GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Approved Minutes
February 7, 2013

Members in Attendance

Patrick Connor, Dr. Maura Dwyer, Cheryl Hall, Mel Jenkins, Ed Landon, Pat McLaine, Barbara Moore, Linda Roberts and Karen Stakem Hornig.

Members not in Attendance

Delegate Nathaniel Oaks, and Mary Snyder-Vogel.

Guests in Attendance

Shaketta Denson – CECLP, Donna Webster – WCHD (via phone), Kaitlin Brennan – CECLP, Wes Stewart – CECLP, Korey Rubeling – AMA, Hosanna Asfau-Means – BCHD, Dana Schmidt – MMHA, John O'Brien – MDE staff, Paula Montgomery – MDE staff, John Krupinsky – MDE staff, Dr. Ezatollah Keyvan-Larijani – MDE staff (presenter), and Tracy Smith – MDE staff.

Introductions

Pat McLaine began the meeting at 9:31 am. Everyone introduced themselves. Edward Landon made a motion to accept the December 6, 2012 minutes, seconded by Mel Jenkins and approved. Patrick Connor requested one correction of the January 5, 2013 minutes. Edward Landon made a motion to accept the January 5, 2013 minutes as corrected, seconded by Karen Stakem Hornig and approved.

Future Meeting Dates

The next Lead Commission meeting is scheduled for Thursday, March 7, 2013 at MDE in the AERIS conference room. The Commission will meet from 9:30am - 11:30am.

Discussion

Pat McLaine reported that she had provided the Lead Commission's recommendations for DHMH to Dr. Joshua Sharfstein and has requested a meeting with Dr.'s Joshua Sharfstein and Clifford Mitchell to discuss the Lead Commission's concerns.

Dr. Ezatollah Keyvan-Larijani (MDE) made a presentation of the Childhood Blood Lead Surveillance in Maryland Report for 2011. The Childhood Lead Registry (CLR) is mandated by state law. Thirty-six (36) labs or clinics analyze blood samples from Maryland children for lead. Eight (8) laboratories submit blood lead laboratory results via either a secure web-site or electronically (approximately 90.3% of BLLs), 16 report by mail and 12 by fax. All blood lead levels $\geq$ 15µg/dL are faxed to MDE within twenty-four (24) hours by Maryland law. Standardized procedures are used for receiving and entering blood lead level results, conversions are processed either electronically or manually. Faxes are entered manually.

The steps for processing data were identified:
Step 1 – review of standard errors. These include type one (All BLLs >60µg/dL, report missing name, DOB, city/zip, date); type two (adult cases, out of state address); type three (non-numerical entry for BLL). In addition, any results reported as "below LOD" are changed to the numeric value of the level of detection for the lab.
Step 2 – geo-coding and address standardization. The data is run through Centrus to standardize the address, assign county code, census tract, and identify latitude and longitude for geomapping.
Step 3 – The file is prepared for import to Stellar (this requires conversion of the data base files into a file that Stellar can read)
Step 4 – import to Stellar. Stellar data is in a relational data base

The Registry conducts several quality control checks on laboratory data.

1. Blood lead lab reports are tracked and checked on a monthly, semi-annual and annual basis.
2. Contact with LEAD Care II users. MDE receives a monthly list of clinics starting to use the Lead Care II instrument from the manufacturer. MDEinforms the new users that they must report and must register with DHMH.
3. Annual match of laboratory lists.
4. The list of reporting labs is matched annually with the list of labs registered with DHMH.
5. Registry check of any report of EBL made by health care provider to make sure it is in the registry.

The Childhood Lead Registry (CLR) was established in 1988, and began in 1989. Electronic data is not available for 1989, 1990 and 1991. The CLR has two data bases, an Historical Data Base, established on January 1, 1992 containing records of blood lead measurements taken through December 31, 1999; and a Current Data Base, with blood lead measurements from January 1, 2000 through current date. Two (2) million blood lead tests have been reported; the Registry contains blood lead data on one (1) million children. On average, 10,500 blood lead reports are processed monthly.

The current Stellar system has advantages: it supports multiple users; has built in criteria; and is good for case management. It also has limitations: processing is slow; MDE can only change one (1) record at a time; the program is written in Clarion, which has been difficult to work with and not very efficient, and it cannot run analyticals.

