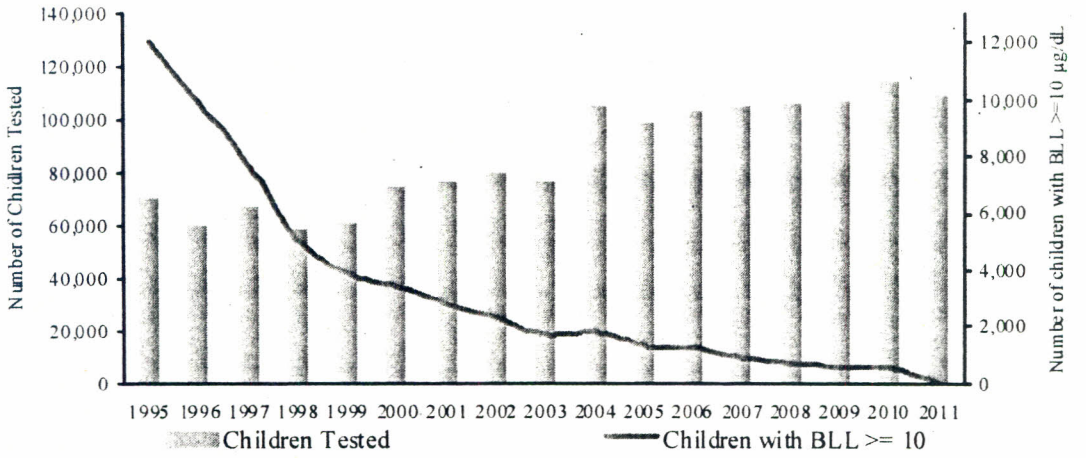
Item	Number	Percent (%)
All Children		
Number of tests	126,554	
Number of children	121,524	
Children 0-72 Months		
Number of tests	114,121	
Number of children	109,534	100.0
Age		
Under One	11,128	10.2
One Year	36,854	33.6
Two Years	29,774	27.2
Three Years	11,934	10.9
Four Years	11,822	10.8
Five Years	8,022	7.3
Sex		
Female	53,411	48.8
Male	55,601	50.8
Undetermined	522	0.4
Highest Blood Lead Level (µg/dL)		
≤4	106,342	97.1
5-9	2,740	2.5
10-14	267	0.2
15-19	95	0.1
≥20	90	0.1
Mean BLL (Geometric mean)	1.44	
Blood Specimen		
Capillary	16,842	15.4
Venous	79,205	72.3
Undetermined[2]	13,487	12.3

1. For detailed analysis and breakdown of numbers refer to Supplementary Data Tables 1-5.
2. In supplementary data tables blood tests with sample type unknown were counted as capillary.

Figure One
Number of Children 0-72 Months Tested for Lead and Number Reported to Have Blood Lead Level ≥10 µg/dL: 1995-2011

Findings

Childhood lead exposure further declined, both in the extent and the severity from 2010 to 2011 (Figures One & Two).



* See Appendix D for more detailed chart

Figure Two
Blood Lead Distribution of Children 0-72 Months Tested for Lead in 2010 and 2011

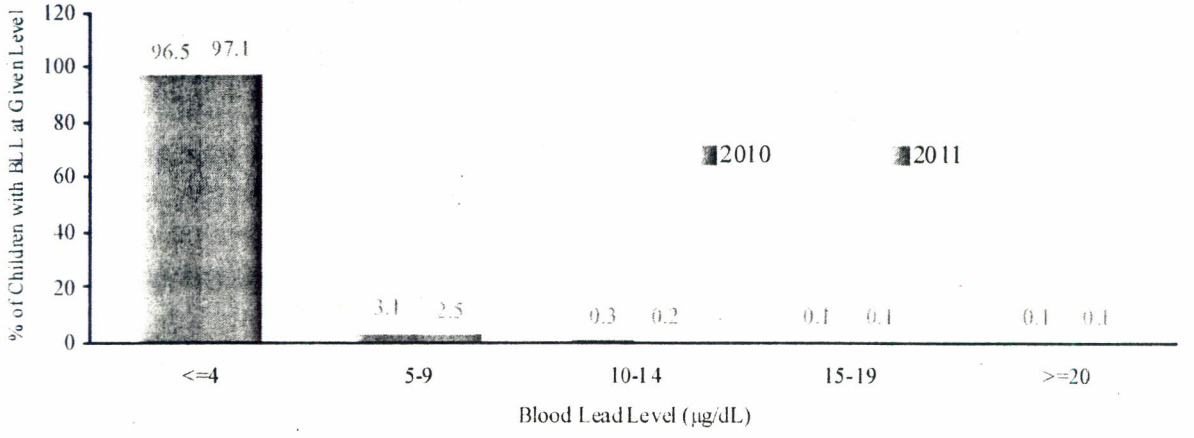


Table Two provides the breakdown of blood lead testing and the status of children with respect to lead exposure by jurisdiction in 2011.

Table Two
Blood Lead Testing of Children 0-72 Months by Jurisdiction in 2011

County	Population of Children[1]	Children Tested		Number of Children with Blood Lead Level ≥10 µg/dL					
				Old Cases[2]		New (Incident) Cases[3]		Total (Prevalent) Cases[4]	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Allegany	4,766	1,359	28.5	4	0.3	5	0.4	9	0.7
Anne Arundel	47,391	8,162	17.2	1	0.0	7	0.1	8	0.1
Baltimore	66,014	16,375	24.8	7	0.0	19	0.1	26	0.2
Baltimore City	55,681	19,049	34.2	76	0.4	182	1.0	258	1.4
Calvert	7,030	778	11.1	0	0.0	0	0.0	0	0.0
Caroline	3,176	751	23.6	1	0.1	3	0.4	4	0.5
Carroll	12,811	1,287	10.0	3	0.2	11	0.9	14	1.1
Cecil	8,884	1,132	12.7	0	0.0	1	0.1	1	0.1
Charles	13,015	1,904	14.6	0	0.0	1	0.1	1	0.1
Dorchester	2,747	681	24.8	1	0.1	0	0.0	1	0.1
Frederick	20,597	3,241	15.7	5	0.2	7	0.2	12	0.4
Garrett	2,185	438	20.0	0	0.0	3	0.7	3	0.7
Harford	20,720	2,970	14.3	0	0.0	5	0.2	5	0.2
Howard	24,261	2,558	10.5	1	0.0	6	0.2	7	0.3
Kent	1,380	266	19.3	0	0.0	1	0.4	1	0.4
Montgomery	87,595	19,843	22.7	4	0.0	32	0.2	36	0.2
Prince George's	79,810	19,672	24.6	2	0.0	37	0.2	39	0.2
Queen Anne's	3,798	475	12.5	0	0.0	2	0.4	2	0.4
Saint Mary's	10,427	1,602	15.4	0	0.0	0	0.0	0	0.0
Somerset	1,742	549	31.5	1	0.2	1	0.2	2	0.4
Talbot	2,600	655	25.2	1	0.2	3	0.5	4	0.6
Washington	12,462	2,691	21.6	2	0.1	10	0.4	12	0.4
Wicomico	8,427	2,215	26.3	1	0.0	4	0.2	5	0.2
Worcester	3,182	877	27.6	0	0.0	2	0.2	2	0.2
County Unknown		4		0		0		0	
Total	**500,702**	**109,534**	**21.9**	**110**	**0.1**	**342**	**0.3**	**452**	**0.4**

1. Adapted from Maryland census population 2010, provided by the Maryland Data Center, Maryland Department of Planning, www.planning.maryland.gov/msdc.
2. Children with a history of an EBL (blood lead level ≥10 µg/dL). These children may have carried over from 2010 or had an EBL test in previous years.
3. Children with the very first EBL in 2011. These children were either not tested in the past or their blood lead levels were below 10 µg/dL. This definition may not necessarily match the criteria for the initiation of case management.
4. All children with at least one blood lead test ≥10 µg/dL in 2011. The selection is based on the highest venous or the highest capillary in the absence of any venous test.
5. Of the 342 New Cases, 292 met the criteria for medical and environmental case management.

Appendix A provides breakdown of blood lead testing and the status of children by age groups of 0-35 and 36-72 months, and by jurisdiction. Appendix B provides summary results for the past eight (8) years at the State, Baltimore City and Counties levels. For detailed breakdown of blood lead data the reader is referred to supplementary data tables: Supplements 1-5.

Statewide activities to reduce (eliminate) childhood lead poisoning

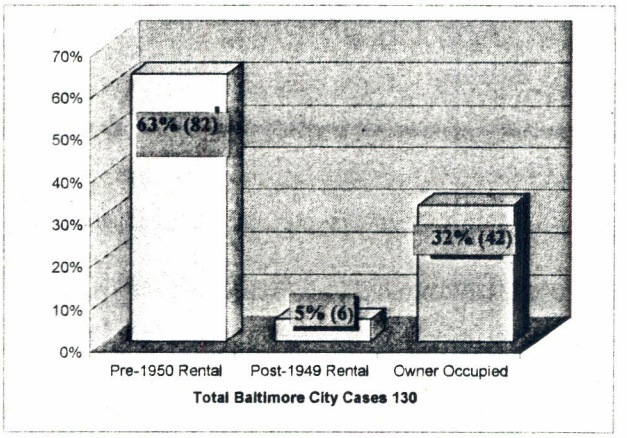
The State Elimination Plan calls for zero new cases of EBL. The plan focuses on primary prevention (removal and elimination of lead hazards prior to child access) while maintaining well-established secondary prevention (identifying children who may be at risk of lead exposure) and tertiary prevention (case management of children exposed to lead) efforts in the state.

Primary Prevention: Much of the decline in blood lead levels is the result of implementation and enforcement of Maryland's "Reduction of Lead Risk in Housing Act" (Act). The Act requires owners of pre-1950 rental dwelling units (Affected Properties) to reduce the potential for child exposure to lead paint hazards by performing specific lead risk reduction treatments prior to each change in tenancy. The State Elimination Plan 2010 called for zero new cases of EBL. Though the percentage of children with elevated blood lead levels is consistently lowering in Maryland, there still remains new case incidence. There also continues to be reduction in children indentified with blood lead levels in compliant Affected Properties that have meet the required risk reduction standard required at change in tenancy.

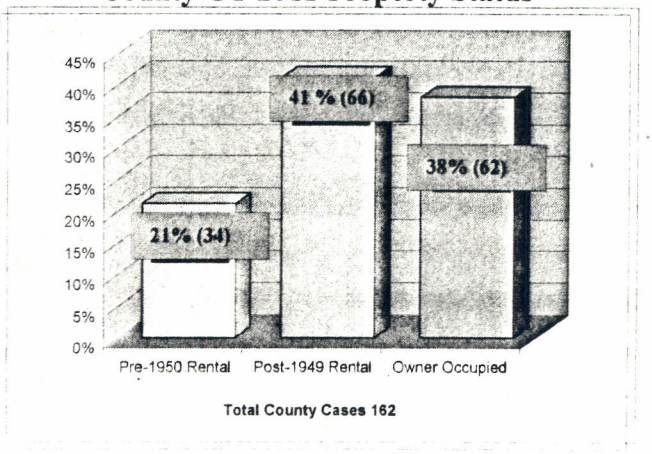
Figure Three

Percent of Children 0-72 Months with Blood Lead Level >10 ug/dL in 2011 and Age of the Housing

Baltimore City CY 2011 Property Status



County CY 2011 Property Status

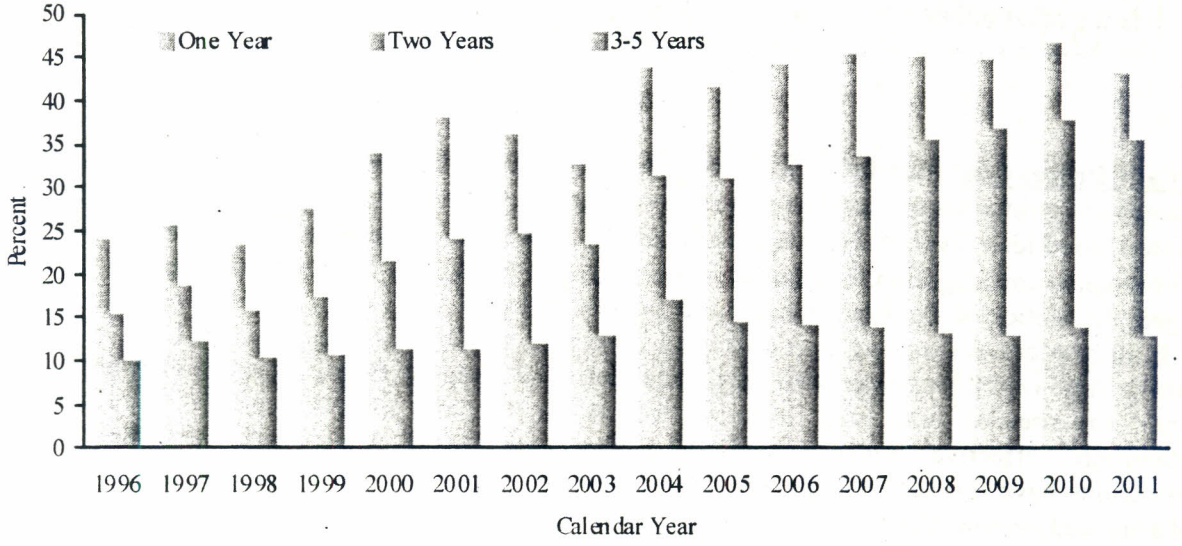


State laws and regulations with impact on childhood lead poisoning

- ✓ Requirements to perform lead hazard reduction at each turnover in rental housing built before 1950. [Environment Article (EA) §6-8]
- ✓ Outreach programs to parents, health care providers, and property owners, especially in at-risk areas. [EA§ 6-8, Health Article §18-106]
- ✓ The Department, health departments or other local jurisdictions effective June 1, 2012 have the authority to order abatements in response to an investigation report of a lead poisoned person at risk.

Secondary Prevention: The second element of the Elimination Plan is to identify children who may be at risk of lead exposure. In particular, children ages one and two years are more likely to be exposed to lead because of their hand to mouth behavior. Maryland requires that children at ages one and two years who are enrolled in the Medicaid, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program or who currently live or have ever lived in one of Maryland's "at-risk" zip codes identified by the "Targeting Plan" should be tested. The percentage of one and two year old children tested for lead has increased substantially since 2004 (Figure Four).

Figure Four
Percent of Children One and Two Years Old Tested for Lead vs. Children of Other Ages



units are more likely to be exposed to lead than children living in other areas. State has a targeted plan that identifies "At-Risk" areas. Universal blood lead testing applies to Baltimore City children (City Ordinance 20 effective July 2000). Table Three presents blood lead testing in the At-risk and Not At-risk areas of the state. At-risk area includes Baltimore City, Allegany, Caroline, Dorchester, Frederick, Garrett, Somerset, Washington, Wicomico, and Worcester counties.

Table Three
Blood Lead Testing in At-Risk and Not At-Risk areas in 2011

		Children Tested		Children with BLL ≥10 µg/dL		Status of Cases of EBL			
						Old Cases		New Cases	
Area	Population	Number	Percent	Number	Percent	Number	Percent	Number	Percent
At-Risk	114,966	31,855	27.7	308	1.0	91	0.3	217	0.7
Not At-Risk	385,736	77,679	20.1	144	0.2	19	0.0	125	0.2
Statewide	**500,702**	**109,534**	**21.9**	**452**	**0.4**	**110**	**0.1**	**342**	**0.3**

Another at risk population for lead poisoning is children enrolled in Maryland's Medical Assistance Program. MDE provides childhood blood lead data to the Maryland Department of Health and Mental Hygiene, Office of Medicaid Administration (DHMH), on a quarterly and annual basis to be matched with a list of children enlisted in the states Medical Assistance Program. Based on data provided, DHMH prepares and distributes an annual report of blood lead testing of children under Maryland's Medicaid Program.

Identifying Children with Lead Exposure

The main goal in preventing childhood lead poisoning is to limit exposure. However, early detection is crucial when a child is identified with an elevated blood lead level. Because there are no specific clinical symptoms, a blood lead test is the most reliable technique to identify children with elevated blood lead levels.

Tertiary Prevention: Maryland's Lead Poisoning Prevention Program has well-established case management guidelines and environmental investigation protocols for follow-up of children with elevated blood lead level. A venous blood lead test ≥10 µg/dL initiates case management and an environmental investigation. Currently, one venous or two capillary blood lead tests ≥10 µg/dL triggers the Notice of Elevated Blood Lead Level (Notice of EBL) to be sent to the owner of a Pre-1950 residential dwelling unit (Affected Property). Under the "Reduction of Lead Risk in Housing Act" (Act), an owner who receives a Notice of Elevated Blood Lead Level is required to perform specific lead risk reduction treatments to limit further exposure to a child. Furthermore, effective June 1, 2012 the Department, health departments or other local jurisdictions have the authority to order abatements in response to an investigation report of a lead poisoned person at risk. Tables Four and Five outline the State's protocol for diagnostic and follow up blood lead testing.

Table Four

Blood Lead Diagnostic and Follow-Up: Confirmation of a Capillary Blood Lead Test

BLL (µg/dL)	Confirm with venous blood lead test within
≤9	Routine blood lead test according to protocol
10 –19	3 months
20 – 44	1 week to 1 month*
45 – 59	48 hours
60-69	24 hours
≥70	Immediately as an emergency lab test

* The higher the BLL, the more urgent the need for confirmatory testing.

Table Five

Blood Lead Diagnostic and Follow-Up: Follow-Up for Venous Blood Lead Testing[1]

BLL (µg/dL)Venous	Early follow-up(First 2-4 tests after identification)	Late follow-up (After BLL begins to decline)
≤9	Routine blood lead test according to protocol	
10 - 14	3 months [2]	6 – 9 months
15 - 19	1 - 3 months [2]	3 – 6 months
20 - 24	1 - 3 months [2]	1 – 3 months
25 - 44	2 weeks – 1 month	1 month
≥45	As soon as possible	Chelation with subsequent follow-up

1. Seasonal variation of BLLs exists and may be more apparent in colder climate areas. Greater exposure in the summer months may necessitate more frequent follow-up.
2. Some case managers or health care providers may choose to repeat blood lead tests on all new patients within a month to ensure that their BLL level is not rising more quickly than anticipated.

Tables adapted from: *Centers for Disease Control and Prevention. Managing Elevated Blood Lead Levels Among Children: Recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention. Atlanta: CDC, 2002.*

Educational Burden of Childhood Lead Exposure

Childhood lead exposure at early ages (before 3 years of age) may adversely affect children's neurobehavioral development and as such their later educational achievements. The effect may not show up until the child enters school (kindergarten). Table Six presents the extent of history of EBL among children who were tested for lead and would be at kindergarten age on September 1, 2012.

Table Six
Blood Lead Testing, and Childhood Lead Exposure of Kindergarten Population

Children who would be 5 to 6 years old (kindergarten age) on September 1, 2012 and were tested for lead and had BLL >=10 µg/dL			
	Children	Children with EBL	
	Tested	Number	Percent
Allegany	741	7	0.9
Anne Arundel	4,989	6	0.1
Baltimore	12,608	33	0.3
Baltimore City	15,365	143	0.9
Calvert	585		0.0
Caroline	517	2	0.4
Carroll	986	8	0.8
Cecil	923	3	0.3
Charles	1,373		0.0
Dorchester	454	3	0.7
Frederick	2,488	12	0.5
Garrett	318	1	0.3
Harford	2,147	3	0.1
Howard	1,633	1	0.1
Kent	198	1	0.5
Montgomery	11,918	30	0.3
Prince George's	12,278	31	0.3
Queen Anne's	378	2	0.5
Saint Mary's	1,121	1	0.1
Somerset	297		0.0
Talbot	368	4	1.1
Washington	1,780	10	0.6
Wicomico	1,491	4	0.3
Worcester	530	3	0.6
County Unknown	65	1	1.5
Statewide	**75,551**	**309**	**0.4**

Data Quality

The CLR is maintained in the "Systematic Tracking of Elevated Lead Levels and Remediation" (STELLAR) surveillance system, obtained from CDC Lead Poisoning Prevention Program. CLR staff makes all efforts to further improve data quality with respect to completeness, timeliness, and accuracy. Staff keep daily track of laboratory reporting to make sure laboratories are reporting all blood lead tests no later than biweekly. The law requires blood lead results ≥20 µg/dL to be reported (fax) within 24 hours after result is known. However, upon CLR request, laboratories agreed to report (fax) the result of all blood lead test ≥10 µg/dL within 24 hours. For all blood lead tests ≥10 µg/dL, staff checks the completeness of data in particular with respect to child's and guardian's name, address, and telephone number.

In 2011, more than 90% of blood lead tests were reported to the registry electronically. The average reporting time, from the time sample is drawn to time the result enters the CLR database is approximately 6 days. The average time for elevated blood lead results (≥10 µg/dL) is approximately 30 hours.

Blood Lead Laboratory Reporting Requirement

The amended law and regulations* of 2001 and 2002 require that:

1-The following child's demographic data should be included in each blood lead test reported:

- Date of Birth
- Sex
- Race
- Address
- Test date
- Sample type
- Blood lead level

2-Blood lead results ≥20 µg/dL to be reported (fax) within 24 hours after result is known. All other results to be reported every two weeks.

3-Reporting format should comply with the format designed and provided by the Registry.

4-Data should be provided electronically.

* EA §6-303, Blood lead test reporting (COMAR 26.02.01, Blood lead test reporting)

Table Seven
Completeness of Data for 2010

ITEM	% Completed
Child's name[1]	100.0
Date of Birth[1]	100.0
Sex/Gender	99.5
Race	49.6
Guardian's name	54.0
Sample type	87.7
Blood lead level	100.0
Address (geocoded)	90.0
Telephone Number[2]	94.6

1. Reports with missing (wrong) name and/or date of birth are held by the program until they are corrected.
2. Quality control for telephone umber started in 2009.

Migration into New System

The Maryland Department of the Environment has partnered with the Maryland Department of Health and Mental Hygiene in the implementation of CDC's: "Healthy Homes and Lead Poisoning Surveillance System (HHLPSS)". Full implementation of the HHLPSS database is expected sometime in December, 2012.

Appendix A
Blood Lead Testing of Children 0-72 Months by Major Age Group and Jurisdiction in 2011

	Population of	Children Tested		Children with Blood Lead Level ≥10 µg/dL					
				Old Cases		New (Incident) Cases		Total (Prevalent) Cases	
	Children	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Allegany County									
0-35 Months	2,409	1,131	46.9	3	0.3	4	0.4	7	0.6
36-72 Months	2,356	228	9.7	1	0.4	1	0.4	2	0.9
Total	4,766	1,359	28.5	4	0.3	5	0.4	9	0.7
Anne Arundel County									
0-35 Months	24,295	5,879	24.2	1	0.0	6	0.1	7	0.1
36-72 Months	23,096	2,283	9.9	0	0.0	1	0.0	1	0.0
Total	47,391	8,162	17.2	1	0.0	7	0.1	8	0.1
Baltimore County									
0-35 Months	33,786	12,583	37.2	2	0.0	17	0.1	19	0.2
36-72 Months	32,228	3,792	11.8	5	0.1	2	0.1	7	0.2
Total	66,014	16,375	24.8	7	0.0	19	0.1	26	0.2
Baltimore City									
0-35 Months	29,933	13,586	45.4	41	0.3	150	1.1	191	1.4
36-72 Months	25,749	5,463	21.2	35	0.6	32	0.6	67	1.2
Total	55,681	19,049	34.2	76	0.4	182	1.0	258	1.4
Calvert County									
0-35 Months	3,362	613	18.2	0	0.0	0	0.0	0	0.0
36-72 Months	3,668	165	4.5	0	0.0	0	0.0	0	0.0
Total	7,030	778	11.1	0	0.0	0	0.0	0	0.0
Caroline County									
0-35 Months	1,571	626	39.8	1	0.2	2	0.3	3	0.5
36-72 Months	1,605	125	7.8	0	0.0	1	0.8	1	0.8
Total	3,176	751	23.6	1	0.1	3	0.4	4	0.5
Carroll County									
0-35 Months	5,993	979	16.3	2	0.2	8	0.8	10	1.0
36-72 Months	6,818	308	4.5	1	0.3	3	1.0	4	1.3
Total	12,811	1,287	10.0	3	0.2	11	0.9	14	1.1
Cecil County									
0-35 Months	4,497	792	17.6	0	0.0	1	0.1	1	0.1
36-72 Months	4,387	340	7.7	0	0.0	0	0.0	0	0.0
Total	8,884	1,132	12.7	0	0.0	1	0.1	1	0.1

Appendix A
Blood Lead Testing of Children 0-72 Months by Major Age Group and Jurisdiction in 2011

	Population of	Children Tested		Children with Blood Lead Level ≥10 µg/dL					
				Old Cases		New (Incident) Cases		Total (Prevalent) Cases	
	Children	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Charles County									
0-35 Months	6,565	1,343	20.5	0	0.0	0	0.0	0	0.0
36-72 Months	6,450	561	8.7	0	0.0	1	0.2	1	0.2
Total	13,015	1,904	14.6	0	0.0	1	0.1	1	0.1
Dorchester County									
0-35 Months	1,438	511	35.5	1	0.2	0	0.0	1	0.2
36-72 Months	1,309	170	13.0	0	0.0	0	0.0	0	0.0
Total	2,747	681	24.8	1	0.1	0	0.0	1	0.1
Frederick County									
0-35 Months	10,094	2,200	21.8	2	0.1	5	0.2	7	0.3
36-72 Months	10,503	1,041	9.9	3	0.3	2	0.2	5	0.5
Total	20,597	3,241	15.7	5	0.2	7	0.2	12	0.4
Garrett County									
0-35 Months	1,054	325	30.8	0	0.0	2	0.6	2	0.6
36-72 Months	1,131	113	10.0	0	0.0	1	0.9	1	0.9
Total	2,185	438	20.0	0	0.0	3	0.7	3	0.7
Harford County									
0-35 Months	10,229	2,096	20.5	0	0.0	3	0.1	3	0.1
36-72 Months	10,490	874	8.3	0	0.0	2	0.2	2	0.2
Total	20,720	2,970	14.3	0	0.0	5	0.2	5	0.2
Howard County									
0-35 Months	11,860	1,706	14.4	1	0.1	5	0.3	6	0.4
36-72 Months	12,401	852	6.9	0	0.0	1	0.1	1	0.1
Total	24,261	2,558	10.5	1	0.0	6	0.2	7	0.3
Kent County									
0-35 Months	694	204	29.4	0	0.0	1	0.5	1	0.5
36-72 Months	686	62	9.0	0	0.0	0	0.0	0	0.0
Total	1,380	266	19.3	0	0.0	1	0.4	1	0.4
Montgomery County									
0-35 Months	44,503	13,741	30.9	0	0.0	21	0.2	21	0.2
36-72 Months	43,091	6,102	14.2	4	0.1	11	0.2	15	0.2
Total	87,595	19,843	22.7	4	0.0	32	0.2	36	0.2

Appendix A
Blood Lead Testing of Children 0-72 Months by Major Age Group and Jurisdiction in 2011

	Population of	Children Tested		Children with Blood Lead Level ≥10 µg/dL					
				Old Cases		New (Incident) Cases		Total (Prevalent) Cases	
	Children	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Prince George's County									
0-35 Months	41,573	12,588	30.3	1	0.0	25	0.2	26	0.2
36-72 Months	38,238	7,084	18.5	1	0.0	12	0.2	13	0.2
Total	79,810	19,672	24.6	2	0.0	37	0.2	39	0.2
Queen Anne's County									
0-35 Months	1,851	366	19.8	0	0.0	2	0.5	2	0.5
36-72 Months	1,947	109	5.6	0	0.0	0	0.0	0	0.0
Total	3,798	475	12.5	0	0.0	2	0.4	2	0.4
Saint Mary's County									
0-35 Months	5,195	1,334	25.7	0	0.0	0	0.0	0	0.0
36-72 Months	5,232	268	5.1	0	0.0	0	0.0	0	0.0
Total	10,427	1,602	15.4	0	0.0	0	0.0	0	0.0
Somerset County									
0-35 Months	918	416	45.3	1	0.2	1	0.2	2	0.5
36-72 Months	824	133	16.1	0	0.0	0	0.0	0	0.0
Total	1,742	549	31.5	1	0.2	1	0.2	2	0.4
Talbot County									
0-35 Months	1,320	555	42.1	1	0.2	3	0.5	4	0.7
36-72 Months	1,281	100	7.8	0	0.0	0	0.0	0	0.0
Total	2,600	655	25.2	1	0.2	3	0.5	4	0.6
Washington County									
0-35 Months	6,226	1,798	28.9	2	0.1	8	0.4	10	0.6
36-72 Months	6,236	893	14.3	0	0.0	2	0.2	2	0.2
Total	12,462	2691	21.6	2	0.1	10	0.4	12	0.4
Wicomico County									
0-35 Months	4,347	1,705	39.2	0	0.0	3	0.2	3	0.2
36-72 Months	4,081	510	12.5	1	0.2	1	0.2	2	0.4
Total	8,427	2,215	26.3	1	0.0	4	0.2	5	0.2
Worcester County									
0-35 Months	1,620	677	41.8	0	0.0	1	0.1	1	0.1
36-72 Months	1,562	200	12.8	0	0.0	1	0.5	1	0.5
Total	3,182	877	27.6	0	0.0	2	0.2	2	0.2

Appendix A
Blood Lead Testing of Children 0-72 Months by Major Age Group and Jurisdiction in 2011

	Population of	Children Tested		Children with Blood Lead Level ≥10 µg/dL					
				Old Cases		New (Incident) Cases		Total (Prevalent) Cases	
	Children	Number	Percent	Number	Percent	Number	Percent	Number	Percent
County Unknown									
0-35 Months		2		0		0		0	
36-72 Months		2		0		0		0	
Total		4		0		0		0	
Statewide									
0-35 Months	255,333	77,756	30.5	59	0.1	268	0.3	327	0.4
36-72 Months	245,369	31,778	13.0	51	0.2	74	0.2	125	0.4
Total	500,702	109,534	21.9	110	0.1	342	0.3	452	0.4

Appendix B
Blood Lead Testing of Children 0-72 Months: 2004-2011

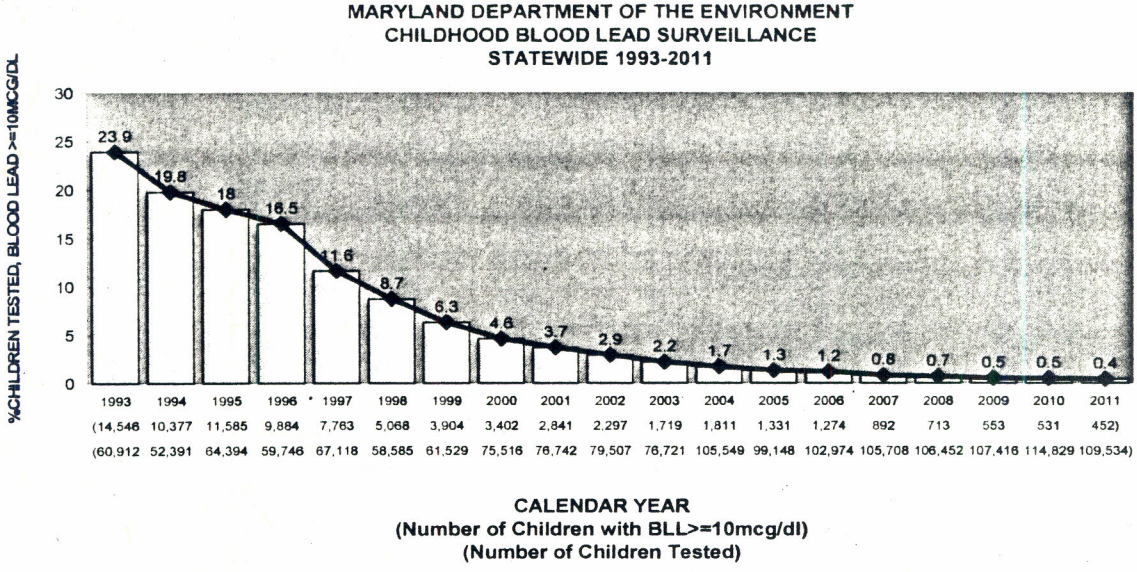
Calendar			Blood Lead Tests		BLL ≥10 µg/dL		Lead Poisoning	
Year		Population	Number	Percent	Number	Percent	Number	Percent
2004								
	Baltimore City	52,796	18,970	35.9	1183	6.2	147	0.8
	Counties	395,310	83,002	21.0	573	0.7	83	0.1
	County Unknown		3,577		55			
	Statewide	**448,106**	**105,549**	**23.6**	**1,811**	**1.7**	**230**	**0.2**
2005					Prevalent cases		Incident cases	
	Baltimore City	53,626	17,943	33.5	854	4.8	534	3.0
	Counties	401,888	80,848	20.1	463	0.6	382	0.5
	County Unknown		357		14		0	
	Statewide	**455,514**	**99,148**	**21.8**	**1,331**	**1.3**	**916**	**0.9**
2006								
	Baltimore City	54,547	18,363	33.7	843	4.6	573	3.1
	Counties	408,784	84,611	20.7	431	0.5	363	0.4
	County Unknown		199		21		20	
	Statewide	**463,331**	**102,974**	**22.2**	**1,274**	**1.2**	**936**	**0.9**
2007								
	Baltimore City	55,142	17,670	32.0	624	3.5	435	2.5
	Counties	413,248	87,760	21.2	267	0.3	218	0.2
	County Unknown		278		1		1	
	Statewide	**468,390**	**105,708**	**22.6**	**892**	**0.8**	**654**	**0.6**
2008								
	Baltimore City	55,959	18,622	33.3	468	2.5	302	1.6
	Counties	418,941	87,830	21.0	245	0.3	187	0.2
	County Unknown		69		0		0	
	Statewide	**474,900**	**106,452**	**22.4**	**713**	**0.7**	**489**	**0.5**
2009								
	Baltimore City	56,431	19,043	33.7	347	1.8	214	1.1
	Counties	422,488	88,368	20.9	206	0.2	165	0.1
	County Unknown		5					
	Statewide	**468,390**	**107,416**	**22.4**	**553**	**0.5**	**379**	**0.4**
2010								
	Baltimore City	57,937	19,702	34.0	314	1.6	229	1.2
	Counties	433,661	94,650	21.8	217	0.2	170	0.2
	County Unknown		477		0		0	0.0
	Statewide	**491,598**	**114,829**	**23.4**	**531**	**0.5**	**399**	**0.3**
2011								
	Baltimore City	55,681	19,049	34.2	258	1.4	182	1.0
	Counties	445,021	90,481	20.3	194	0.2	160	0.2
	County Unknown		4		0		0	
	Statewide	**500,702**	**109,534**	**21.9**	**452**	**0.4**	**342**	**0.4**

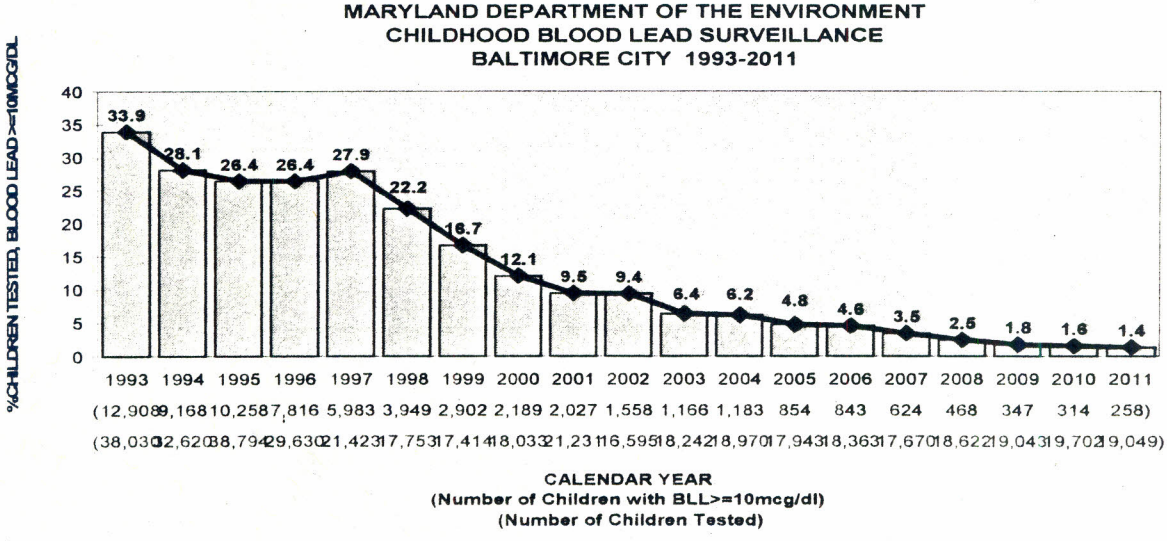
Appendix C

Children with the First Blood Lead Level of 5-9 µg/dL in 2011

Children 0-72 Months Tested for Lead and Had the First Blood Lead Level 5-9 µg/dL in 2011			
	Sample Type		
County	Capillary*	Venous	Total
Allegany	47	14	61
Anne Arundel	30	37	67
Baltimore	129	120	249
Baltimore City	309	641	950
Calvert	6	7	13
Caroline	5	8	13
Carroll	5	20	25
Cecil	12	4	16
Charles	4	10	14
Dorchester	3	6	9
Frederick	8	30	38
Garrett	3	6	9
Harford	13	11	24
Howard	10	7	17
Kent	3	4	7
Montgomery	73	85	158
Prince George's	74	147	221
Queen Anne's	4	1	5
Saint Mary's	17	2	19
Somerset	0	10	10
Talbot	6	6	12
Washington	21	120	141
Wicomico	11	31	42
Worcester	1	7	8
County Unknown	0	1	1
Statewide	**794**	**1,335**	**2,129**
* Sample types unknown were counted as capillary			
Note: If a child ever tested for lead and had a blood lead level ≥5 µg/dL before 2011 or a blood lead level ≥10 µg/dL in 2011 is not included in this table.			

Appendix D


MARYLAND DEPARTMENT OF THE ENVIRONMENT
CHILDHOOD BLOOD LEAD SURVEILLANCE
STATEWIDE 1993-2011
%CHILDREN TESTED, BLOOD LEAD >=10MCG/DL
30
25
20
15
10
5
0
23.9
19.8
18
16.5
11.6
8.7
6.3
4.6
3.7
2.9
2.2
1.7
1.3
1.2
0.8
0.7
0.5
0.5
0.4
1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011
(14,546 10,377 11,585 9,884 7,763 5,068 3,904 3,402 2,841 2,297 1,719 1,811 1,331 1,274 892 713 553 531 452)
(60,912 52,391 64,394 59,746 67,118 58,585 61,529 75,516 76,742 79,507 76,721 105,549 99,148 102,974 105,708 106,452 107,416 114,829 109,534)
CALENDAR YEAR
(Number of Children with BLL>=10mcg/dl)
(Number of Children Tested)


MARYLAND DEPARTMENT OF THE ENVIRONMENT
CHILDHOOD BLOOD LEAD SURVEILLANCE
BALTIMORE CITY 1993-2011
%CHILDREN TESTED, BLOOD LEAD >=10MCG/DL
40
35
30
25
20
15
10
5
0
33.9
28.1
26.4
26.4
27.9
22.2
16.7
12.1
9.5
9.4
6.4
6.2
4.8
4.6
3.5
2.5
1.8
1.6
1.4
1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011
(12,908 9,168 10,258 7,816 5,983 3,949 2,902 2,189 2,027 1,558 1,166 1,183 854 843 624 468 347 314 258)
(38,030 32,620 38,794 29,630 21,423 17,753 17,414 18,033 21,231 16,595 18,242 18,970 17,943 18,363 17,670 18,622 19,043 19,702 19,049)
CALENDAR YEAR
(Number of Children with BLL>=10mcg/dl)
(Number of Children Tested)

Grant Program: Lead Hazard Reduction Demonstration Grant
Grants Agreement number: MDLHD0248-12
Grant Organization: Department of Housing and Community Development
Green, Healthy, and Sustainable Homes Division
Project Title: Lead Hazard Reduction Program
Grant Period: 7/1/2012-06/30/2015
Project Manager: Sheneka Frasier-Kyer

Work Plan

A. State the problem

In 2010, 19,702 children were screened for lead. Of that total 314 had elevated blood lead levels. This is the result of the city's old housing stock, with 87 percent of the units built before 1978, and 43 percent built before 1940. The presence of lead hazards in and surrounding older structures has been found to be closely correlated with deterioration of lead based-paint.

Blood Lead Testing of Children 0-72 Months in 2010

County	Population of Children [1]	Children Tested		Number of Old Cases [2]		Children with New (Incident) Cases[3]		BLL≥ µg/dL Total (Prevalent) Cases[4]	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
Baltimore City	57,937	19,702	34.0	85	0.4	229	1.2	314	1.6

1. Adapted from the Census Bureau: "State Interim Population Projections by Age and Sex: 2000-2030" http://www.census.gov/population/www/projections/projectionsagesex.html.
2. Children with a history of an EBL (blood lead level ≥10 µg/dl). These children may have carried over from 2009 or had an EBL test in previous years.
3. Children with the very first EBL in 2010. These children were either not tested in the past or their blood lead levels were below 10 µg/dL. This definition may not necessarily match the criteria for the initiation of case management.
4. All children with at least one blood lead test ≥10 µg/dL in 2010. The selection is based on the highest venous or the highest capillary in the absence of any venous test.
(Source: Maryland Department of the Environment 2011 Lead Summer Study Report)

Persistent population losses add to the extensive housing deterioration and abandonment in many parts of the city. Most of the existing homes in Baltimore are in poor condition. The failure of roofs further

damages substrates and create lead hazards. Based on estimates from the Office of Rehabilitation – A citywide program providing repairs to homes of low-income homeowners – about one-third of older structures have leaking roofs. Leaking roofs lead to paint deterioration and for structures that contain lead-based paint this could bring about unwanted lead exposure.

The number of Baltimore housing units with deteriorated lead-based paint, and lead contaminated dust is high. Declining incomes do not help the problem. According to the 2010 Census, State of Maryland Health Department, and Baltimore City Health and Housing Departments there were 131, 368 housing units with lead that were occupied by households with incomes equal to or less than 80 percent of the regional Household Area Median Income (HAMI). Of these units, some 91,876 were occupied by households with incomes equal to or less than 50 percent of HAMI.

Safe lead paint removal is very expensive and even limited hazard reduction can be very costly if done properly. It is estimated that hazard reduction control work currently costs between $5,000 and $25,000 depending on the size of the property and degree of the problem. Poverty prevents owner-occupants from maintaining major systems and removing lead hazards, and low property values makes owners of rental properties unwilling to invest in such maintenance and removal.