The CLR data was to be migrated to the National Electronic Disease Surveillance System (NEDSS) but was this plan was changed by CDC in 2005. CDC then developed new software – the Healthy Housing Lead Poisoning Surveillance System (HLPSS), to be used by state programs to manage and report childhood blood lead levels. This is a stand-alone system (lead only). DHMH computers will be used to hold the data, but MDE would own and operate the data. Migration from Stellar to the new system is to be completed by Spring 2013.

Reports on the data can be generated daily, weekly, monthly, yearly, or on an "ad hoc" basis. Case management for children and adults is tied to this laboratory-based reporting system. The CLR is managed by four (4) full-time MDE employees.

Achievements (trends) / graphs

Over the past few years, there has been a massive shift. Both the percentage of children with blood lead levels of > or = to 10µg/dL and the average lead levels of Maryland children have declined. The number of children that were tested in CY '11 did decrease compared to CY'10. The preliminary number of children that were tested in CY '12 is higher than the number tested in CY '11. Trends are more important than the number of tests in a single year.

Dr. Keyvan responded to a large number of questions from Commissioner Cheryl Hall.

- Page 2, the 110 children (old cases) with blood lead levels ≥ 10 µg/dL were tested at that level in a previous year. The 342 children who are new cases in 2011 may have been previously tested but all previous results were below 10µg/dL.

- Regarding the 452 children who theoretically needed case management in 2011, no information was available about how many actually received case management services. Some families may have moved or have been hard to locate. .

- Regarding achievement of case management outcomes (identification of source, lower the BLL, eliminate the hazards), the Commission was informed that outcomes were achieved but no further information was provided.

- Regarding evaluation of successful and unsuccessful case management, which could better inform intervention and policies, the Commission was informed that MDE is not a research organization.

- Regarding the discouraging testing rate of 23%, and what would be a good goal for testing, the Commission was informed that MDE is the custodian of data and does not do enforcement with health care providers. There is no state law **requiring** lead blood testing. Maryland recommends testing of 1 and 2 year olds; Medicaid requires blood lead testing. Approximately 80% of children in Medicaid are tested. Dr. Keyvan reported that providers would use BLL test for children who fail the screening questionnaire. Use of the screening questionnaire is not reported. If children were determined not to be exposed, they would not be tested.

- Regarding which agency is responsible for addressing the testing rate, Commissioners were told that MDE does not have responsibility for this. Medicaid is responsible for oversight of Medicaid children.

- Regarding the question "Can it be expected that health care providers will comply with state law", Commissioners were told that state law recommends but does not require testing and that we hope providers will test children.

- Regarding whether the persistently low numbers reflect a measure of priority given to lead testing, the CLR does not know.

- Regarding whether responses to the risk questionnaire are in the report, because these are not reported to the CLR, they are not in the report. This may reflect the lower rate of testing seen, but it is not possible to know and there is no mechanism to track this.

- Regarding lack of determination of gender for 522 children, this is less than 0.5 of one percent of results reported. If the gender is not marked on the specimen paperwork, the CLR will not have that information.

- MDE processes approximately 10,000 reports a month. Labs, clinics constantly change. MDE does not have enough resources to check each and every entry of each and every report for accuracy and completeness. Nothing is done by MDE for results of < 10µg/dL that are missing sex or race. For children with BLLs of 10+µg/dL, MDE may request this information.

- 12.3% of specimens had no specimen type (listed as "undetermined"). This is not a criteria for rejection and all results were less than 10µg/dL. Because they were <10µg/dL, these tests would not be repeated and there was no requirement for follow-up. The number of "undetermined" BLL samples is an underestimate because MDE corrects any "undetermined" reports of 10µg/dL or higher.

- Page 7, Table 2, the numbers of children tested increased in Montgomery, Queen Anne, and Washington counties. What accounts for this? CLR does not know. There is an annual variation. High risk areas should encourage more BLL testing. This may be a result of personal interest in lead poisoning prevention in the counties.

- Page 12, Table 6: regarding how many of the children were in case management, the CLR does not report case management information. Case management may be more likely in Baltimore City.

- Regarding school-aged children with higher BLLs, these children are less likely to receive case management if they are older than age six. Child exposure for lead is more common at younger ages, and concerns are greater because of the risk of neuro-behavioral problems. Higher BLL at an older age may be associated with lead-contaminated environment or may be a result of earlier exposures and long term storage

of lead in the bone, serving as a source for continued internal exposure to lead. Blood lead exposure and BLL measures are one measure of risk for educational outcomes.