B. Purpose of the Program

The purpose of the Department of Housing and Community Development's Lead Hazard Reduction Program (DHCD-LHRP) is to: 1) reduce lead-based paint hazards in Baltimore's occupied housing stock by targeting high risk areas that are least likely to receive services available through other channels; 2) coordinate and mobilize private and public resources to develop the most cost effective methods for reducing lead-based paint hazards; 4) educate across a range of geographic, racial, and ethnic communities on lead hazards, sources of lead-based paint poisoning, and ways to reduce and eliminate such hazards; 5) promote integration of lead hazard reduction activities with housing rehabilitation, weatherization, code enforcement, and healthy home initiatives; and 6) promote collaboration, data sharing, and targeting between health and the LHRP.

Goal	Objective	Output
Goal1: Increase the number of children protected from lead poisoning	Objective: Reduce lead in owner occupied and rental occupied units	210 units completed and cleared
Goal 2: Increase the number of children protected from lead hazards	Objective: identify lead in owners occupied and rental occupied units	280 units inspected
Goal 3: Increase Public Awareness of Lead Hazards and Available Services	Objective: Educate clients about Lead Hazards and Lead Poisoning Prevention	360 clients educated
Goal 4: Increase Public Awareness of Lead Hazards and Available Services	Objective: Reach 2000 clients and educate them about Lead Hazard Reduction Services	80 outreach events conducted

C. **Program Management**

1. *Staffing*

   a. *Roles and responsibilities of key staff*

The Day-to Day Program Manager Sheneka Frasier-Kyer, will dedicate 100% of her time to this program, and be responsible for the following:

- Ensure completion of the grant application process including final approval of all applications prior to the scheduling of risk assessments
- Coordinate risk assessments, remediation, clearance inspections, relocation, program reporting and analysis, lead worker training, and outreach and education
- Assist the Program Director in ensuring program compliance with all HUD OHHLHC requirements, Lead Hazard Reduction Demonstration Program protocols, DHCD departmental policies, the Lead Safe Housing Rule, and Title X.
- Write quarterly and final reports to HUD
- Evaluate program outcomes based upon data collected and experiences in the field
- Coordinate activities of program partners to achieve specific program goals and benchmark deliverables and broader program objectives in targeted communities
- Oversee program staff and sub grantee agencies
- Attend meetings of the program staff and of all collaborative meetings

The Deputy Commissioner Ken Strong will serve as Program Director. Mr. Strong will dedicate 20% of his time this program and be responsible for the following:

- Assist in the initial planning phases and overall coordination of program
- Ensure implementation of project plan; meeting contract deliverables, unit production benchmarks, and effective management of the program.
- Ensure program compliance with all HUD OHHLHC requirements, Lead Hazard Reduction Demonstration Program protocols, DHCD departmental policies, the Lead Safe Housing Rule, and Title X.
- Attend regular meetings of all collaborative members
- Supervise and oversee the Program Manager
- Ensure timely and complete fulfillment of all reports associated with the grant. Review quarterly and final reports and evaluations prepared by Program Manager

The Health Program Administrator Timothy Crusse will serve as Director of Field Operations. Mr. Crusse will dedicate 100% of his time to this program and be responsible for the following:

- Conduct initial assessments of residential homes and properties that have been identified with lead contamination
- Assess overall cost of lead hazard reduction, structural soundness, and basic system repairs
- Prepare written scopes of work and cost estimates that incorporate finding of the risk assessment

- Assign contractors to lead hazard risk reduction projects
- Ensure adherence to project schedules
- Consult with property owners and lead hazard control contractors to negotiate contracts
- Perform both announced and unannounced site visits of the residential home and or property to ensure conformance with contract documents, historic preservation , and applicable lead safe work practices
- Conduct clearance visual inspections of residential home and property once lead hazards have been stabilized or removed
- Conduct final assessments of residential homes and properties that have been identified with lead
- Assess the condition of completed lead hazard risk reduction
- Report on unit status and overall case load to Program Manager
- Maintain project records and databases
- Supervise Risk Assessors and Intake Coordinator
- Attend regular meetings

The Construction Builder Inspector Derrick Milligan will serve as a Risk Assessor. Mr. Milligan will dedicate 100% of his time to this program and be responsible for the following:

- Conduct initial assessments of residential homes and properties that has been identified with lead contamination
- Assess overall cost of lead hazard reduction, structural soundness, and basic system repairs
- Prepare written scopes of work and cost estimates that incorporate finding of the risk assessment
- Consult with property owners and lead hazard control contractors to negotiate contracts
- Perform both announced and unannounced site visits of the residential home and or property to ensure conformance with contract documents, historic preservation , and applicable lead safe work practices
- Conduct clearance visual inspections of residential home and property once lead hazards have been stabilized or removed
- Conduct final assessments of residential homes and properties that have been identified with lead
- Assess the condition of completed lead hazard risk reduction
- Report on unit status and overall case load to supervisors
- Maintain project records
- Attend regular meetings

The Social Services Coordinator Supervisor Romeo Joyner-El will serve as Enrollment/ Outreach Supervisor. Mr. Joyner – El will dedicate 100% of his time to this program and be responsible for the following:

- Assist clients with completing applications

- Collect and record documentation for program eligibility
- Disseminate handouts, brochures , and related documentation for information and use
- Provide education on topics concerning lead hazards, sources of lead-based paint poisoning, and ways to reduce and eliminate such hazards
- Review, monitor, process client cases involving the provision of lead hazard risk reduction to City residents
- Recommend work plans to clients to response to various housing, health , social, and financial problems and needs,
- Consult with Program Manager and other professionals on cases in order to gather counsel, observations, evaluations and recommendations on case dispositions
- Report on unit status and overall caseload to Program Manager
- Maintain accurate up-to-date and detailed client case records and files
- Ensure confidentiality of client case records and files
- Enter client data into a database record system
- Develop outreach materials
- Supervise Outreach Workers and Underwriters
- Ensure underwriters meet project submission and settlement goals, collect all eligibility documents, and resolve conditions
- Facilitate all temporary relocations and ensure adherence with Uniform Relocation Act
- Attend regular meetings

The Real Estate Agent Brenda Winston will serve as the Underwriter. Ms. Winston will dedicate 100% of her time to this program and be responsible for the following:

- Participate in negotiations with property owners , property management companies, lawyers and others for the purpose of determining the benefit of lead hazard risk reduction grant
- Compile financial data for use in the evaluation of property owner's financial situation
- Search land records, credit reports , and property and judgment reports for titles, liens, debt, and ownership information
- Consult with risk assessors regarding cost estimates for lead hazard risk reduction work
- Prepare documents for settlements and related documents for City , state, and federal government agencies
- Prepare leases, subordinations, and pay-offs for property owners and title companies
- Interface with City, state, and federal agencies, property owners, and applicant families to ensure compliance with all relevant regulations
- Maintain project records, databases and files
- Report on unit status and overall case load to Program Manager and Enrollment/ Outreach Supervisor

The Office Assistant III will serve as the Intake Coordinator. (Currently, this position is vacant.) This person will dedicate 100% of his/her time to this program and be responsible for the following:

- Developing and maintaining files, databases, and record systems requiring knowledge of complicated, innovative indexing methods for lead hazard risk reduction programs
- Enter client information into databases
- Interface with City agencies d to make, track, and follow-up on referrals and applications
- Monitor the collection of program documentation and applications
- Provide direction , guidance and training to employees involved in the activities of the programs
- Compile reports, forms, and summaries for the program management reviewing and investing a variety of sources to secure complete and accurate information about the program
- Recommend and implement work procedures to improve effectiveness or efficiency to accommodate changes in program operations or new functions
- Answering unusual or complicated questions or complaints regarding work procedures or program operations
- Provide information and assistance to the public including community groups, representatives of private organizations and lead hazard reduction program client in executing forms or obtaining services in situations requiring unusual tact or approaches which differ from normal work procedures
- Consult with Real Estate Agent/ Underwriter and Social Service Coordinators/ Outreach Workers
- Report on overall case status to Program Manager and Director of Field Operations
- Attend regular meetings

b. Timeline to hire staff

At this present time most of the key staff has been hired. However, DHCD plans to hire 4 new staff members to fill the positions of Construction Builder Inspector I/ Risk Assessor, Real Estate Agent I/ Underwriter, Social Services Coordinator/ Outreach Worker, and Office Assistant III/ Intake Coordinator within two months. As a result of that the DHCD Lead Hazard Reduction Program will have two Construction Builder Inspectors /Risk Assessors, two Real Estate Agents/ Underwriters, an additional Social Service Coordinator/Outreach Worker, and an Office Assistant/ Intake Coordinator. Job responsibilities will be the same as described above.

Employees	**Target Completion Date**
Sheneka Frasier- Kyer (Program Manager)	Hired (2/6/2012)
Ken Strong (Program Director)	Existing Position
Tim Crusse (Director of Field Operations)	Existing Position
Derrick Milligan (Risk Assessor)	Existing Position
Brenda Winston (Underwriter)	Existing Position
Romeo Joyner-El (Enrollment/Outreach Supervisor)	Existing Position
Construction Building Inspector I (Risk Assessor)	To be hired (12/1/2012)
Real Estate Agent I (Underwriter)	To be hired (12/1/2012)
Office Assistant III (Intake Coordinator)	To be hired (12/1/2012)

Social Services Coordinator (Outreach Worker)	To be hired (12/1/2012)

2. *Partners*
   a. *Roles and Responsibilities of key partners*

There are two primary partners to the LHRP in the areas of community awareness education, outreach, and recruitment- the Coalition to End Childhood Lead Poisoning and the Health Department. Each partner has provided a letter of commitment and will enter a formal contractual agreement after the LHRP receives approval for the Release of Funds.

The Health Department is the local government responsible for acting on reports of elevated blood lead levels and reports received from the Maryland Department of the Environment. Sanitarians and Public Health Inspectors respond to verify lead hazards, issue violation notices, and provide the family health coordinating services. The Health Department also responds legally to require property owners to remove lead hazards from properties that had a poisoned child. As sub grantee in this grant the Health Department will do the following: 1) provide case management, and education service for 180 LHRP clients referred to the Health department by LHRP; 2)explain the significance of the elevated blood lead levels to the parent or guardian of the child with a blood led level of 5-9 µg/dL, review lead poisoning prevention educational materials, encourage the parent or guardian to complete follow-up blood lead testing as appropriate, and provide other lead poisoning prevention information; 3)refer the client to other lead poisoning prevention resources where appropriate ; 4) report progress of mutually agreed upon benchmarks on a quarterly basis and include work status , work progress and any impediments encountered; 5) provide invoices and staff timesheets quarterly ; and 6) participate in meetings and conference calls as requested.

The Coalition to End Childhood Lead Poisoning is a 501(c) nonprofit organization that works to create, implement, and promote programs and policies to eradicate childhood lead poisoning and further healthy homes. As partner in this sub grantee the Coalition to End Childhood Lead Poisoning will do the following: 1)provide case management, education, and family advocacy service for 180 LHRP clients referred to the Coalition by LHRP; 2)explain the significance of the elevated blood lead levels to the parent or guardian of the child with a blood led level of 5-9 µg/dL, review lead poisoning prevention educational materials, encourage the parent or guardian to complete follow-up blood lead testing as appropriate, and provide other lead poisoning prevention information;3) assist the client in sending a Notice of Defect to their rental property owner for the repair of chipping, peeling paint and other defects where applicable; 4) refer the client to other lead poisoning prevention resources where appropriate; 5) provide a lead poisoning prevention kit to 180 client which will include: two buckets, mop replacement mop head, two sponges, rubber gloves , and a cleaning solution ; 6)conduct 80 outreach and education trainings, presentations, or events reaching 2,000 Baltimore City residents; 7) purchase and supply outreach and education materials for 2,000 Baltimore City residents ; 8) maintain a HEPA-Vacuum Loan Program for homeowners, rental property owners, tenants, and other Baltimore City residents to loan HEPA –vacuums; 9) maintain a 800 lead poisoning telephone hotline to answer question and link residents to prevention resources in Baltimore City; 9)maintain a Coalition website

that includes lead poisoning prevention information , resources and link to LHRP; 10) conduct post clearance remediation education services in up to 210 units ; 11)provide post remediation education to the property owner of each property including a review of lead safe work practices, fair housing, Title X disclosure, EPA RRP, and the Maryland Reduction of Lead Risk in Housing Law as applicable; 12) educate the owner on how to sustain the lead hazard reduction intervention through regular maintenance practices, how to conduct any such work in a lead safe manner, and how to comply with any local , state or federal lead laws; 13) distribute a lead safe maintenance kit to the owners of up to 210 units receiving post remediation education that will include: 2 buckets , mop, replacement mop head , 2 sponges , rubber gloves, cleaning solution, duct tape, wet sanding sponge, roll of 5 ml plastic; 14) provide a post remediation education letter and educational materials package to each owner that includes compliance information on local, state, and federal lead laws, copy of the Lead Risk Assessment and clearance inspection results with the property owner and occupants including any leaded surfaces that may remain following the intervention ; 15)report progress of mutually agreed upon benchmarks on a quarterly basis and include work status, work progress and any impediments encountered; 16) provide invoices and staff timesheets quarterly; and 17) participate in meetings or conference calls with LHRP and the Health Department staff to review cases of children with elevated blood lead levels and to assist with referral and triaging of 5-9 µg/dL cases for case management services. In addition, Coalition to End Childhood Lead Poisoning Program Director will assist LHRP in program planning, implementation, and training.

b. Interagency Coordination

Other organizations committed to offering the most comprehensive and cost effective services to at – risk children include a number of housing agencies. Their contribution to the program will assist Baltimore in maximizing the number of children less than six years of age protected from lead poisoning.

The Office of Rehabilitation is a sister program to the LHRP. The Office of Rehabilitation works to correct health and safety violations and major system deficiencies in owner- occupied properties of seniors and low-income CDBG eligible families. This Office will assist with structural and roofing problems that often make homes ineligible for lead hazard reduction.

The Weatherization Assistance Program (WAP) another sister program to the LHRP; seeks to assists low-income residents in making their homes energy efficient. WAP is required to do its energy conservation work in a lead safe manner, but it is not permitted to work in houses where there are apparent lead paint hazards. Three contractors have been chosen in Baltimore City (one of them is the Coalition to End Childhood Lead Poisoning), who are jointly certified to perform weatherization and lead abatement work. Houses that need and qualify for both programs will receive these services in more time efficient and cost effective ways than if the services were delivered separately.

The Housing Code Enforcement Program is also part of HCD. The Housing Code Enforcement Program works to enforce the City's housing, zoning, and building related codes. Housing Code Enforcement issue violation notices for homes with cracking, flaking, and peeling paint on the exterior of the house. The Housing Code Enforcement Program will provide LHRP staff with periodic lists of addresses where paint-

related violations have been cited. All of the information collected by housing inspectors, including any indications of children under six living in the home will be made available to LHRP staff. They will send property owners with paint violations contact information for public and private resources for lead hazard reduction, health care management, and health-related home maintenance guidance. They will also collaborate on lead hazard cross-training of housing inspectors and LHRP staff.

The L.IG.H.T Program (Leading Innovation for a Green and Healthy Tomorrow) seeks to streamline and integrate resources with public, non-profits, and private partners to collaboratively braid services to holistically address health, energy, safety, and financial needs of the client through a number of agencies. The L.I.G.HT program uniquely funds roof repairs and furnace replacements for houses that could not otherwise receive lead hazard reduction or weatherization services. The L.I.G.H.T Program additionally provide fall/injury prevention home improvements, services to reduce the incidence of asthma, integrated pest management and a wide range of green and healthy home improvements. The L.I.G.H.T Program will screen their clients and make referrals to the LHRP for lead hazard control services.

Target Populations for Partner Agencies and Services Provided

Partner Agency	Target Populations	Services Provided
Health Department	All	Provide targeted preventive in-home resident education, issue violation notices, and enforcement
Coalition to End Childhood Lead Poisoning	All	Provide direct community training and education, targeted preventive in-home resident education, property owner post remediation education, Informational websites and hotlines
Office of Rehabilitation	Low- Income Residents and Seniors	Provide assistance with structural and roofing problems
Weatherization	Very Low-Income Residents	Provide energy audits, safety testing , repair of heating equipment, and installation of many conservation measures
Leading Innovation for a Green and Healthy Tomorrow	All	Provide assistance with roof repair and furnace replacement, fall and injury improvements, and referrals to LHRP
Code Enforcement	Landlords, Homeowners, Renters	Referrals to LHRP

c. *Communicating with partners*

The DHCD Day-to- Day Program Manager will follow up with program partners periodically, troubleshooting any obstacles that arise and perform periodic quality assurance checks to promote successful outreach. The Program Manager will check- in with all Program Partners weekly; via e-mails, letters, telephone calls, and /or site visits to ensure progress towards meeting benchmarks and overall goals. The Program Manager will also, convene monthly triage meetings with Program Partners to ensure cases move smoothly through the pipeline.

3. *Selection Process for sub grantees and subcontractors*
   a. *Contractors*

The City's formal Request for Bids process is followed. This process is overseen by the Bureau of Purchasing. Eight contractors are currently under contract. A request for Bids was placed out for contracting companies to remove and dispose of lead paint and lead contaminated materials in full and strict compliance with local, State, and Federal regulations. All contractors should be Maryland- state-certified Lead Abatement Supervisors and Workers. The contractors must meet the City's Lead Hazard Control Program's Selection Criteria process which includes; insurance (general, business automobile liability, workers compensation), bid bond, lead licensing and certification, and MBE and WBE requirement.

b. *Community Based Organization*

The Community Based Organizations must summit a commitment letter to the Program Director. If approved by the Program Director, documents are submitted to Bureau of Purchasing for the creation of an Open Market Requisition. The process should conclude in the formulation of a contractual agreement.

c. *Laboratory and Risk Assessment Services*

The City's formal Request for Bids process is followed. This process is overseen by the Bureau of Purchasing. The NLLAP approved laboratory currently under contract is Schneider Laboratories Global. This laboratory is a sub contractor of Arc Environmental, Inc. A request for Bids was placed out for a company to provide labor, material, equipment, and supervision necessary for an incidental to perform various types of services for lead testing by a risk assessor having the lead paint services accreditation for the State of Maryland and capacity to collect and analyze dust wipe samples, and to analyze dust wipe samples taken by LHRP staff who are accredited by the State of Maryland following establish procedure and, and trade and safety practices. Arc Environmental must also have insurance (general, product, professional, commercial excess/umbrella, and business automobile liability), and performance bond.

d. Relocation Services

The City's formal Request for Bids process is followed. This process is overseen by the Bureau of Purchasing. The relocation company currently under contract is Walter's Relocation, Inc. A request for Bids was placed out for a moving service company to provide moving services for temporarily relocating families from their residences to another location and later move them back again into the original house. Also, to provide moving boxes and delivery of those moving boxes to a central location once date has been scheduled for moving.

4. Identification, Selection & Prioritization of Properties

LHRP offers its services city- wide to eligible owner and tenant occupants, but will focus on housing units built before 1978 with children with who test in the EBL range of 5-9 and 10 and above. Homes are selected according to age and condition of the structure, the number of children under the age six, children who spend more than 24 hours in a property with lead hazards, pregnant woman in a property with lead hazards, families with young children who received benefits from Office of Rehabilitation or Weatherization, number of bedrooms, basic system function, environmental and historical review, and Federal settlement agreements. The LHRP will also focus on housing with: 1) Excessive levels of leaded dust; 2) peeling, flaking, chipping, chalking or otherwise noticeably deteriorated on friction, impact, or accessible surfaces; and 3) present in excessive amounts in accessible locations such as floors, window sills, or wells.

(Vacant units are the lowest of priority and will need approval from the GTR prior to enrollment. The overall goal of the LHRP is to prevent children from ever becoming lead poisoned and the City has more than enough occupied units with lead hazards.)

The LHRP will receive potential applicants through referrals from Health Department and Coalition for Childhood Lead Poisoning Programs. LHRP proactively determined to utilize its housing resources for more primary prevention by developing a referral process with the Health Department to target and receive referral lists of households where children have been tested and found to have elevated blood levels in the range of 5 to 9. This referral pool will provide over 500 referrals of low income families with children to the LHRP per year. The Baltimore City Health Department will receive test results from the Maryland Department of the Environment, and will forward those addresses to LHRP. The LHRP will continue to work with the Health Department in triaging cases of elevated blood lead levels f 10 and above. In addition, the Coalition works with numerous community organizations providing specific access to families in need. The Coalition will seek referrals from those programs where the prevention of lead poisoning is often the goal, including: Head Start, Women Infants and Children, Healthy Start, Health Centers, and Maryland Lead Poisoning Prevention Partnership Meetings.

After receipt of application, the potential applicant's eligibility will be reviewed in accordance with the criteria requirements for acceptance into the program. Enrollment is open year- round to all residents in the City who qualify according to income guidelines, have a child under age of six or be a pregnant woman that may be impacted by lead. Applicants who are owner –occupants must meet the following guidelines:

- Proof of ownership , i.e., a Deed
- Provide proof of property insurance, be current on mortgage and property taxes
- Provide social security cards, birth certificates, and photo IDs
- Reside in the building where lead hazard reduction activity will take place
- Have a household income not more than 80 percent of the Area Median Income (AMI)
- At initial occupancy, include a child(ren) who are under the age six, or a pregnant woman
- Agree to have their child(ren) tested screened for lead poisoning before and after lead hazard control activities, or according to the schedule of the recommended screening guidelines for new children occupying the property (at age 1, 2, &3 or older if child was never screened).
- Agree to live in the property for a least three years after the completion of the lead hazard control activities
- Consent to participate in the program by completing and signing all necessary documents.

Applicants who are investor- owners must meet the following guidelines:

- Proof of ownership , i.e., a Deed
- Provide proof of property insurance, be current on mortgage and property taxes
- Provide social security cards, birth certificates, and photo IDs
- Be in good standing and qualified to do business in Maryland
- Be registered with MDE under the Maryland Reduction of Lead Risk in Housing Law and be current with all applicable fees
- Have legal capacity and legal corporate authorization to incur the obligations of loan or grant
- Match 20% of the total lead intervention cost
- Agree in writing to assist with the relocation of tenants to the extent required by the Federal Uniform Relocation Act
- Agree to rent the property for at least three years after the completion of the lead hazard control activities to a family with a child(ren) under age six
- At initial occupancy, include a child(ren) who are under the age six, or a pregnant woman
- Tenants have a household income not more than 50 percent of the Area Median income (AMI) except in building of 5 or more units, may have 20 percent of the units occupied by families with incomes above 80 percent of the Area Median Income (AMI)
- Tenants agree to have their child(ren)tested screened for lead poisoning before and after lead hazard control activities, or according to the schedule of the recommended screening guidelines for new children occupying the property (at age 1, 2, &3 or older if child was never screened).

- Consent to participate in the program by completing and signing all necessary documents.

These applicants who qualify for the program will be eligible for a grant or loan up to a maximum of $11,500/per unit. (It should be noted that cost may exceed $11, 500, however, LHRP does not want to make it the practice. Adjustments in cost per unit must be approved by the Program Manager).

5. *Blood Lead testing*

Coalition to End Childhood Lead Poisoning Prevention Program and the Health Department will be helping families obtain blood tests for children under six prior to lead hazard reduction work. The Health Department will share test results received from the State with the LHRP. Records of blood tests, any and all medical information LHRP obtains in the course of managing the lead hazard reduction process will be safeguarded and respected according to HIPAA standards and regulations.

In addition, LHRP, the Coalition to end Childhood Lead Poisoning Prevention Program and the Health Department have agreed to meet every month to triage new reports of elevated blood lead levels, new referrals of children at risk but not poisoned, families experiencing resistance or obstacles to abatement services. A key goal of triage meetings is to decrease lag time and make sure that families receive the best and most appropriate services for their needs.

6. *Education and Outreach*
   a. *Community outreach*

LHRP and Leading Innovation for a Green and Healthy Tomorrow Program will schedule home visits to households with EBLs 5 and above in partnership with staff from either the Coalition to End Childhood Lead Poisoning Prevention Program or the Health Department. LHRP and Leading Innovation for a Green and Healthy Tomorrow staff will explain and offer lead abatement, weatherization, housing rehabilitation, and other services using a single division application, a laptop computer, a portable scanner, and electronic signature pad. The Coalition and Health department staff will explain the significance of EBL levels, review educational materials, provide cleaning supplies, and assist the family in arranging future blood tests. Families will be offered the opportunity to enroll in Primary Prevention Case management via the Health Department and the full range of services that the Coalition to End Childhood Lead Poisoning Prevention Program provides. Families who received lead hazard reduction services will also receive post remediation education including a review of lead safe work practices, fair housing, federal Title X disclosure, the EPA Renovation, Repair, and Painting Rule, and the Maryland Reduction of Lead Risk in Housing Law as applicable. The objective of the post remediation education session with the property owner is to educate the owner on how to sustain the lead hazard reduction intervention through regular maintenance practices, how to conduct any such work in a lead safe manner, and how to comply with any local, state or federal lead laws.

Through the work of the LHRP, Coalition to End Childhood Lead Poisoning Prevention Program, and Community Partners, education will occur through community forums, training to Head Start partners, families and children, WIC Centers, local schools, Parent-Teacher Organizations, community-based

Youth Opportunity programs, education with pediatric, family care and ob/gyn offices and clinics, monthly Maryland Lead Poisoning Prevention Partnership Meetings, Maryland Lead Poisoning Prevention Awareness Week events, health fairs, state fairs, and the local media. The Program's grassroots and faith-based Community Partners have long standing relationships with community residents and will support the LHRD's outreach initiative.

b. Collateral Materials

The Coalition to End Childhood Lead Poisoning Prevention Program will provide a lead safe maintenance kit: two buckets, mop, replacement mop head, two sponges, rubber gloves, cleaning solution, duct tape, wet sanding sponge, and roll of 5 ml plastic during home visits sand post remediation services. They will provide a post remediation education letter and educational materials package to each owner that includes compliance information on local, state, and federal lead laws, a copy of the Lead Risk Assessment and Clearance Inspection Reports for the property and a resource list of lead poisoning prevention related resources. In addition, vacuums will be made available to reduce lead dust hazards and to promote lead safe work practices for owners, families, and contractors performing renovation activities that disturb lead-based paint in non-Program units in the City. In response to the growing population of Latino residents in the City, the Coalition to End Childhood Lead Poisoning Prevention Program will utilize not only Spanish language materials but also bi-lingual educators where appropriate. They will also work in partnership with the Baltimore City Office of Hispanic Affairs and use its bilingual staff to ensure that all materials are linguistically appropriate for LEP residents of the targeted areas and that the program's resources are sufficiently marketed to each community.

c. Infrastructure/ Support

Prevention education will be disseminated through the Coalition to End Childhood Lead Poisoning Prevention Program website www.leadsafe.org and a link to LHRD will be created. Potential applicants that log onto the website can learn about learn hazards and how to protect their families from lead poisoning. The Coalition will also operate an 800-370-LEAD hotline to answer questions and link residents to prevention services and to self refer to remediation services.

7. Inspection/ Risk Assessment testing procedures

ARC Environmental performs the X- Ray Fluorescence analysis and dust wipe testing to create a report certifying the presence and extent of lead in painted services, evaluate the presence of lead dust within the house and in the soil surrounding the house. The composite report of testing is the basis for scopes of work developed by LHRP's Risk Assessors. Pictures also document the findings of the tests and are part of the final report. The results of the risk assessment are given to the property owner so they can comply with the Maryland and federal lead disclosure requirements and the Lead Safe Housing Rule. ARC Environmental will conduct a lead-based paint inspection/risk assessment by performing a visual inspection, dust sampling, and surface-by-surface XRF inspections to verify the presence of lead paint and lead hazards. Testing methods will follow all federal, state and local regulations. In all testing, current federal standards of 1.0 mg/cm^2 or 0.5% by weight as the criteria for leaded paint will be

utilized. The Risk Assessment Report assists the Program Manager, Field Director of Operations, and Risk Assessors in selecting the best possible lead hazard control methods.

Once the initial lead paint inspection is performed and test results are compiled, the Field Director of Operations and Risk Assessors decides which components in the structure will undergo lead hazard control and which treatment will be used. The units may receive a combination of treatments depending upon dust wipe analysis results and leaded substrate. Historical Preservation requirements will also determine the type of lead hazard control methodology chosen for any structure.

8. Process for Developing Work Specification and Bids

Risk Assessors are trained and certified to develop scopes of work that lead abatement contractors will carry out. The scopes of work are limited to the removal of lead hazards identified through the independent testing yielding a risk assessment report. But experienced Risk Assessors also assign work that is necessary to enable hazard reduction or protect painted surfaces from erosion, abrasion, or deterioration. Risk Assessors also use pictures to document the conditions and the rationale for their scopes of work Contractors provide estimates of the cost for each work item in the scope based upon their contract bids accepted by the Bureau of Purchasing. The owner, the contractor and the Risk Assessor conduct a final walk through to make sure that nothing has been overlooked and so the owner understands what work has been and how to maintain a lead safe home environment.

9. Relocation Plan

Relocation of all occupants whose dwelling unit is undergoing lead hazard control activities will be provided the option of temporary relocation. The City has a contract with a Walter's Relocation, Inc – a minority business enterprise- that will provide moving and storage services. The Outreach/Enrollment Supervisor or Outreach workers will make arrangements to conduct a home visit to screen the property, check for infestations, and provide the occupants wishing to participate in relocation a temporary relocation packet. The packet will provide detailed information on the temporary relocation process including: steps of the relocation process, relocation expenses covered and not covered by LHRP, temporary housing option, and temporary housing occupant and moving responsibilities.

When the temporary relocation is required, the staff will explore the various options available to the occupant, based upon needs expressed and expenses that will be incurred. LHRP staff will make sure that the relocation site is lead safe and in good condition before occupants enters. LHRP will use one of four motel/hotels that completed the City's competitive bidding process. The relocation staff will make final arrangements for the move once the start date of the project is determined. Staff will provide boxes for packing. The relocation staff along with the applicant will complete an inventory checklist of all house hold valuables not placed in storage. Contractors will provide polyethylene coverage for all furniture not moved and stored by Walter's Relocation. On –going support and troubleshooting will also be provided to occupants for the duration of the project. Once clearance standards are met in unit occupants will be allowed to return. Landlords will be responsible for the costs and the arrangements for relocation of tenant families during lead abatement construction. The LHRP will rely on the protocols contained in the Department's Temporary Relocation Plan and the requirements of the Uniform

Relocation Act (URA) to guide all relocation elements including: moving, storage, payment of daily stipends, and the securing of temporary housing facilities for the relocated occupants.

10. Levels of Intervention and Clearance Procedures

LHRP will focus on the control of lead dust by limiting the generation of lead dust, containing lead dust within work areas, ensuring daily and final cleaning, and clearance testing. The interior and exterior treatments will be identified by a licensed risk assessor and must be identified as a lead hazard in order to be an eligible cost under the Program. The interior and exterior treatments include:

a. Interior treatment

1). Floors -if surface is smooth and tight, but has deteriorated paint then prepare and paint or polyurethane (primer, two coats finish gloss or semi-gloss floor paint) to make easy to clean. If surface is not smooth and tight and has deteriorated lead paint or high lead dust then cover with ¼" Luan plywood (fastening with ring-shanked or glue coated nails, or comparable fastener),next paint or polyurethane (as above), or cover with approved flooring (vinyl tile, sheet goods, or carpet) to make surface smooth, tight, and easy to clean. 2). Walls/Ceilings- if painted surface is damaged then remove deteriorated paint, prepare surface, coat with primer and top coat of paint; or remove deteriorated paint and cover with approved material-plasterboard (properly surfaced), wood paneling, etc. 3). Doors/jambs- if doors are ill fitting repair door (re-hang, plane edges, replace broken hinges, etc.) to prevent edges from contact with jamb, then stabilize deteriorated paint, prepare surfaces, coat with primer and top coat of paint of polyurethane. If component is deteriorated then replace. 4). Trim/Baseboards- if deteriorated paint exits remove, prepare surface, and coat with primer and two coats of finish paint, or stabilize surface, test, patch, and apply coating as per manufacturer instruction (Note: not suitable for surfaces subject to abrasion). If components are deteriorated by water or past termite infestation replace. 5). Windows (Wood)- If paint is deteriorated on trim, stool, apron then replace sash, the entire unit or those additional components with new wood that is properly coated. 6).Cabinetry- if paint is deteriorated then stabilize or replace. 7). Stair Systems (Post / Spindles / Banister)- if paint is deteriorated remove from all components, prepare all surfaces, re-paint with primer and two coats of finish paint, or If deteriorated, replacement; properly enclosed with an approved, mechanically-fastened, material, or stabilize surface, test patch, apply coating as per manufacturer instructions (Note: not suitable for surfaces subject to abrasion – treads and risers). 8). Treads /Risers- if paint is deteriorated remove from all components, prepare all surfaces, re-paint with primer and two coats of finish floor paint; remove deteriorated paint and cover with carpet or other approved flooring (vinyl tile with metal bull nose, laminate riser with luan and coat).

b. Exterior Treatment

Any damage contributing to lead-based paint failure will be replaced, properly enclosed with an approved, mechanically-fastened, material, or removed from all components, prepare all surfaces, repaint with primer and two coats of finish paint.

c. Contractor Clean-up Specifications for both Interior and Exterior

The contractor will work in a lead safe manner to minimize the generation of lead paint chips and dust, including: properly sealing floors with tarps, working "wet", creating dust barriers at work area egresses, wrapping debris in plastic or properly bags before removal from work area, and proper on-site storage of debris. The contractor will clean all work areas as work progresses and at the completion of the work for the area. The contractor will clean all areas by wet-stripping gross debris, HEPA vacuuming and washing of all surfaces in the property to remove lead dust, according to the HUD guidelines. The contractor will be responsible for the removal and proper disposal of all work debris and refuse in accordance with Federal, State, and Local guidelines. The contractor will be responsible for properly protecting exterior areas during exterior work to prevent lead paint chips and dust from entering the soil. If the contractor contaminates the soil through work activities, the contractor is responsible to properly abate the soil, as determined by the LHRP. The contractor must establish critical barriers and seal entire floor or work area with 6-mil plastic, to contain debris generated by the intervention.

Cost estimates for some of the common types of work completed by contractors on behalf of the Program:

Final Clean = $1.50 sq. ft.	Door rework = $250.00 ea.
Painting = $1.50 sq. ft.	Sheetrock = $4.50 sq. ft.
Floor Tile = $5.50 sq. ft.	Window replacement = $500.00 ea.

Site supervisors working for the LHRP contractors are required to have taken and passed the Maryland Lead Abatement Supervisor's course which means the person can supervise lead paint removal and demolition projects in residential, commercial and public buildings. The contractors will also be required to have taken and passed the EPA's Renovation, Repair and painting class. Before work begins on occupied properties the occupants are relocated to a motel/hotel. The types of work being supervised may include paint stabilization, encapsulation, as well as paint removal, component replacement and enclosure. The contractor's workers are trained as Maryland Lead Abatement Workers meaning they can work with any lead paint hazards under the supervision of an accredited lead supervisor. Upon completion of the appropriate course, the supervisors and workers take a third party test and then apply for the workers certificate or supervisor's accreditation to MDE. LHRP will request and keep copies of all certificates and accreditations on file.

LHRP staff will visit sites throughout construction to monitor the work in progress to ensure that all federal, state and local laws are being followed. During the visits Risk Assessors will check that warning signs are posted, proper containment of the property is in place and lead safe work practices are being followed. LHRP will also check that workers and supervisors are present at the site and have the required certifications and accreditations.

11. Evaluation Process

a. Program outcomes and interim benchmarks

Through lead hazard reduction in the home and a targeted outreach approach LHRP will reduce the prevalence of lead among children in City of Baltimore. The LHRP will increase the number of children protected from lead poisoning by reducing lead in 210 owner occupied and rental occupied units, increase the number of children protected from lead hazards by indentifying lead in 280 owner occupied and rental occupied units, and increase public awareness of lead hazards and available services by educating 360 clients and providing information to at least 2000 clients on lead hazards and lead poisoning prevention.

b. Performance Measures and Procedures for assessing performance relative to benchmarks

The Day-to-Day Program Manager and LHRP staff will review, analyze, and input collected data in various data management systems on a daily basis. The Day-to-Day Program Manager will review and make sure all programmatic materials are updated and coincide with program goals. The Day-to-Day Program Manager will follow-up with LHRP staff daily and program partners monthly; troubleshooting any obstacles that arise. The Day-to-Day Program Manager will perform quality assurance checks to promote the success of lead hazard control activities and compliance with local, State, and Federal regulations. The Day-to-Day Program Manager and designated fiscal officer will develop payment schedules for applicable program partners that will include regular receipt of invoices tied to program deliverables.

Outcome	Output	Measurement
Increased number of children protected from lead poisoning	210 units completed and cleared	• Eligibility verification • Review of policy and procedure manual • Review of required Local, State, and Federal regulations and certifications • Quality Assurance Checks/ Follow-up • Data analysis • Regular staff meetings • Monthly triage meetings • Quarterly reporting
Increased number of children protected from lead hazards	280 units inspected	• Eligibility verification • Review of policy and procedure manual • Review of required Local, State, and Federal regulations and certifications • Quality Assurance Checks/ Follow-up • Data analysis

		• Regular staff meetings • Monthly triage meeting • Quarterly reporting
Increased public awareness of lead hazards and available services	360 clients educated	• Quality Assurance Checks/ Follow-up • Data analysis • Review of forms and programmatic materials • Payment schedule • Monthly Triage meetings • Quarterly reporting
Increased public awareness of lead hazards and available services	80 outreach events conducted	• Quality Assurance Checks/ Follow-up • Data analysis • Review of forms and programmatic materials • Payment schedule • Monthly Triage meetings • Quarterly reporting

c. *Data items and data collection methods*

The LHRP will use various data management systems (i.e. excel, access, Hancock, Efforts to Outcomes, etc) to monitor and track program progress. Many data bases will be created including: referral, enrollment, outreach and group presentation, lead hazard control pipeline, weekly progress report, inspections, historical and environmental, underwriting, relocation, grant log, and etc. Databases will be created on an as needed basis. Databases will be crossed checked for errors. All LHRP staff will be trained on the different databases and will be responsible for managing at least one. Most information will be gathered through the application, programmatic forms, and required eligibility documents, and one-to-one interviews.

d. *Procedures for reporting progress*

Quarterly reports will be submitted to HUD, summarizing the progress of the LHRP in relation to benchmarks and overall goals. A final report will be submitted to HUD at the end of the grant period, in format specified by HUD. The final report will detail activities- number of units completed and cleared, number of units inspected, and number of people who become educated about lead hazards, number of people who receive information about lead hazards and the LHRP, evaluation of the methods used, findings, and recommended future actions at the conclusion of grant activities.

e. *Actions to make changes in grantee program if performance targets are not met within established timeframes*

The Day-to-Day Program Manager will meet regularly with staff and program partners to reexamine performance measures and make necessary adjustments to grant materials or activities based on the lead hazard control strategies and approaches implemented at that time. The Day-to-Day Program Manager will also identify technical assistance needs of LHRP staff and program partners and resolve them in a timely manner.

12. *Financial Management*

a. *Plan for Request for Release of funds*

Per 24 CFR Part 58, an environmental review record for DHCD has been completed. The project met the conditions specified for Determination of Exemption under sections 24 CFR 58.34 (a), (3), (4), (5), (6), (8), (9) and Categorical Exclusion 24 CFR 58.35 9 (b), (2), (3). There were no public objections or comments to the Request for Release of funds within the designated public comment period. Tier II site–specific Environmental Review will be completed for each project when information becomes available. DHCD will commit and expend HUD and non- HUD funds to undertake lead- based paint hazard control intervention activities that will have a physical impact upon enrolled eligible housing units once other grant conditions have been satisfied.

b. *Flow of funds/tracking*

Regular financial oversight of grant funds will be carried out in tandem between the DHCD's Fiscal staff along with the City's Finance Department. Collectively these departments will work with project managers to ensure expenditures are in compliance with grant requirements and the allocated amount. These funds will be included in the City's overall financial reports that are based on GASB 34 account principles. Under this framework the City's financial statements are comprised of three components: government-wide financial statements, fund financial statements, and notes to the basic financial statements.

Mr. Jaikishin Chughani will be DHCD's designated fiscal officer to interface with the City's Finance Department. Mr. Chughani will maintain budget records and monitor program spending. Mr. Chughani will provide the day-to-day Program Manager with monthly income statements that itemizes expenses, and administration cost to the program. Mr. Chughani along with the Program Manager will ensure that payments to collaborative partners involve regular receipt of invoices tied to program deliverables.

Mr. Ed Cole will be DHCD's authorized user for LOCCS, and will be drawing down for the LHRP on a monthly basis. Mr. Cole will make reimbursement request using the Voice Response System, and completing and submitting all supporting documentation.

c. *Underwriting*

The underwriter determines the applicant's benefit of the grant or loan. For grants, applicants must have incomes less than 80 % of the Area Median Income. They must also have a front end ratio greater than 28% and have a back end ratio greater than 40%. Investor- owners must contribute 20% of the lead cost and settlement fees. Applicants with incomes greater than 80% of the Area Median Income must

take out a loan and make a 10% match due at settlement. The interest rate on each loan will be 6% or less based on the applicants ability to pay. Some loans will be deferred if applicant demonstrates inability to payback, forgiven at the time of transfer to the extent that the loan exceeds the equity in the property, o r forgiven after 20 years.

d. Payment to Contractors

Grant funds for the LHRP can be accessed while work is progress and upon final inspection and approval of completed work by the Field Director of Operations and Risk Assessor. Before work begins a Requisition is created and is approved by the designated fiscal officer and Bureau of Purchasing. The contractor receives confirmation of approval, which includes a Purchase Order and the Release Number. Soon after the work begins the Field Director of Operations creates a receipt in Citybuy under the contractor's Purchase Order and Release number so that the contractor can receive payment. For payment approval the Field Director of Operations notifies the designated fiscal officer amount to be paid to the contractor. After work is complete, Field Director of Operations and Risk Assessor must visit the property to be sure work is completed and satisfactory. Contractor emails and invoice Field Director of Operations and Purchasing Bureau. The City pays contractor within 30 days.

D. Sequence of Tasks

Task	Who	Timeline
Identification Selection, Prioritization of Units	DHCD- LHRP LIGHT	10/1/2012- 6/1/2015
Intake/ Enrollment	DHCD- LHRP LIGHT	10/1/2012- 6/1/2015
Pre- hazard Control Blood Lead Testing	Health Department	10/1/2012- 6/1/2015
Underwriting	DHCD- LHRP	10/1/2012- 6/1/2015
Paint Inspections/ Risk Assessments	DCHD- LHRP Lead Risk Assessors, Arc Environmental	10/1/2012-12/31/2014
Laboratory Analysis of Samples	Schneider Laboratories Global	10/1/2012-12/31/2014
Work Specifications	DHCD- LHRP Field Director of Operations and Risk Assessors	10/1/2012- 6/1/2015

Bid Process/ Contractor Selection	DHCD- LHRP Field Director of Operations and Risk Assessors	10/1/2012- 6/1/2015
Temporary Relocation	DCHD- LHRP Outreach / Enrollment Supervisor	1/1/2013- 6/1/2015
Interim Controls	Lead Abatement Contractors	1/1/2013- 6/1/2015
Quality Control – Contractor Performance	DHCD- LHRP Field Director of Operations and Risk Assessors	1/1/2013- 6/1/2015
Clearance Evaluations	DHCD- LHRP Project Supervisor and Lead Risk Assessors	1/1/2013- 6/1/2015
Maintenance Plan – Unit Follow Up	DHCD- LHRP Lead Risk Assessors	6/1/2014-6/30/2016
Community Outreach / Education	DHCD – LHRP Outreach Workers Coalition to End Childhood Lead Poisoning Health Department	10/1/2012- 6/30/2015

E. Objectives and Milestones

Goal/ Objective: **210 Units Completed and Cleared**

Year 1

Quarter	Quarterly Milestone
Jul-Sep	**N/A**
Oct-Dec	**N/A**
Jan-Mar	**8**
Apr- Jun	**14**

Year 2

Quarter	Quarterly Milestone

Jul-Sep	**24**
Oct-Dec	**24**
Jan-Mar	**20**
Apr- Jun	**24**

Year 3

Quarter	Quarterly Milestone
Jul-Sep	**34**
Oct-Dec	**18**
Jan-Mar	**20**
Apr- Jun	**24**

Goal/ Objective: **280 Units Inspected**

Year 1

Quarter	Quarterly Milestone
Jul-Sep	**N/A**
Oct-Dec	**31**
Jan-Mar	**31**
Apr- Jun	**31**

Year 2

Quarter	Quarterly Milestone
Jul-Sep	**31**
Oct-Dec	**31**
Jan-Mar	**31**
Apr- Jun	**31**

Year 3

Quarter	Quarterly Milestone
Jul-Sep	**31**
Oct-Dec	**32**
Jan-Mar	**N/A**
Apr- Jun	**N/A**

Goal/ Objective: **360 Clients Educated**

Year 1

Quarter	Quarterly Milestone

Jul-Sep	**N/A**
Oct-Dec	**36**
Jan-Mar	**36**
Apr- Jun	**36**

Year 2

Quarter	Quarterly Milestone
Jul-Sep	**36**
Oct-Dec	**36**
Jan-Mar	**36**
Apr- Jun	**36**

Year 3

Quarter	Quarterly Milestone
Jul-Sep	**36**
Oct-Dec	**36**
Jan-Mar	**36**
Apr- Jun	**N/A**

Goal/ Objective: **80 Events**

Year 1

Quarter	Quarterly Milestone
Jul-Sep	**N/A**
Oct-Dec	**8**
Jan-Mar	**8**
Apr- Jun	**16**

Year 2

Quarter	Quarterly Milestone
Jul-Sep	**8**
Oct-Dec	**16**
Jan-Mar	**8**
Apr- Jun	**8**

Year 3

Quarter	Quarterly Milestone
Jul-Sep	**8**
Oct-Dec	**8**
Jan-Mar	**N/A**
Apr- Jun	**N/A**

Baltimore City Program Update

Lead Hazard Reduction Program

October 4, 2012

I. Work Plan – Distributed for Feedback, Submitted to HUD

II. Other Start Up Issues for the next two months

A. Relocation Rebidding
B. Resolving some non-complying loans from the past
C. Hancock Computer System, customizing for lead abatement
D. Formal agreements with health Department and Coalition regarding home visits
E. US Conference of Mayors funding for HCD and Coalition via BCHD
F. New State agreement for LHRGLP

III. Following through on some cases carried over from State funding last year

A. Settlement on 14 properties for Chesapeake Habitat tomorrow
B. Cases referred to Rehab office and NHS for where housing condition and financial obstacles to lead program may be overcome

IV. Issues for Commission Consideration

A. Status of State and Local Response to children testing 5 to 9
B. Rethinking underwriting criteria for grants versus loans

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Request for Comment on Management of Childhood Lead Exposure

In May, 2012, the U.S. Centers for Disease Control and Prevention (CDC) responded to recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP) to revise the guidelines for childhood lead poisoning. The CDC adopted the ACCLPP's recommendation that eliminated the term "level of concern" (since there is no known safe blood lead level, or BLL) and the recommendation for a new BLL reference level of 5 mg/dL, based on the current lead levels in the population. The CDC also agreed in principle with ACCLPP recommendations that "no children in the U.S.[should] live or spend significant time in homes, buildings or other environments with lead-exposure hazards." However, CDC did not describe a specific plan to achieve this goal. The CDC also agreed in principle with the ACCLPP's recommendations that clinicians should:

- [B]e a reliable source of information on lead hazards and take the primary role in educating families about preventing lead exposures. This includes recommending environmental assessments PRIOR to blood lead screening of children at risk for lead exposure.
- [M]onitor the health status of all children with a confirmed BLL ≥5 µg/dL for subsequent increase or decrease in BLL until all recommended environmental investigations and mitigation strategies are complete, and should notify the family of all affected children of BLL test results in a timely and appropriate manner.
- [E]nsure that BLL values at or above the reference value are reported to local and state health and/or housing departments if no mandatory reporting exists and collaborate with these agencies in providing the appropriate services and resources to children and their families.

CDC also accepted in principle other ACCLPP recommendations regarding the need to emphasize the importance of environmental assessments to identify and mitigate lead hazards before children demonstrate BLLs at or higher than the reference value, and adopt prevention strategies to reduce environmental lead exposures in soil, dust, paint, and water before children are exposed. However, no specific plans were proposed by CDC for these recommendations.

On June 7, 2012, the Department released a letter to health care providers with information about the CDC response and the Department's position. Key points of the letter were:

1. There is no change in the recommendations for the age of testing for children in Maryland. The requirement remains that children living in zip codes identified as "at-risk") in the Maryland State Targeting Plan (view at-risk zip codes: http://fha.dhmh.maryland.gov/mch/Documents/Lead-revisedatriskareas2004a.pdf), and all children enrolled in Maryland Healthy Kids (EPSDT), should receive a lead test at ages 12 and 24 months.
2. DHMH, *consistent with the new CDC guidance, recommends that children with a lead level greater than the new reference level of 5 mg/dL should be retested within 3 months.* In addition, families whose children have a confirmed level greater than 5 mg/dL should receive lead and nutritional education, and be assessed for possible sources of lead exposure.
3. *There has been no change in the Maryland law related to housing and lead levels.* Maryland law still recognizes a level of 10 mg/dL as the level that triggers regulatory action related to rental housing.

As noted in the June 7, 2012 letter, children with a venous lead level greater than the new reference level of 5 mg/dL should be retested within 3 months. A child with a capillary test of 5 – 9 mg/dL should always have a confirmatory venous sample drawn as soon as possible. In addition, families whose children have a confirmed level greater than 5 mg/dL should receive lead and nutritional education, and be assessed for possible sources of lead exposure.

Referral and Case Management

Currently, when the Maryland Childhood Lead Registry (CLR) receives a test of 10 mg/dL or greater, that result is reported to the local health department (LHD) in the jurisdiction where the child resides.

At that point, there is typically telephone or in-person contact by a case manager at the LHD with the family, to evaluate possible sources of exposure, discuss clinical follow up if necessary, and otherwise manage the case. This takes place for approximately 500 new cases each year, under the former CDC guidelines.

An outstanding question is how the new CDC guidelines should influence current protocols for referral and case management.

The Department is considering two alternatives for case management under the new guidelines. These are:

1. *Continue current case management strategies with lower levels* – Under this option, there would be no difference between the LHD response to a child regardless of the lead level – as long as the level is 5 mg/dL or higher, the LHD would do the same thing (contact the family, arrange for follow up if necessary). Health Departments would be instructed to prioritize children with higher lead levels. Without substantial additional funding, this would likely contribute to a significant increase in workload, and could result in delays in processing cases.
2. *Create an alternative case management strategy for children with lower blood lead levels* – This option involves creation of a modified case management strategy, involving greater reliance on follow up by the primary care provider. Under this strategy, case managers at the LHD would notify the primary care provider, who would be expected to perform follow-up testing, screen family for risk factors, and refer for case management if indicated.

The Department is seeking public comment on the pros and cons of these two strategies and whether other approaches are optimal. Please comment on whether the current approach to children with lead levels over 10 is optimal for children with leads of 5-9 mg/dL, given potential other sources of lead exposure besides the household for these children.

Look-Back for Children

The Department is also requesting comments and public input on the most appropriate management of children who have previously had blood

lead levels between 5 – 9 mg/dL. Prior to the new CDC recommendations, general clinical recommendations were to follow up on children with any detectable lead, since there is no "natural" level of lead in the human body. However, in practice there may have been children with blood lead levels less than 10 who did not have either a follow up lead test or evaluation to determine whether there was a source of possible lead exposure that could be eliminated.

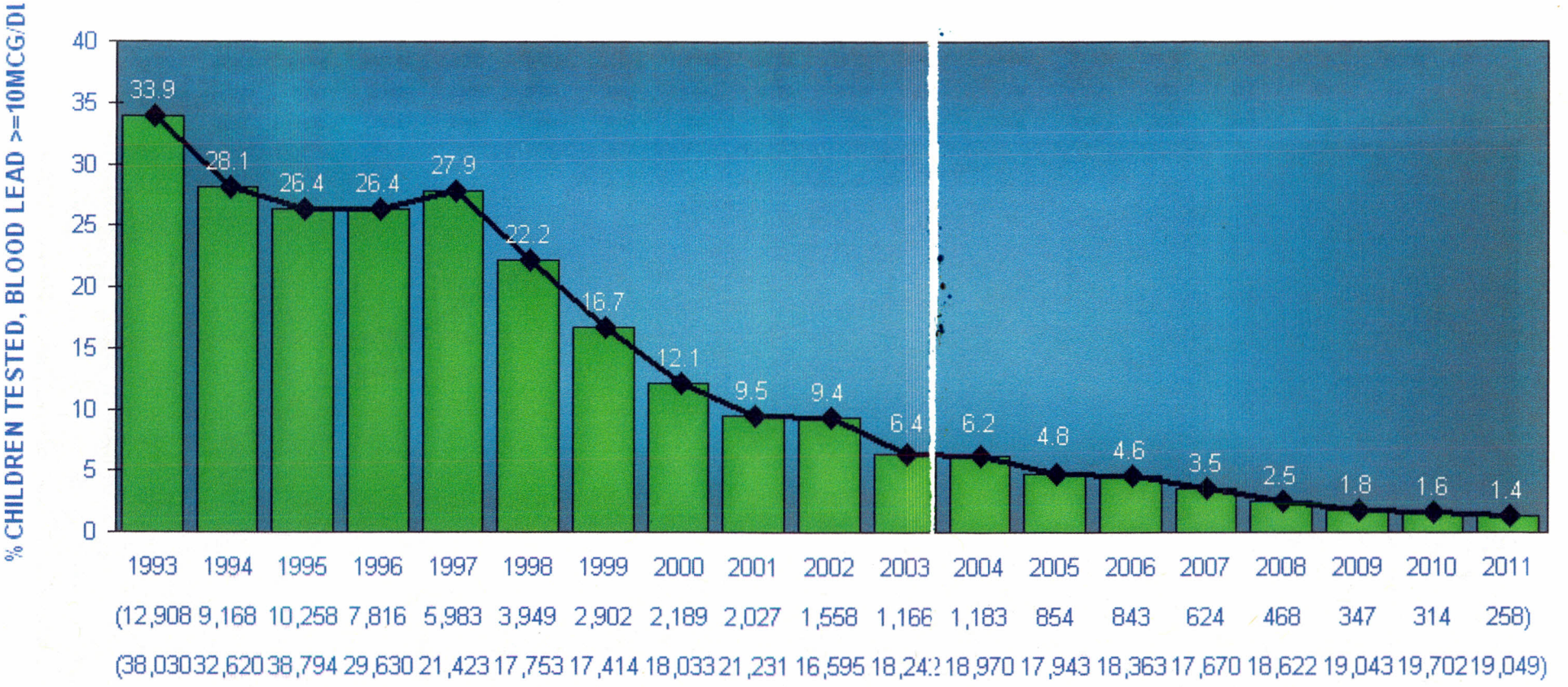
The Department is considering working with MDE to notify parents of children who tested between 5 and 9 mg/dL in recent years of the new levels and recommending retesting as an initial step, to be followed up as appropriate. Possible reasons for retesting might include confirmation of a single capillary test, tests reported to clinicians only as "less than 10," or other indications.
The Department seeks comment on the appropriate length of time for this "look-back," given the fact that lead exposure peaks by the age of 3 years (36 months) and then starts to decline, particularly after 6 years (72 months) of age.

The Department requests comments by Friday, September 28, 2012, on these issues and any other recommendations related to the new CDC guidelines. The Department has also asked the Lead Poisoning Prevention Commission to review public comments and to make recommendations on whether the Department should take any additional action. The Lead Poisoning Prevention Commission was created by statute in 1994 (Chapter 114, Acts of 1994). The Commission studies and collects information on the effectiveness of the Lead Poisoning Prevention Program and current risk reduction treatments in reducing exposure to lead as well as risk and liability issues including availability of insurance (Environment Article, Secs. 6-801, 6-848). In addition to reviewing written comments, the Council will hold a hearing to solicit public input on the questions above on October 11, 2012. The Commission will then vote on recommendations to forward to the Secretary of Health and Mental Hygiene regarding the consent form and the consent and age verification procedures.

Written comments should be submitted by Friday, September 28, 2012, at 5:00 PM.

Comments may be submitted by mail to Michele Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 W. Preston St., Room 512, Baltimore, MD 21201 or call 410-767-6499, TTY: 800-735-2258, or by email to regs@dhmh.state.md.us, or by fax to 410-767-6483.

MARYLAND DEPARTMENT OF THE ENVIRONMENT
CHILDHOOD BLOOD LEAD SURVEILLANCE
BALTIMORE CITY 1993-2011

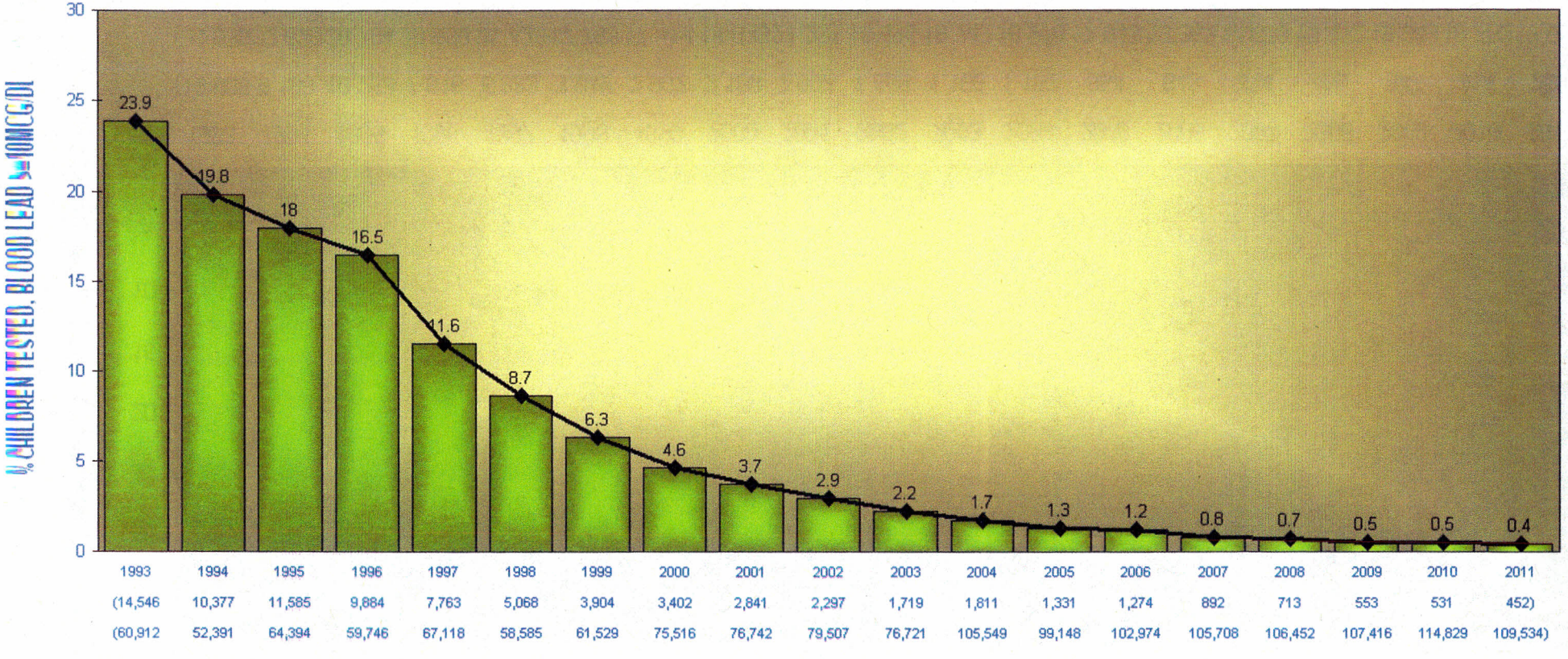


CALENDAR YEAR
(Number of Children with BLL >=10mcg/dl)
(Number of Children Tested)

MDE

MARYLAND

MARYLAND DEPARTMENT OF THE ENVIRONMENT
CHILDHOOD BLOOD LEAD SURVEILLANCE
STATEWIDE 1993-2011



CALENDAR YEAR
(Number of Children with BLL>=10mcg/dl)
(Number of Children Tested)

MDE

MARYLAND

NOVEMBER 8, 2012

LEAD POISONING PREVENTION COMMISSION MEETING

MEMBERS

Governor's Lead Commission Meeting Attendance Sheet

11/8/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

Name/Signature	Representing	Telephone/Email
CONNOR, Patrick	Hazard ID Professional	
DWYER, M.D.Maura	Department of Health and Mental Hygiene	
HALL, Cheryl	Office of Child Care	
HORNIG, Karen Stakem	~~Maryland~~ Insurance Administration	
JENKINS, Melbourne	Property Owner Pre 1950	
LANDON, Edward	Dept. Housing and Community Dev.	
McLAINE, Patricia	Child Health/Youth Advocate	
MOORE, Barbara	~~Health~~ Care Provider	
OAKS, Nathaniel (Delegate)	Maryland House of Delegates	
ROBERTS, Linda Lee	Property Owner Post 1949	
SNYDER-VOGEL, Mary	Child Advocate	
VACANT	Secretary of the Environment or Designee	
VACANT	Local Government	
VACANT	Parent of a Lead Poisoned Child	
VACANT	Financial Institution	
VACANT	Child Care Providers	
VACANT	Insurer	
VACANT	Property Owner Pre 1950 Outside Baltimore City	
VACANT	Maryland Senate	

GUESTS

Governor's Lead Commission Meeting Attendance Sheet

11/8/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

Name	Representing	Address/Telephone/Email
John Krupinsky	MDE	Ext 3844
Chris White	Arc	443 250-6011 cwhite@arcenvironmental.com
[illegible] Duke	Howard County HD	410 313 7568
Ron WinehoLt	AOBA	rwineholt@aoba-metro.org
Lisa Hoover	AOBA	
Cynthia Erville	Fluoride Action Network	fluoridealert.org self ervillec@aol.com
Ruth Ann Norton	CECLP	RANORTON@leadsafe.org
Hosanna Asfaw-Means	BCHD	hosanna.asfaw-means@baltimorecity.gov
Paula Montgomery	MDE	-
Shaletta Denson	CECLP	sdenson@leadsafe.org
Shawna Coffin	CMP Peds office	JHH Bayview SCOFFIN5@JHMI.edu
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Ali Golshiri	PGC HD	301-883-7662
Dana Schmidt	MMHA	dschmidt@mmhaonline.org
Kathy Howard	MMHA	

NAME / PRINT	Representing	email
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✓ PATRICK McKENNA	DHMH/Johns Hopkins	patrick.mckenna @ maryland.gov
✓ DAVID SKINNER	CECLP	dskinner @ Leadsafe.org
John O'Brien	MDE - staff	
Tracy Smith	MDE - staff	

Maryland Lead Poisoning Prevention Commission
Public Meeting on Management of Lead in Maryland
Thursday, November 8, 2012
Maryland Department of the Environment
1800 Washington Boulevard
Baltimore, MD 21230
10:00 AM – 12:00 PM

Print Name	Signature	Representing	Email
Ruth Ann Norton		CECLP	rnorton@leadsafe.org
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Ken Strong		HCD Balt City	Ken.strong@baltimorecity.gov
Ali Golshiri		PG Co.	
		Howard Co. Hlth Dept	
		Community Hlth Nurse	
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GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230
APPROVED
November 8, 2012

Members in Attendance

Cheryl Hall, Karen Stakem-Hornig, Ed Landon, Pat McLaine, Barbara Moore, Delegate Nathaniel Oaks, and Mary Snyder-Vogel.

Members Not in Attendance

Patrick Connor, Dr. Maura Dwyer, Mel Jenkins, and Linda Roberts.

Guests in Attendance

Shaketta Denson – CECLP, Hosanna Asfaw-Means, Rita AuYeung – UMB student, Ron Wineholt – AOBA, Lesa Hoover – AOBA, Kathy Howard, MMHA, Donna Webster – WCHD (via phone), Chris White – ARC, Eunice Dube –Howard Co. Hlth. Dept., Cynthia Erville – Fluoride Action, Ruth Ann Norton – CECLP, Shawna Coffin – CMP Peds Office, Jeff Fretwell – MDE, Lisa Horne – DHMH, Sara Reese-Carter – DHMH, Ken Strong – HCD Baltimore City, Rita Au-Teny – UMB, Denise Hinds – BCHD, Ali Golshiri – PGCHD, Dana Schmidt – MMHA, Sybil Wojcio – DHMH, Patrick McKenna – DHMH/Johns Hopkins, David Skinner – CECLP, Lisa Morgan, John O'Brien – MDE staff, Paula Montgomery – MDE staff, John Krupinsky – MDE staff, and Tracy Smith – MDE staff.

Introductions

Pat McLaine began the meeting at 9:32 am. Everyone introduced themselves. Minutes for September 2012 meeting – two changes were made to page 3. Ed Landon recommended approval, seconded by Cheryl Hall, all in favor of accepting the minutes as amended.

Future Meeting Dates

The next scheduled meeting is Thursday, December 6, 2012 at MDE in the AQUA conference room. The Commission will meet from 9:30am - 11:30am.

Agency Reports

MDE – nothing to report
DHMH – Cliff Mitchell reported that DHMH has been working on updating the targeting plan and a strategy has been identified.
DHCD – nothing to report
BCHD – nothing to report
Childcare Administration – nothing to report
MIA – nothing to report

smarter and more efficiently. Maryland and Baltimore can be proud of where Baltimore has come to in a green and healthy homes initiative. This allows a comprehensive, holistic look at the risks and potential hazards, tying together 27 entitlement programs. If Maryland is smarter and more efficient, we will continue to be a national leader.

Mr. Ali Golshiri (Prince Georges County Health Department) talked about the need for funding local health departments. Prince Georges County has had no money for two years. Teaching about lead is not easy and takes resources. His county has the 2nd highest number of children with EBLLs. He pointed out that the County's ability fo follow up on cases is limited; the nurse case manager does not always go out on visits but levels of 10µg/dL and above always receive investigation. Prince Georges County is concerned about how to deal with historic levels 5 – 9. If the children are still less than 6 years, should they be seen? What would happen if the County gets hundreds of new cases? Would MDE pay for more sampling? What about outreach funding? The Prince George's Health Department has been paying for dust sampling themselves, at about $10.50/ sample and also pays for blood lead tests. The Department is still doing phone follow up, as well as paying for translation services when they are required. The closure of blood lead and environmental lead laboratories by the DHMH Laboratories Administration affected local health departments. The PG County Health Department is paying for re-sourcing the XRF analyzer, owned by MDE.

Ken Strong added that there should be exploration of support from either Baltimore City or the State to support enhanced weatherization or weatherization plus (application to public service commission). Specifically, there are funds from the Exelon merger ($18-20 million) for weatherization, and this could be tied to abatement of lead and healthy housing activities.

The Commission discussed the need to invest in primary prevention. Dr. Navas Acien from Johns Hopkins School of Public Health could be asked to speak about the impact of lead on adults. Community Transformation Grants from the Department of Health and Mental Hygiene could potentially include provisions for lead poisoning prevention (the Coalition is interested in doing a webinar with DHMH on CTG applications). Ruth Ann Norton suggesting an ongoing "human capital" bond related to green/healthy housing.

In addition, the Coalition endorses re-instituting blood lead and environmental testing by DHMH Labs.

Pat McLaine asked for additional comments from LHDs.

Eunice Dube (Howard County HD) current guidelines suggest home visits for blood lead >= 10. HCHD currently contacts PCP and family to ensure appropriate followup. They speak with family about sources of lead and ask if the family has a PCP. For BLLs of 5-9µg/dL, indicated that CHN should contact families to make sure they have information. She asked if testing was necessary every 3 months, and about frequency of testing again when the level gets below 5µg/dL. Are there financial or health insurance implications for continued surveillance. Indicated that additional resources may be needed – county only has 4-5 active cases now.

Regarding look-back, suggested that assessment of behavior might be done for children less than 13 years and wondered if there might be similar effects on adults who had been previously exposed.

Cheryl Hall asked if there was a standard protocol for case management in the state of Maryland and asked if resources were provided to counties based on the numbers in case management. John Krupinsky indicated that there is a state protocol but each county decides how they will provide case management. He added that MDE only funds Baltimore City and the Eastern Shore at this time. Sara Reese-Carter noted that MCH Blockgrant from DHMH funds a suite of primary prevention activities, including lead. Seven counties get these funds. General Funds are now being used for MCH programs. In light of revisions to the targeting plan, DHMH will need to look at this again. There are five counties that do not now provide home visits for children with BLLS of 15µg/dL and above. Only 3 counties and Baltimore City provide home visits for children with BLLs of 10-14µg/dL and above. This was new information to Commissioners. Pat McLaine asked which 5 counties were not making home isits at BLLs of 15µg/dL; Ruth Ann Norton asked which counties were not making visits at levels of 10µ/dL and requested that the Commission provide a report to Governor on the status of resources. The question was raised whether a local health officer can opt out entirely from making a response to a poisoned child. Paula clarified that MDE continues to perform environmental investigation at levels of 10µg/dL. John Krupinski stated that MDE provides assistance with case management to local health departments on request. Local health departments must provide notice of EBL, and contact the provider and family; home visits are not specified. Cliff Mitchell indicated that local HDS have lost 37% of funding from general funding and lost local funding matched to that. LHD staff have very broad responsibilities; what are realistic goals for case management given current restraints? Barbara Moore indicated that home visits for environmental investigation were being done routinely for poisoned children but that local case management efforts were variable. Additional information of interest to the Commission includes: (1) ID of current counties that are or are not providing case management home visits; (2) More outreach to address private providers; (3) Prevention activities; and (4) How much funding is going to local health departments. Cheryl Hall (MSDE) asked about how we would monitor.

Hosanna Asfaw-Means – (Baltimore City) very concerned about the 5 – 9 level. Currently, they are doing telephonic case management at 5 – 9. Working on outreach to larger groups. Providers are reaching out to health department and providing information about children at risk. Sanitarians are now responding to children with BLLs 5-9µg/dL; they can issue a notice of defect but cannot issue a violation notice. Collaboration in the city with BCHD, Housing and the Coalition has been encouraging.

Pat McLaine expressed concern that no providers had provided testimony. Cliff Mitchell had contacted AAP and Family Practitioners; Pat McLaine had contacted nurse practitioner organizations.

Ruth Ann Norton noted that CDC's Advisory Committee Meeting is scheduled for next week. She requested that any questions for implementation be emailed to her before next Tuesday.

There being no further discussion, ??? made a motion to end the meeting, seconded by ???. The meeting ended at 11:49.

LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Thursday, November 8, 2012
9:30 AM - 11:30 AM

AQUA Conference Room
Main Lobby
AGENDA

I. Introductions

II. Approval of September and October 2012 minutes

III. Future meeting dates:
The next Lead Commission meeting is scheduled for Thursday, December 6, 2012 at MDE in the AQUA Conference Room – Front Lobby, 9:30 am – 11:30 am.

VI. Agency Updates
- A. Maryland Department of the Environment
- B. Department of Health and Mental Hygiene
- C. Department of Housing and Community Development
- D. Baltimore City Health Department
- E. Office of Childcare
- F. Maryland Insurance Administration
- G. Other Agencies

VII. Public Hearing on CDC Recommendations for follow-up of children with BLLs 5-9µg/dL. Two questions will be considered:
- A. How should the new CDC guidelines influence current protocols for referral and case management, particularly for children with a confirmed blood lead between 5 and 9 micrograms/deciliter (mcg/dL)? In particular, should local health departments have the same response for children with blood leads between 5-9 mcg/dL as they do for those children with blood leads of 10 mcg/dL and above?
- B. What is the most appropriate management of children who have previously had blood lead levels between 5-9mcg/dL?

Lead Commission Hearing Issues

For children with NEW BLLs 5-9:

Provide educational materials to providers and parents and serve as a resource, but do not provide active case management.

Active case management – MDE to notify local HD, local HD to contact family and health care provider

No resources available for local HDs to do any case management at this level

Medical home to provide follow-up

Develop demonstration programs

Provide training for primary care providers

- On-line materials
- Professional training format

Consider outreach to groups, populations rather than on individual level

Look at issuing Notice of Defect for children with BLL 5-9 where defects are present

Continue to encourage collaboration

Historic Cases of BLLs 5-7

- Go back 2 years, provide investigation and case management services
- Beyond 2 years, make educational materials available
- Send letters home to parents through school system; give school nurses access to lead registry
- Go back 5-6 years, or children who have not yet entered puberty
- Look back 3 years only, if at all

Additional resources for primary prevention (housing)

Request funding for a window replacement program

Improved access to state and grant programs for housing resources

Make resources for relocation available outside Baltimore City

Expand Housing Choice Voucher program to other jurisdictions

- Do we need increase in number of housing choice vouchers?

Invest in additional hazard control

Address issues in owner-occupied housing

Improve compliance with primary prevention efforts

Examine option for Medicaid funding for housing intervention (Rhode Island model)

Improve public access to on-line information:

- Info about individual properties (leadsafehomes.info) including inspection and compliance data

Additional resources for local health departments

Ensure that local health departments are reimbursed for environmental investigation services to Medicaid recipients

Provide additional resources for case management and follow-up at local level

More funding to local health departments

- XRF resourcing, dust wipe testing
- Nursing case management staff
- Translator services

Match funding of local HDS to identified need (need for targeting plan)

Ensure that all local health departments provide case management home visits to children with BLL of 10 and above.

ID counties currently not making HVs at BLLs of 10+ and 15+

Ensure adequate staffing to provide nurse case management to all cases of 10+ (we currently do not have that capacity)

Change in approach or resources – primary prevention

Increase targeting of Eastern Shore and Western Maryland

Develop interactive education program on maintenance of lead-safe housing

- For home owners and rental property owners
- Invest in community education so families know what to do to stay safe

Consider immediate clean-up as strategy to reduce hazards prior to LT intervention

Find additional $ for interventions

Work smarter and more efficiently – green and healthy approach

Find additional funds for weatherization and tie to lead hazard control efforts

Further invest in primary prevention

Increase resources

<u>Change in approach – secondary prevention</u>

Pursue Medicaid funding for case management (have now for EI)

Increase targeting of Eastern Shore and Western Maryland

Ensure investigations will look at all sources of lead, including home, soil, water, playground, cookware, medications,e tc.

Ensure standard requirements and protocols for CM and EI across state and resources needed to conduct this work.

Standard for case management - every case needs home visit from case manager

Ensure oversight of county follow-up of children with BLLs of 10+

Clarify requirements for follow-up testing by insurers

ID counties currently not making HVs at BLLs of 10+ and 15+

<u>Changes to infrastructure or laws</u>

Amend laws where needed to CDC reference level, rather than BLL of 10 or "of concern"

Adapt new reference level

Change law

Multi-family housing approach: If lead hazards identified in one unit, all units must be similarly treated unless inspection rules out problems in other units.

Invest in surveillance testing and reporting

Re-open blood and environmental lead laboratories at DHMH

Laboratory Issues

Ensure venous testing, with proper sampling supplies

Look at lab protocols and equipment issues

- Is LOD low enough?

Provide additional oversight of private labs

Other

Eliminate fluoride

Recommend special water pitchers

Testimony before the Maryland Lead Poisoning Prevention Commission by

Kenneth J. Strong
Deputy Commissioner
Division of Green, Healthy and Sustainable Homes
Baltimore City Department of Housing and Community Development

November 8, 2012

Public Meeting on Management of Lead in Maryland

A Moral and Professional Imperative

I speak to you this morning on this very important public policy related to the health of a great many children in the State of Maryland and their futures wearing both a professional and a personal hat. I am the Deputy Commissioner of Green, Healthy and Sustainable Homes in Baltimore City's housing department and one of the local government officials responsible for responding to the unfinished business of preventing childhood lead poisoning. I am also a father and a citizen and I cannot divorce my personal feelings and my values from this public policy issue. This is why I say that bringing everything we have to bear on the response to children who we know already have been poisoned at levels of five and above, and preventing more children from being poisoned at that level or any level is a moral and professional imperative.

I use the word "poisoning" liberally and intentionally. The Centers for Disease Control and government agencies use nuanced terms such as "reference levels" and "levels of concern" which undermines the urgency of what the CDC determination this spring was and how it should be read. I read it as an emergency alarm and a call to arms. It said that the best scientific and medical evidence in the nation concludes that there is no safe level of lead in the blood of children, and that there

are certainly negative and lifelong consequences for the medical, social and mental health of children testing at five and above. So I read the report to say that children at this level, and even below this level, are effectively being poisoned, most often by the hazards of lead paint in their home environments. And I suggest as a society and as government agencies we must treat these facts about childhood lead poisoning as true emergencies.

How does that translate in terms of public policy and how federal, state, and local agencies should respond to the unfinished business, and the continuing crisis of children being poisoned by lead even as we speak.

First of all, we must intensify and invest in public information and community education on what families could do right now at little or no cost to reduce the risks of lead paint poisoning in homes. In the same way that every parent knows that keeping toxic medicines in medicine cabinets out of the reach of children to prevent accidental poisoning, we have to ensure that every parent knows that lead paint chips and lead paint dust is just as toxic and that focused cleaning and home maintenance can prevent poisoning.

Secondly, we must intensify and invest in surveillance, testing, and reporting. Our current efforts are not enough and not good enough when measured against the crisis and emergency of children being poisoned. The CDC's response to their own report, reducing investment in the very resources that could identify which children are most at risk of poisoning, makes me want to scream, "don't you read your own reports and don't you care about what they mean." I'm speaking of the agency as a whole not people working within it. So that means at the state and local level, we who had read and care about this report need to find the will and the resources to

do more and to do better.

Third, we must intensify and invest in our immediate and urgent response to the known cases of children testing with lead in their blood systems at five and above. Health professionals need to be in that home as soon as possible to explain to the family what those tests results mean, what families can be doing immediately to reduce and prevent lead poisoning, and assess the healthy home needs of that family. This should lead as soon as possible to a referrals, case management and action, coordination of healthy homes improvements, helping homeowners and enforcing laws upon landlords. If, in order to do this, the legal model of health code violations that current exists for children testing at ten and above is needed, I am all in favor of it. It will and should require greater governmental investment, at all levels of government, in the first responders in our health departments.

Finally, I recommend that we reflect upon on the great things we have done together, examine closely what has worked, because the reduction of lead paint poisoning oat the higher levels year after year for more than a decade is a public health success story. And within that story are many lessons that inform my earlier recommendations. Uniquely in Baltimore, we have weaving a way of doing business in government and in partnership with the non-profit community. The Green and Healthy Homes Initiative in Baltimore is real. We have been paving the way for comprehensive home improvements that make houses green, healthier and more sustainable. We are also pioneering comprehensive benefits analysis and healthy home improvements programs so that we bring resources to address the financial health of a family as well as the physical conditions of the home. Housing is a health issue and poverty is a health issue. To meet the challenges ahead and most particularly the challenge laid out by the CDC report, we need to work more

efficiently and effectively together. We're doing that in Baltimore. We're doing with the Coalition to End Childhood Lead Poisoning every time we weatherize a house that is also get lead abatement work/. We're doing it with non-profit partners and the Johns Hopkins School of Nursing when we braid fall and injury prevention for seniors with lead abatement in multi-generational households. We're doing it when we help a family qualified for food stamps the assistance they are entitled to and which also makes their family healthier. We're doing it when we look at whole families and whole houses and we say what are the services that make this house and this family healthy, safe, efficient and sustainable.

So that's the challenge I see in the CDC report and that's the challenge that I hope this hearing and this commission will meet. We have to summon the resources for more education, more code enforcement, more physical removal of lead hazards, and more coordinated healthy home services to more households. And if we do that, we will have a continuing public health success story that will make us and our children proud.

MMHA is comprised of over seventy (70) Apartment Owner/Managers representing about one hundred twenty thousand (120,000) apartment units in the Baltimore area. It is an affiliate of the national Apartment Association.

The Department has asked for comment on two questions:

1. How should the new CDC guidelines influence current protocols for referral and case management? In particular, should local health departments have the same response for children with blood leads between 5-9 mcg/dL as they do for those children with blood leads of 10 mcg/dL and above?
2. What is the most appropriate management of children who have previously had blood lead levels between 5 – 9 mcg/dL?

MMHA submits for the record and minutes of this hearing the following observations relevant to these issues that are of serious concern to multifamily property owners who are often part of the Health Department's lead exposure investigations.

1. The new Reference Value is intended for use in currently found levels from current test results. The Reference Value should NOT to be retroactively applied to test results gathered over the last 21 years. To do so will result in a case management volume that cannot be reasonably addressed in any meaningful way and will lead to exponential increases in litigation exposure for responsible rental property owners.
2. Venous Blood Lead Levels must be the only trigger for Case Management and Field Investigations. All other detection results should be addressed by educational services through mail, e-mail or telephone. We must have reliable results to trigger a field response.
3. Case Management (ENV Assessment) if performed at 5 MUST include a RISK ASSESSMENT that addresses not only the listed address (which BCHD reports in not accurate more than 30% of the time) but all secondary locations as well as the GENERAL ENVIRONMENT. With ambient dust-lead and soil-lead levels in Baltimore City being 1,000 to 60,000 micrograms of lead per square foot (dust-lead) and over 400 parts per million (soil-lead) – how are Health Department investigators providing a clear prevention and exposure picture to the parent if ALL SOURCES are not evaluated?
4. Lab results for these Reference Values must be reliable. This has been an ongoing issue regarding sample results for years where "reporting" levels of less than 10 or now 5 were not reliable-specifically as follows
    a. Lavender top tube situation. MDE and DHMH have both reported these results are not reliable. The Commission has repeatedly discussed the need for lab protocols to be followed on this issue to avoid sample contamination
    b. Laboratories – 10 to 20 years ago did not routinely set the Level of Detection at a value where the Reporting Limits could accurately represent 5 micrograms per deciliter- thus as indicated in Number 1 , above there is no reliable way to retroactively try to do case management regarding this level now.

Low Cost Ideas for Blood Lead Mitigation and IQ Retention

Agents can *reduce* or *enhance* lead absorption in an organism even as the environmental exposure is constant. . Several minerals have been found to decrease lead absorption in animal research, but the findings have never influenced providers to provide any mineral supplements either preventively or as a treatment for identified children. Offering pediatric zinc supplements can be a low cost modality in both the prevention and treatment of the low blood lead levels we are discussing today.

I am turning now to other ideas- dropping clues in a scavenger hunt – with the intention of inspiring a few of you to locate, read, then act upon, relevant information, namely,

1. How silicofluorides added to drinking water enhance lead absorption, and

2. About children's IQ loss from fluoride, irrespective of lead.

According to Masters and Coplan's epidemiological studies, silicofluorides enhance lead absorption. Children thus absorb *more* lead from a given environment if they are concomitantly exposed to silico fluorides (hydrofluorsilicic acid, H2, Si F6, and sodium silicofluoride, Na2 Si F6). This means, in Baltimore and elsewhere where lead is in a child's environment, some children could absorb less lead if silicofluorides simply were not put in the water.

The CDC and Health Canada both recommend water fluoridation. But when Health Canada advised tiny Thunder Bay, in northern Ontario, to fluoridate its water, workers at the water company decided to measure whether the addition of fluoride would leach lead from its town's pipes, *before* consenting to fluoridation. They experimented with various forms of fluoride, and found that silicofluorides leached the most lead from lead pipes, then sodium fluoride, with both forms leaching more lead than if no fluoride were added. They also determined that buffering the water could compensate to some degree.

The Army Corps of Engineers in DC did not run such a test on DC's water before the city invested in replacing lead pipes. Part of the spikes of lead in water created during the conversion could have been prevented by first halting water fluoridation, at the very least, during the tine frame of the conversion.

Lead, cadmium, and arsenic are present as contaminants in the industrial by-products used to fluoridate many Maryland water districts, thus a minute amount of lead is actually *placed* in drinking water. No assays of the waste are required when shipments are received. The amount is generally thought to be below the maximum contaminant level, MCL, but the maximum contaminant level goal, MCLG, is zero - so *no* lead should be added to water.

Most of us probably committed to preventing lead poisoning in children because we wished to help children retain their innate potential.

So let's pay attention to the international research about *fluoride's* lowering the IQ. India and China were trying to see out whether it made economic sense to invest in removing naturally occurring fluoride, indigenous to some regions there, since they have compelling water and sewage infrastucture development basic needs. So they did studies to determine whether and at what levels fluoride decreases intelligence.

The Fluoride Action network has been making these studies available on its web site for years, and sponsored the translation of Chinese research. This summer, NIEHS's publication, Environmental Health Perspectives, published a meta analysis done by the Harvard School of Public Health, which warned of the association of fluoride and neurological harm. (July 10, 2012) One of the authors, Philippe Grandjean, had earlier contributed to lead poisoning research.

Nonetheless, the Oral Health department at the CDC is still advising cities and states, to fluoridate. The funding stream for the promotion of water fluoridation should be channeled instead to programs with the potential for positive outcomes.

It took decades to elucidate and decree the existence of harm from very low levels of lead . We have an opportunity to not take as long with fluoridation. Halting water fluoridation costs nothing, needs no ongoing program, saves utilities on the costs of buying industrial waste products, and can decrease future public health expenditures and long term care costs for those with Alzheimer's Disease. (The fluoride ion enables aluminum to cross the blood brain barrier.) Adding "fluoride" to water has neurologic disadvantages for us elderly, but is perhaps most injurious to those infants whose caregivers have mixed powdered formula with fluoride- enriched tap water to make their baby bottles. Nature does not allow fluoride to get in breast milk even if the mother is herself drinking copious amounts of fluoridated water. We must take the Handle off this Pump, whether or not we are able to divert the CDC funding from the promotional pumping of water fluoridation to lead poisoning prevention programs.

Cynthia Erville, Silver Spring, MD. Fluoride Action Network, Maryland co-representative. I can be reached at 301 445 4541, or ervillec@aol.com

FAN's extensive web site is **fluoridealert.org**
links to the fluoride / IQ studies and other health citations and summaries at that site.

http://www.nap.edu/openbook.php?record_id=11571&page=222 National Academies Science bookstore site, which has the National Research Council 's 2006 book about water fluoridation online. Departments should have ordered this book in 2006.

Recommended book for historical perspective, The Fluoride Deception, Christopher Bryson Recommended book for institutional and medical issues, The Case Against Fluoride, How Hazardous Waste Ended Up in Our Drinking Water *and* the Bad Science and Powerful Politics That Keep It There, Paul Connett, PhD, James Beck, MD, PhD, H>S> Micklem, DPhil

COALITION to END CHILDHOOD LEAD POISONING

Coalition Recommendations for Guidelines and Protocols Handling Blood Lead Levels between 5-9 µg/dL

Baltimore, Maryland - November 8, 2012 - The Coalition to End Childhood Lead Poisoning promotes policies and programs to eliminate childhood lead poisoning and create Green & Healthy Homes. Founded in 1986, the Coalition has lead the efforts, in partnership with the Maryland Departments of Environment, Health, and Housing, local health departments, health care providers, and other community partners, that has resulted in a 98% decline in childhood lead poisoning in Maryland. In order to eliminate childhood lead poisoning, the Coalition works with a number of federal, state, and local governments and non-governmental organizations to advocate for primary prevention policies and the development of prevention resources. The Coalition serves as national advisor to CDC, HUD, the US Conference of Mayors and number of other agencies on lead poisoning prevention strategies.

To date, great strides have been made to eliminate childhood lead poisoning as a major public health threat but over 3,100 children are still suffering annually in Maryland from the negative effects of elevated blood lead levels. We know that the effects of lead poisoning rob children of their ability to earn, learn and live productive lives. Given the impact that lead poisoning has on children even at lower levels, it is our duty to stay steadfast and aggressive in our effort to eliminate lead poisoning in Maryland. The recent lowering of the Blood Lead Level "reference level" to 5 µg/dL by The Center for Disease Control (CDC) is a major advancement in seeing that goal come to fruition. In light of the new reference level and the CDC's conclusion that scientific research has firmly established that there is **no safe level of lead** in the human body, there needs to be significant changes at the state and local levels to manage and address the "new" cases of lead poisoning.

The Coalition presents the below recommendations, guidelines and protocols that we are confident will aid in the ultimate goal of eliminating lead poisoning and address the 2,740 new children who tested with blood lead levels of 5-9 µg/dL in 2011 and those tested in previous years.[1] While significant progress has been made in reducing childhood lead poisoning in Maryland, thousands of children, homes and communities remain at high risk for the irreversible effects that lead poisoning causes. Maryland has the opportunity to end lead poisoning if we take strategic preventive actions.

Surveillance - The goal of surveillance is to provide the general public, advocates, and local health and environmental staff with easy access to reliable information about blood lead levels in Maryland. A substantial increase in new cases of lead poisoning, based on the CDC new reference level, can be seen throughout the state including the Eastern and Western counties in Maryland. In 2011, the Western counties of Maryland had 204 case blood lead levels for children 0-72 months of age,

[1] Maryland Department of the Environment, Childhood Blood Lead Surveillance in Maryland, Annual Report 2011, http://www.mde.state.md.us/programs/Land/Documents/LeadReports/LeadReportsAnnualChildhoodLeadRegistry/LeadReportCLR2011.pdf.

resulting from venous tests. On the Eastern shore, there were 49. This is a total of 253 new cases of lead poisoning based on the new reference level. These increases occur despite the result of testing, on average, only 21.45% of the children in Western Maryland and 22.61% on the Eastern Shore respectively. As a state, there needs to be higher testing rates, reporting and monitoring if we are to have a chance at truly eliminating lead poisoning. We recommend that the Maryland Department of Health and Mental Hygiene develop a new targeted blood lead testing plan that incorporates increased resources and innovative strategies to increase testing rates for children under age 6 throughout the State of Maryland. We also recommend that the Department through regulation or the State through new legislation improve procedures to ensure that all clinicians and laboratories are reporting all cases of children with blood lead levels of 5 µg/dL or higher.

It is critical to fully integrate data systems that not only include information about childhood lead levels and laboratory reports, but also include information about the compliance history for a property owner and/or a rental unit and any lead inspection, housing code, or other related information for the property. By fully integrating child lead levels and compliance history, tenants, homeowners, advocates, the general public and local health and environmental staff can more effectively and efficiently survey the progress in eliminating childhood lead poisoning. The Coalition recommends that the MDE affected property database be fully integrated with the DAT Property Database and local lead violation and housing code databases so that the public can readily ascertain the compliance status and poisoning history of a prospective rental property.

The Coalition supports improving online public information resources regarding lead violation history by updating leadsafehomes.info, publicizing the Marylandhousingsearch.org website, putting the Coalition Lead Safe Housing Registry online in a searchable format, and including lead violations on BaltimoreHousing.org (or similar local websites) in a searchable database format. Additionally, working with municipal, county and state officials, the Coalition supports integrating a searchable database for housing code and health code violations. Identifying a lead violation as a housing code violation is key to the aforementioned integration. The Coalition also recommends that the State more rapidly implement the CDC Healthy Homes and Lead Poisoning Surveillance System (HHLPSS) to assist in more comprehensively integrating case management information with property inspection and compliance information.

Case Management and Environmental Investigation - Case management is necessary to ensure that state and local authorities have the necessary laws and resources that support prompt environmental treatment of a residence. The majority of elevated blood lead level cases in Baltimore City and all over Maryland occur in low and very low income homes. The reduction in the blood lead reference level will result in an increase in the number of low income families seeking assistance from local health departments, the Coalition and other statewide organizations and departments to address lead hazards in their homes. In Maryland, we are only testing an average of 21% of the children under age 6 and, only 34% in Baltimore City when our testing rates should be 100%.[2] As we increase blood lead testing rates and identify new children with EBLs, this will compound the problem of the lack of adequate case management, environmental investigation, and housing assistance resources for lead affected families in Maryland. As a state, Maryland needs to meet this challenge and respond accordingly with new policies and additional resources that increase testing rates while providing sufficient case management and environmental investigation. This includes developing permanent funding streams to compensate for Maryland's recent loss of

[2] See Footnote 1.

$600,000 in CDC funding for case management, environmental investigation, and surveillance staffing. In light of the ruling in 2012 to permit Medical Assistance funding to be used for medical case management and environmental investigation related services in EBL properties, the Coalition recommends that the Department pursue the regular use of Medicaid funding to supplement state and local funding for case management and environmental investigation. Reimbursement was approved by Maryland Medicaid in 2010, but Baltimore City Health Department has been the only jurisdiction to start to seek reimbursement for these services to our knowledge. This development of additional funding resources is especially important to assure that as we expand services to children at lower blood lead levels, we are able to maintain the same level of service and attention to higher level blood lead cases of 10 µg/dL and above.

With regard to case management, the Coalition believes that the current blood lead level of 10 µg/dL or above to initiate intensive case management efforts is too high and should be lowered to match the CDC recommendations to 5 µg/dL or any future reference level. The Coalition recommends that all laws, regulations, and action levels in Maryland be revised to match the new reference level. With all cases of confirmed blood levels of 5 µg/dL or higher, families should be provided with medical case management and have access to a Registered Nurse and in-home resident education that includes education on: lead's health effects, lead sources, nutrition, development and referrals to other resources. Case management should provide ongoing follow-up with reminder letters/phone calls to ensure children are being retested as needed in an effort to prevent any increases in blood lead levels. Additionally, the resources available to families outside of the City of Baltimore for relocation and lead hazard reduction are minimal. The Lead Housing Choice Voucher Program in Baltimore City has been successful in ensuring long term family stability in lead safe housing for some the highest risk lead affected families. The Coalition suggests using similar program partnerships with Housing Choice Voucher Programs in all jurisdictions in Maryland and that families with children with levels of 5 µg/dL or higher be designated as a priority for housing relocation and housing intervention resources.

There needs to be environmental investigation and mitigation strategies for every child with a blood lead level of 5 µg/dL or higher. There needs to be an increase in sanitarians to investigate and identify the lead hazards in homes for children with blood lead levels of 5-9 µg/dL. Many counties do not have health department sanitarians that are available to conduct lead inspections and for those counties that do possess sanitarians, the staffing resources are inadequate to the number that will need environmental investigation at the new reference level. Currently, there are only three MDE inspectors for the entire state of Maryland to investigate elevated blood lead levels and the potential source of the lead hazard in a home for counties that do not have a county health department sanitarian. Increasing inspection funding to allow for environmental investigation at 5 µg/dL is critical and must be a component in Maryland's prevention strategy to prevent higher level poisonings and to reduce blood lead levels below the new reference level.

In terms of the timing of the application of the new CDC reference level, the Coalition recommends that all cases from the past two years be handled under the revised policies and protocols for case management and environmental investigation. All children with blood lead levels of 5 µg/dL in the past two years who have not been previously provided monitoring and assistance, should receive case management and environmental investigation services. Clinicians, local health departments, and MDE should be monitoring the status of **all** children with a confirmed blood lead level of 5-9 µg/dL or higher for subsequent changes in blood lead level until all environmental investigations and lead hazard reduction remediation have been completed sufficient to reduce the child's blood lead level

below 5 µg/dL. This includes children for which the CDC recommendations affect retroactively. Parents with children who in the past tested with a confirmed blood lead level of 5-9 µg/dL, should be contacted and informed of the changes in the CDC reference level and what that means for their child and how they should proceed going forward. It should also provide resource information for assistance with nursing services, tenants and homeowner rights, and early childhood development assistance. The Coalition supports the CDC recommendation that clinicians report reference values to the local and state health or housing departments if no mandatory reporting exists and there should be follow up that the appropriate services and resources are provided to all families with affected children. No child should be slipping through the cracks because there is inadequate testing, there are not enough investigators, or there is a lack of case management follow up.

Primary Prevention - Primary prevention is essential to ensure that all owners have the resources to remediate lead hazards in their home and use lead safe work practices and procedures to renovate or maintain their pre-1978 residential properties at the appropriate standard of care. Strong enforcement strategies are important to ensure that the number pre-1950 rental units in Maryland that are compliant with the lead inspection and registration requirements under the Maryland Reduction of Lead Risk in Housing law increases. The number one way to eliminate lead poisoning is through primary prevention strategies that remediate lead hazards in homes before a child is lead poisoned. . Maryland should also make sure that it moves expeditiously following the passage of HB644 to obtain authorization from the EPA to enforce the EPA RRP Rule and to adopt new implementing regulations for the law. The effective enforcement of the EPA RRP Rule in Maryland will increase lead hazard reduction remediation, improve lead safe work practices in pre-1978 properties, and reduce the number of children with levels of 5 µg/dL.

Instead of dealing with lead poisoning after the fact, Maryland must be more aggressive and proactive to prevent lead poisoning from occurring at the new reference level of 5 µg/dL. To achieve the collective goal of eliminating childhood lead poisoning in Maryland, a substantial investment is needed in primary prevention funding to remediate lead hazards in homes. The greatest impediment to ending childhood lead poisoning is the lack of financial resources available to parents and rental property owners to more permanently reduce lead paint hazards in their properties. Many lower income and middle income homeowners and some rental property owners cannot afford to permanently replace windows and doors or use certified contractors to perform work safely. Lead poisoning is a 100% preventable illness but only if lead hazards are remediated in homes to prevent exposure. 90% of Maryland's leaded hosing stock can be made safe with reasonable, cost effective lead hazard reduction treatments that do not require the full lead abatement of the entire property.

The Coalition also supports the CDC recommendation that if a lead hazard is identified in any unit within a multi-family housing complex, the same response must be applied to ALL similar untested units. This is an important primary prevention tool. We should not turn a blind eye to hazards simply because a child has yet to be poisoned.

As has consistently been our position, the Coalition supports the implementation of a statewide window replacement program which is crucial to permanently reducing childhood lead poisoning in Maryland. The national evaluation of HUD funded lead hazard reduction programs showed that window replacement was a common, effective lead hazard control strategy adopted by many local

governments receiving HUD grants.[3] A substantial reduction in the number of children with elevated blood lead (EBL) at or above 10 µg/dL from 1990 to 2000 can be largely explained by window replacement and other more permanent hazard remediation measures. Data showed that lead loadings were significantly lower in rooms that underwent window replacement, cleanup and clearance. A lead safe window replacement initiative would provide enduring reductions in lead paint hazards, substantial home energy savings, improvements in affordable housing due to the grants, higher home values, and associated neighborhood revitalization. Maryland must increase the availability and accessibility of lead hazard reduction grant funding for window replacement and other lead hazard reduction treatments.

Recent trends have shown an increase in the number of children with elevated blood lead levels residing in homeowner occupied properties. Improving access to loan and grant programs would help to correct lead hazards in the home, thus eliminating sources of exposure. The current process for the State of Maryland Lead Abatement Program administered by DHCD can be arduous and often challenging for low income families who are most at risk for lead poisoning and have the greatest need. Low income families are challenged to navigate the application process due to their inability to complete the underwriting process for the grant or loan. Under other income based programs like HUD, these families would also often qualify housing intervention funds if such funding was available in their regions and could more readily access those funds if the process were simplified.

Outreach and Education -The establishment of a reference level of 5 µg/dL increases the need for training to residents, homeowners, rental property owners, property management personnel, and contractors on lead sources, lead effects, and essential maintenance practices and lead safe work practices that are needed to safely maintain homes constructed prior to 1978 in order to prevent children from being exposed to lead hazards. There needs to be an increase in compliance assistance education, training for rental property owners on the Environmental Protection Agency (EPA) Renovation, Repair and Painting, federal Title X, the Lead Safe Housing Rule and the requirements of all local and Maryland rules.

The increasing percentage of children with elevated blood lead levels who reside in homeowner properties dictates that new outreach strategies need to be employed to reach homeowner populations. There needs to be an increase in targeted outreach and education in Western Maryland and the Eastern Shore due to the amount of affected properties there, the age of the housing stock, and the number of children who are affected by the new CDC reference level. There needs to be an increase in information available through already existing programs in these counties, including but not limited to local pediatricians and other healthcare providers, Woman, Infants and Children (WIC) Programs and the local Department of Social Services. The Coalition supports providing demonstrations and examples of lead safe housing to visually educate the tenants and property owners on a healthy, lead safe home and what lead hazards may exist.

[3] Nevin, Rick and David E. Jacobs, Windows of Opportunity: Lead Poisoning Prevention, Housing Affordability, Housing Policy Debate, 17:1 (2006) (This is the source for all of the information in this paragraph).

Thank you for your consideration of these recommendations.

Coalition to End Childhood Lead Poisoning
Ruth Ann Norton, Executive Director
2714 Hudson Street, Baltimore, Maryland 21224
410-534-6447 or 800-370-LEAD
www.ghhi.org

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein M.D., Secretary

Prevention and Health Promotion Administration

Donna Gugel, MHS, Acting Director

Bonnie S. Birkel, CRNP, MPH, Acting Director, Maternal and Child Health Bureau
Clifford S. Mitchell, MS, MD, MPH, Director, Environmental Health Bureau
Kelly L. Sage, MS, Acting Director, Cancer and Chronic Disease Bureau
Deborah B. McGruder, MPH, PMP, Director, Infectious Disease Bureau

October 26, 2012

To Persons Interested in Lead Poisoning Prevention:

As a person interested in lead poisoning prevention, I would like to inform you about a public meeting being held by the Maryland Lead Poisoning Prevention Commission. This meeting is being held to address important questions resulting from recent recommendations of the U.S. Centers for Disease Control and Prevention (CDC).

Maryland Lead Poisoning Prevention Commission
Public Meeting on Management of Lead in Maryland
Thursday, November 8, 2012
Maryland Department of the Environment
1800 Washington Boulevard
Baltimore, MD 21230
9:30 AM – 12:00 PM

The Commission has been asked by the Department of Health and Mental Hygiene to provide input into two questions related to the CDC's recent recommendations that now provide a reference level of 5 micrograms/deciliter (as opposed to the former "level of concern" of 10 micrograms/deciliter). The two questions of concern for the Department are:

1. How should the new CDC guidelines influence current protocols for referral and case management, particularly for children with a confirmed blood lead between 5 and 9 micrograms/deciliter (mcg/dL)? In particular, should local health departments have the same response for children with blood leads between 5-9 mcg/dL as they do for those children with blood leads of 10 mcg/dL and above?
2. What is the most appropriate management of children who have previously had blood lead levels between 5 – 9 mcg/dL?

201 W. Preston Street, Baltimore, Maryland 21201
410-767-6742 Fax 410-333-5995
Toll Free 1-877-4MD-DHMH TTY for Disabled
Maryland Relay Service 1-800-735-2258

500 N. Calvert Street, 5th Fl, Baltimore, Maryland 21202
410-767-5227 • Fax 410-333-6333 • TDD for Disabled 410-333-4800
Toll Free 1-800-358-9001 • TTY for Disabled
Maryland Relay Service 1-800-735-2258

Web Site: http://ideha.dhmh.maryland.gov or http://fha.dhmh.maryland.gov/

The Commission invites interested members of the public and health care community to attend the meeting and present their opinions on these questions. If you would like to attend and need more information, please contact the DHMH environmental health help line toll-free at 1-866-703-3266. If you wish to submit written testimony, please provide the Commission with 20 copies.

Sincerely,

Clifford S. Mitchell, MS, MD, MPH

INFORMAL COMMENTS
CONCERNING

Management of Childhood Lead Exposure

Ending September 28, 2012

1. Jennie Holmes
2. John Dugan
3. Verna Garrett
4. Sara Smith, RN
5. Eunice Dube R.N.
6. Elizabeth M. Ruff, M.D. and Penny Bramlett, R.N., Carroll County Health Dept.
7. Nancy J. Miller, M.S.N., FNP-BC

MARYLAND

Lead Poisoning casemanagment regs

Jennie Holmes (DHMH) <jennie.holmes@maryland.gov> Tue, Sep 11, 2012 at 2:48 PM
To: regs@dhmh.state.md.us

As a public health nurse I feel obligated to respond to the proposed alternatives for case management.
1. I agree that this first alternative would lead to a rise in workload for health departments not only due to the lowered level, but also because MCO's and private insurance do not offer care management for children with lead poisoning.
2. As for alternative # 2, the primary providers for the most part are not up to date with the care management protocols and rely heavily on the local heath departments for direction. This would not take the workload off the local health departments, but instead increase it.
3. Locating children with historical levels between 5-9 could probably be accomplished by extrapolating them from the lead registry, as our LHD enters those results, if not already done by MDE from notification from labs.
4. Another concern in "looking back" is the responsibility of the LHD once the child has been identified is first to try to locate them. another is the responsibility to the school system in reporting more current lead levels to them for children who have already entered into the school system, referrals to Infants and Toddlers or Child Find, as well as WIC as Lead Poisoning is a "high risk " factor requiring referral to those listed.

—

Jennie Holmes R.N., M.S.N.
Program Manager
Caroline County Health Department
403 S. 7th St.
P.O. Box 10
Denton, MD 21629
410-479-8015
Quote: "Remember you never get a second chance to make a good first impression"
jennie.holmes@maryland.gov

MARYLAND

Comment on Management of Childhood Lead Exposure

rosiedean@speakeasy.net <rosiedean@speakeasy.net> Wed, Sep 12, 2012 at 8:11 AM
To: regs@dhmh.state.md.us

The first comment I have is that if your department is so incompetent to refer to the levels as 5 and 10 mg/dL (milligrams per deciliter) as opposed to the correct levels of ug/dL (micrograms per deciliter) then you should get another job. Not only is the level incorrect once – it is incorrect throughout both your posts.

The real point is that these regulations are unneeded. You have created an industry based on lead levels and now it needs more work. The number of children damaged by lead paint in Baltimore City is miniscule compared to the number of children damaged by our underfunded public schools or the lack of crime control. It is a butter or guns scenario where the money spent chasing the last vestiges of lead exposure take away from the real problems that affect our children. Please insert some sanity into the public policy (that you clearly don't understand if you are referring to milligrams rather than micrograms - 3 orders of magnitude).

If the economy were better, I would suggest you all get better jobs. This is a waste of time and money.

Sincerely

John Dugan

443-320-2246

Phone Comment Regarding Childhood Lead Paint

Date: 9/13/12
Call received from: Verna Garrett 410-935-1736
Call taken by: Michele Phinney (ORPC) x75623

Ms Garrett doesn't know what would be best way to handle this.

The parents don't take the children to the Doctor to begin with.

Does the State have enough employees to follow up with the children who are born to determine whether they have been or should be tested for lead paint poisoning?

Very concerned about the children, but doesn't know how this would work...

MARYLAND

Fwd: public comment lead

Michele Phinney <Phinneym@dhmh.state.md.us>
To: dhmh.regs@maryland.gov

Fri, Sep 14, 2012 at 8:13 AM

>>> On 9/14/2012 at 8:01 AM, in message <5052E72C.034A.00E5.0@dhmh.state.md.us>, Sara Smith wrote:

107 South Shore Rd

Elkton, MD 21921

September 14, 2012

Michele Phinney, Director

Office of Regulation and Policy Coordination

Department of Health and Mental Hygiene

201 W. Preston St

Room 512

Baltimore, MD 21201

Dear Ms. Phinney,

I was recently made aware of the request for comment on the management of childhood lead exposure. I am a nurse for our local health department and have been involved in our lead program, educating providers and families for the past 10 years. I live in a small county with a population of about 101,000 people. We certainly don't see as many children with elevated lead as some of our counterparts, but are absolutely devoted in our belief that one child is too many!

I would like to offer the following suggestions that I feel could work for our county.

As for the first alternative: to continue current case management strategies with the now lower levels, this would create quite a hardship for our county. Without any financial support there would not be enough personnel to handle the number of referrals the new lower levels will generate.

Alternative number 2 seems more feasible if no financial support is provided. Our providers and the local health department have a very good working relationship and have worked collaboratively in the past to benefit clients. The managers and providers would need educational material to give to the families and reassurance that the local health department is always available for any questions or concerns. Providers have been mandated prior to this year to screen families for risk factors, so this actually wouldn't be new to them. I would like to add to this alternative that if 2 consecutive blood lead levels were between 5 and 9, then a referral to the local health department is warranted. Our local health department would continue to case manage all blood lead levels of 10 or over.

As for the management of children that were previously tested, I would like to offer this solution. For children that had blood lead levels between 5 and 9 in the past 5 years, a form letter be customized by each local health department and given to the parents. Locating the families will be the largest issue. May I suggest that the letters be given to the school system to send home with any child that is school age. (The letters would be in sealed envelopes with only the child's name on the outside of the envelope, thereby we wouldn't break any HIPAA laws.)

While we are working on lead issues, could we look into having the school nurses be able to access the lead registry? This would be beneficial to the schools and the families. If school nurses were able to access the registry, the blood level certificates could be completed by the school nurses. The school nurses in our county are able to access ImmuNet and are now able to access immunization history without contacting our office. If school nurses were able to access the lead registry, physicians/office personnel would not have to take time from their day to fill out the certificate. Families are often billed a fee to even fill the certificate out.

Thank you for giving me the opportunity to offer my suggestions.

Sincerely,

Sara Smith, RN

MARYLAND

Comments on Management of childhood lead exposure per DHMH request

Dube, Eunice <edube@howardcountymd.gov> Fri, Sep 21, 2012 at 12:25 PM
To: "regs@dhmh.state.md.us" <regs@dhmh.state.md.us>
Cc: "Osborne, Lisette" <losborne@howardcountymd.gov>

"How the new CDC Guidelines should influence current protocols for referral and Case Management"

I agree with option # 1 of the Department's alternative , and to include:

1. Lab notifies Pediatrician(PMD) of all lead levels, and MDE of levels 5 and over; MDE then notifies LHD;

2. CHN then contacts family by phone for levels 5-9 to ensure they have information, and have access to a Pediatrician in their neighbourhood for child surveillance Is it necessary then to test them every 3 months and what is the cut-off point e.g 2 consecutive levels below 5? Continue existing protocol for levels 10 and over. What are the financial/health insurance implications for this added surveillance?

3. PMD and LHD to continue liaison with each other and the family.

4. Depending on size of caseload, resources may have to be increased for that LHD(e.g. there is no allocated time for lead management in our LHD since cases have been so few. It's all part of generalized community health nursing).

5. "Look-back" could go back 5-6 years to "catch" those kids who were tested at age 12-18 months , or those currently pre-pubertal to assess behavior and iron levels in addition to current lead levels in line with their routine adolescent health screen.

Eunice Dube R.N.

Community Health Nurse

Howard County Health Department

7180 Columbia Gateway Drive

MD 21046

Tel. 410 313 7568

MARYLAND

Management of Childhood Lead Exposure

Elizabeth Ruff (DHMH) <elizabeth.ruff@maryland.gov> Mon, Sep 24, 2012 at 12:51 PM
To: regs@dhmh.state.md.us

Comments on proposal.
The following points should be taken into account:
1. The PMD or clinic that ordered the Lead test is the first to know the result. The LHD is notified of elevated blood lead levels by MDE — and generally the time involved is dependent on the blood levels, and ranges from 24 hours to days.
2. We feel that the PMD should be responsible for education re. lead ingestion, nutritional education, assessing the source of exposure, and repeating and tracking the blood lead level.
3. The Local Health Dept. will continue to be involved in cases where the blood level is greater than or equal to 10mg/dL (i.e. case management and tracking). We no longer have the staff to do more than this.
4. Given the current lack of funding, the LHD cannot provide individual intervention for children with blood levels between 1 and 9 mg/dL.
5. Re. "look-back" at those children with a history of levels of 5-9 mg/dL, if MDE has the capability to outreach to these families, only the past three years should be looked at.

Elizabeth M. Ruff M.D.
Penny Bramlett R.N.

–
Elizabeth M. Ruff M.D.
Deputy Health Officer,
Carroll County Health Department,
Westminster, MD

Tel: 410-876-4927

MARYLAND

Lead case management comments

Nancy Miller <nancymiller143@gmail.com> Thu, Sep 27, 2012 at 11:01 PM
To: regs@dhmh.state.md.us

The primary care provider should assume responsibility for the follow up of children with BLL <10 mcg/dl for the following reasons:

1) MCHP provides coverage for lead testing for the majority of Maryland children that do not have private heatlh insurance; these children are enrolled in MCOs where they should be routinely screened for lead exposure at age 1 and 2 years. Essentially all children in Maryland should have a primary source of care.

2) Quality health care is achieved by having a medical home where the care is delivered by a consistent provider. Adding the Local Health Department (LHD) staff creates unnecessary fragmentation.

3) Primary care providers have been required to test children who live in or have ever lived in at risk zip codes for several years; they are already experienced in providing case management for these children.

4) LHDs do not have adequate resources and manpower to take on an additional mandate; they should continue to use their expertise in the coordination of care of children with higher levels of exposure.

5) Parents of children who have had BLL of 5-9 mcg/dl should have already been counseled by their primary care providers. Any further notification should be done by the primary care provider.

Thank you for the opportunity to comment on these regulations.

Nancy J. Miller, M.S.N., FNP-BC

DECEMBER 6, 2012

LEAD POISONING PREVENTION COMMISSION MEETING

MEMBERS

Governor's Lead Commission Meeting Attendance Sheet

12/6/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

Name/Signature	Representing	Telephone/Email
CONNOR, Patrick PC	Hazard ID Professional	
DWYER, M.D.Maura	Department of Health and Mental Hygiene	
HALL, Cheryl	Office of Child Care	
HORNIG, Karen Stakem	Maryland Insurance Administration	
JENKINS, Melbourne	Property Owner Pre 1950	
LANDON, Edward	Dept. Housing and Community Dev.	
McLAINE, Patricia	Child Health/Youth Advocate Pat McGuire	
MOORE, Barbara	Health Care Provider Barbara Moore	
OAKS, Nathaniel (Delegate)	Maryland House of Delegates	
ROBERTS, Linda Lee	Property Owner Post 1949	Same
SNYDER-VOGEL, Mary	Child Advocate	
VACANT	Secretary of the Environment or Designee	
VACANT	Local Government	
VACANT	Parent of a Lead Poisoned Child	
VACANT	Financial Institution	
VACANT	Child Care Providers	
VACANT	Insurer	
VACANT	Property Owner Pre 1950 Outside Baltimore City	
VACANT	Maryland Senate	

GUESTS

Governor's Lead Commission Meeting Attendance Sheet

12/6/2012

PLEASE NOTE: This sign-in sheet becomes part of the public record available for inspection by other members of the public.

Name	Representing	Address/Telephone/Email
Ron Winehol[illegible]	AOBA	rwinehol[illegible]@aoba-metro.org
John Krupinsky	MDE	jkrupinsky@mde.state.md.us
Shaketta Denson	CECLP	sdenson@leadsafe.org
Patrick McKenna	DHMH	patrick.mckenna@maryland.gov
Ken Strong	Balto. City HCD	ken.strong@baltimorecity.gov
Lisa Horne	DHMH	lisa.horne@maryland.gov
Dana Schmidt	MMHA	dschmidt@mmhaonline.org
Sara Reese-Carter	DHMH	s.reese-carter@maryland.gov
Rita [illegible]	UMB	lovelyrita.ay@gmail.com
Hosanna Asfaw-Means	BCHD	hosanna.asfaw-means@baltimorecity.gov
Horacio Tablada	MDE	
Tamara Aviles	MWPH	1708 W. Rogers Ave 21209
Ruth Ann Norton	CECLP	
~~Shaketta Denson~~	~~CECLP~~	
Dana Webster via phone		

LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Thursday, December 6, 2012
9:30 AM - 11:30 AM

PATUXENT Conference Room
6th floor
AGENDA

I. Introductions

II. Approval of October and November minutes

III. Future meeting dates:

The next Lead Commission meeting is scheduled for Thursday, January 3, 2013 at MDE in the AQUA Conference Room – Front Lobby, 9:30 am – 11:30 am.

IV. Presentation on the Lead Report and Recommendations of the Lead Liability Protection Workgroup – Karen Stakem-Hornig, Maryland Insurance Administration
The final report is now posted on our website, with links from both the P&C Reports page and the Legislative Information page:
http://www.mdinsurance.state.md.us/sa/docs/documents/home/reports/leadfinalreport.pdf

V. Discussion of the testimony from the November 2012 hearing

VI. Proposal for Recommendations to DHMH

VII. Agency Updates

A. Maryland Department of the Environment
B. Department of Health and Mental Hygiene
C. Department of Housing and Community Development
D. Baltimore City Health Department
E. Office of Childcare
F. Maryland Insurance Administration
G. Other Agencies

VII. Public Comment

NOTE: please review the 2011 Annual Report, Childhood Blood Lead Surveillance in Maryland which can be found by clicking (ctrl/click) on this link: http://www.mde.state.md.us/programs/Land/LeadPoisoningPrevention/HealthCareProviders/Pages/Programs/LandPrograms/LeadCoordination/healthcare/index.aspx and send any questions or concerns to Tracy Smith prior to our January 3, 2013 meeting

GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

APPROVED Minutes (2/7/13)
December 6, 2012

Members in Attendance

Patrick Connor, Cheryl Hall, Karen Stakem Hornig, Pat McLaine, Barbara Moore, Linda Roberts.

Members not in Attendance

Dr. Maura Dwyer, Mel Jenkins, Ed Landon, Delegate Nathaniel Oaks and Mary Snyder-Vogel.

Guests in Attendance

Shaketta Denson – CECLP, Hosanna Asfaw-Means, Rita AuYeung – UMB student, Ron Wineholt – AOBA, Donna Webster – WCHD (via phone), Ruth Ann Norton – CECLP, Lisa Horne – DHMH, Sarah Reese-Carter – DHMH, Ken Strong – HCD Baltimore City, Dana Schmidt – MMHA, Patrick McKenna – DHMH, Tamara Aviles – MWPH, Horacio Tablada – MDE, John O'Brien – MDE staff, John Krupinsky – MDE staff, and Tracy Smith – MDE staff.

Introductions

Pat McLaine began the meeting @ 9:40 A.M. with introductions. Not enough members were present for a quorum and there will be no voting or actions. DHMH's proposals will be handled via e-mail and there will be suggestions only for October and November minutes.

Approval of Minutes

Several corrections were suggested for the October and November minutes and provided to Tracy Smith. Ken Strong commented that the minutes of the November hearing captured the testimony well. Approval of the minutes was deferred until the January 2013 meeting.

Future Meeting Dates

The next scheduled meeting is Thursday, January 3, 2013 at MDE. The Commission will meet from 9:30am - 11:30am.

Discussion

A. Presentation on the 2012 Summer Study Group

Commissioner Karen Stakem-Hornig from the Maryland Insurance Administration reviewed the findings from the report of the legislatively mandated 2012 Lead Liability Protection Workgroup. The report is available at: http://www.mdinsurance.state.md.us/sa/docs/documents/home/reports/leadfinalreport.pdf . The workgroup looked at four issues: (1) feasibility of encouraging private marketplace to offer insurance; (2) feasibility of establishing other mechanisms; (3) feasibility of establishing a state

insurance fund; (4) Availability of risk management tools (insurance, bonds). The conclusions of the work group were:

1) Some private insurance is available but not generally affordable for landlords with small numbers of properties that are not certified lead free
2) There are limited options for unique products – e.g. Risk Retention Groups – but these are probably not available for landlords with small numbers of properties
3) A state insurance fund is not economically feasible. The workgroup estimated that $2.1 billion would be needed in initial reserves. The fund would have to be funded by all owners, with a $5230 per unit start-up fee. Annual premiums would be borne by the insured pool. This would support insurance claims going back 21 years (18 plus 3 years); to support going back 21 years would require $4.2 billion in initial reserves.
4) Other options – Eastern Shore landlords had suggested that any state funds should be used to incentivize landlords to improve conditions of their properties. The qualified offer provision could be altered to withstand Court of Appeals scrutiny (this would require amending the act).

Ruth Ann Norton made a comment that the qualified portion of the previous law cut off at the age of six (6). The $7500 in medical is typically not used because the children are covered by Medicaid. Karen Stakem-Hornig indicated that the qualified offer had been used eighty-three (83) times.

The issue of liability on lead paint manufacturers would require a change in state laws and one must be able to prove where the paint came from. Karen Stakem-Hornig indicated that a Maryland Automobile Insurance Fund type of approach was also not feasible for lead paint. Ruth Ann Norton commented on the commendable job of work study group.

B. Review of testimony from the November, 2012 hearing.

Pat McLaine began the discussion with the two questions from DHMH: how to handle new blood lead levels of 5-9μg/dL and, b. what to do about historic cases of 5-9μg/dL. Other concerns include resource issues (i.e. primary prevention by health departments) and lab issues. The Commission will vote on a set of recommendations, which will be approved via e-mail as only five of the eleven Commission members were present at this meeting. [At least six (6) members are needed for a quorum.] A four page summary highlighting issues raised at the hearing was distributed to help guide the discussion.

Barbara Moore indicated that the hearing went well and many of the comments had been previously identified by the Commission's workgroup. She expressed concern about lack of resources. Karen Stakem-Hornig noted that the take-away was budgetary issues and pressure, especially on local governments. The presentation on fluoride provided a perspective about lead that goes well beyond paint.

Patrick Connor questioned what counties' responses will be at blood lead levels of 5μg/dL if they are already not responding at 10μg/dL. Patrick Connor also asked why we continue to perform

modified paint inspections rather than risk assessment using Chapter 16 of the HUD Guidelines (investigations for elevated blood lead levels) that have been procedures/recommendations in place since the early 1990s. Patrick Connor expressed concern that that limited lead-based paint testing based on Chapter 7 of the HUD Guidelines state is not sufficient for children with elevated blood lead levels.

Pat McLaine commented that the whole purpose of CDC's recommendations is primary prevention. Maryland does not have adequate resources for follow-up at the level of 10μg/dL and the state does not have an unlimited budget. Regulations require properties to pass a dust test with no chipping, flaking, or peeling paint. Systems in place include on-line registration (of rental properties) and authority for health departments to order abatements. Problems in owner-occupied properties are still not adequately addressed but there will be some improvements with implementation of RRP. Maryland is doing better with regards to funding than other states; some have lost programs. Emphasis should be on primary prevention, making housing safer in Maryland, and (limiting) missed opportunities.

Ruth Ann Norton suggested that the Commission consider a five year fund focused on primary prevention and highest risk properties. Housing assessment is key – how can we use primary prevention resources to prevent initial exposure? Ruth Ann Norton cited studies in Rhode Island that have found that a one dollar investment resulted in a $200 return. She suggested triaging homes at highest risk and enforcing to a clear standard. Setting aside a pot of money is key – it is time to end this problem. Ruth Ann Norton suggested meeting with housing commissioners to find out what they need to end this problem. She suggested focusing on protecting children, not chasing them around.

Patrick Connor commented about the need to expand our focus on the child's environment. Including but not limited to the need to clean up city parks and accessible areas where children play that have more than 400 ppm of lead in the soil.

John Krupinsky commented that clear guidance was available from CDC's 2010 primary prevention manual. Ken Strong indicated that an additional $19 million had been made available by the Public Service Commission to Baltimore City for a more flexible approach. Housing conditions are big inhibitors to solving lead problems and this will support repairs to roofs, heating systems, etc. The state also has an allocation from the State Public Service Commission.. Other federal, state and local housing programs may provide opportunities to increase the stock of lead safe properties.

Pat McLaine asked if MDE and local counties were addressing properties where more than one child had been poisoned. Patrick Connor commented that education for compliance is not getting out to the public. Ruth Ann Norton and Pat McLaine commented about education being part of the law and that tenants have a right to get lead hazards in their homes addressed. Pat McLaine commented that not enough tools are available for owner-occupied properties and that education

alone won't work. Ruth Ann Norton commented that the education of property owners and contractors does work.

Cliff Mitchell noted that the conversation about primary prevention was helpful but asked what a clinician and a local health department should do if a child has a BLL of 7μg/dL.

Pat McLaine suggested that health care providers could possibly identify at risk housing situations (example – children spending time on porches with peeling chipping paint) where follow-up would be needed and could provide general education about how to stay safe. Providing pictures of at-risk conditions to health care providers would help with assessments. Concern with accuracy of blood lead tests is also a concern. Cliff Mitchell asked who would be responsible: doctors, health departments, MDE staff? John Krupinsky commented that there is a lack of awareness of a high risk questionnaire.

Donna Webster explained how the follow-up process for children with BLLs of 5-9μg/dL worked on the Eastern Shore. She mails packets out to families of children with BLLs of 5-9μg/dL containing information on primary prevention, RRP, grant/loans, information appropriate for rental or homeowner, dieting and eating. The age of the property is checked using the Department of Assessment and Taxation (DAT) on-line database. Follow-up calls are placed to the family to complete the Environment 6-8 questionnaire. Further investigation is done if the house is a rental property. The Environment 6-8 questionnaire is used for owner occupied properties to identify at-risk conditions. Families are advised to obtain a second blood lead level test within 1 - 3 months.

Of 48 children in Wicomico County with BLLs between 5-9μg/dL identified in one quarter, living in 47 properties:
* 36 were rental properties (77%), 11 were owner-occupied
* 26 were constructed pre-1950 (54%), 12 post-1978, 9 pre-1978.
* Eight Notice of Defects were completed.

Donna reported that the challenges for the Health Department included difficulty finding parents, residents refusing to provide information, many families renting, and occupants being unable to move/relocate from housing in poor condition.

Pat McLaine commented that families may be reluctant to complete a Notice of Defect because they fear landlord retaliation. Ruth Ann Norton commented that people maybe fearful and less likely to file if government is involved. Partnering with legal or tenant advocacy services for Notice of Defects may be needed. Donna Edwards commented that concern of eviction was a real fear for tenants on the Eastern Shore. Shaketa Densen commented was made that the situation on Maryland's Eastern Shore may be different the rest of the state. The Notice of Defects process was explained. By law, tenants have the right to file a Notice of Defect if they identify potentially hazardous conditions in their rental unit and the landlord has 30 days to

correct the problem. The notice is signed and sent in triplicate by certified mail. Anyone can issue a Notice of Defect. Could this be used in the health care provider's office?
Pat McLaine commented about strategies for children with BLLs of 5-9µg/dL. Could MDE operate a hot line to check on property registration and determine if properties appear to meet standards (current registration, dust test results on file)? We anticipate six times the number of children with BLLs of 5-9µg/dL compared to 10+µg/dL.

Sarah Reece Carter noted that DHMH nurses visit health care provider offices now. Perhaps it is time to revisit taking the approach used in 1997 when DHMH staff communicated with every family medicine and pediatric practice group. Donna Webster commented that half of the physician offices in all four Eastern Shore counties had never seen HB 644 or heard about CDC's new lead recommendations. Concerns were raised about providers not completing high risk assessments and previously identified but unresolved barriers such as laboratory and transportation to draw sites and overwhelmed clinicians.

Cliff Mitchell suggested that follow-up BLL results in the 5-9µg/dL range could be referred to a local or centralized entity.

Donna Webster commented about difficulties in locating families due to incorrect addresses. The re-mailing of packets drains resources and is time consuming.

Pat McLaine suggested the commissioners think outside of the box – how might we be able to effectively improve primary prevention for six times the number of children without spending a lot of money and resources? One option would be to check addresses to see if they are in compliance; why wait until a child has a blood lead level of 10µg/dL?

Patrick Connor suggested reducing the requirements for modified risk reduction to 5µg/dL. This could be done by integrating MDE's rental data base with the Department of Assessment and Taxation's (DAT's) data base, identifying post 1950 rental properties, e-mailing Notices of Defects, and triggering compliance.

Cliff Mitchell asked if ownership information was accurate; how reliable is DAT's information? Horacio Tablada commented that the Homestead Credit ends this year, so DAT will have better information about owner occupied properties. Patrick Connor suggested that ownership information could be confirmed with the DAT data bases and notices could be sent out electronically.

A comment was made about automatic letters for BLLs < 5µg/dL and Notice of Defects for non-compliant properties with children with BLLs 5 - 9µg/dL. Ken Strong suggested that perhaps levels for intervention could be dropped over a several year period, starting with 9µg/dL, then dropping progressively to 8, then 7, etc.

Horacio Tablada indicated that MDE is looking at what they can do. MDE would like to map all entry points within the system and would like to be able to trigger compliance efforts. MDE could send letters out to owners of rental properties housing children with BLLs of 5-9μg/dL.

Ken Strong suggested that agencies should tap whatever resources are available to spread prevention. There are 5,000 home visits for energy; why can't they do something about lead?

Cliff Mitchell commented that DHMH is looking for recommendations and public health rationale to back up recommendations for health care practitioners.

Pat McLaine asked Commissioners to continue discussions on these matters via conference call later this month so that written recommendations can be approved for DHMH. She reminded Commissioners that the recommendations for "historical 5-9μg/dL" BLLs have not been discussed.

Pat McLaine commented about a lack of resources available now for public health follow-up at levels of 10μg/dL. We need to make sure that something happens when hazardous conditions are identified in a home. We need to make sure our focus is on primary prevention and improving population outcomes.

Sarah Reese Carter indicated that we have a door of opportunity to work with primary care providers; they are waiting for the next round of information and recommendations.

Cliff Mitchell commented that a concerted effort would be needed for increasing BLL testing.

There was a motion to adjourn; the meeting ended at 11:43 a.m.