- Regarding who will guarantee that appropriate agencies and schools have been notified, families and local health departments can share information with the local school system or early childhood intervention program.

- Local health departments have access to histories of blood lead tests for children in their jurisdictions.

- If a child is receiving case management, blood lead levels are checked. CDC has an established case management protocol.

Pat McLaine thanked both Dr. Keyvan and Cheryl Hall, who was the only Commission member to submit questions.

Patrick Connor commented about the completeness of data on page 13 (table 7). He also asked if the law requires demographic data to be reported, why MDE would not reject data missing race designation. He asked if the Commission should consider amendment to the law or regulations. Dr. Keyvan indicated that some individuals think race is confidential and do not declare that to the lab. Linda Roberts asked if the lab could check the box when they were drawing blood; Dr. Keyvan indicated he did not know. Race is reported on BLL reports to the CLR 50% of the time. Dr. Clifford Mitchell indicated that 50% reporting for race is good compared to other programs at DHMH. After a question about whether laboratory reports could be rejected due to missing data, Dr. Keyvan commented that Maryland can't punish labs for missing data. Pat McLaine indicated that the issue of racial disparities in lead poisoning is a concern, so reporting by race is of interest to the Commission. Race is difficult to report and there are changes in way people self identify race. This is a problem with other national surveillance registries. Data that is filled out by a nurse or clerk could also inaccurately record race. A comment was made about changing the law. A better understanding of the importance of health care reporting of race is needed.

Commissioner Cheryl Hall asked if there was any requirement for health care providers to perform BLL tests; tests are required for children enrolled in Medicaid. She asked what would happen if parents did not want to test their children. John Krupinsky commented that schools required that proper screening take place, and recommends that children have a BLL test. Children living in at-risk zip codes or positive by questionnaire should have a test. Commissioner Cheryl Hall indicated that the Office of Child Care Licensing requires that all children enrolled in child care have a BLL test.

Commissioner Karen Stakem Hornig asked if there was a plan to mandate submitting forms electronically. Dr. Keyvan stated that some clinics using the hand held devices did not have the

capacity to do electronic reporting and stated that he did not want to discourage testing. The manufacturer's software for reporting for the hand held instruments was insufficient for MDE to process. Commissioner Karen Stakem Hornig indicated that all insurance claims in Maryland are filed electronically. Pat McLaine suggested that with increased use of electronic medical records, we should take another look at how we might be able to do this. It might be possible to use a scan able form to report data, which would be quick, reliable and accurate. Given the many changes in our health care system, this may be timely.

Dr. Keyvan expressed concerns that testing results may be lost from the system if the issue of electronic reporting is pushed. Or clinics, required to purchase reporting software, may stop testing. Commissioner Pat McLaine commented that the reporting of testing has been a national concern since the early 1990's and manufacturers of the hand held instruments have long known what was needed for reporting to state childhood lead programs.

Commissioner Patrick Connor asked how big the problem was. More than 90% of BLLs are reported electronically – 3 laboratories report 85% of Maryland test results. Only 9,000 to 10,000 tests are linked to Lead Care II units. Commissioners asked (1) how many Lead Care II units are in use in Maryland; and (2) how many results are being reported from each of the units in use and in total. Dr. Keyvan indicated that he could obtain that information. 3.3µg/dL is the detection limit for the hand-held units. Dr. Cliff Mitchell commented that DHMH has met with Health Care II people about electronic reporting requirements and expects that this will be addressed in legislation to be developed this summer.

Commissioner Karen Stakem Hornig asked if there was a correlation between the 10,000 manual entries and the problem of errors and missing data points, discussed earlier. Dr. Keyvan said he did not know.

Commissioner Linda Roberts asked if MDE had a mechanism to alert the labs that they have a high percent of missing data. Dr. Keyvan noted that MDE does let the labs know. Commissioner Linda Roberts asked if there is anything on the reporting form that talks about reporting of all fields. Dr. Keyvan indicated that MDE does not provide such a form but does send each lab a copy of the regulation. Commissioner Pat McLaine suggested that compliance with reporting was DHMH's responsibility, not the responsibility of MDE. Commissioner Linda Roberts asked who was doing QA/QC for missing information on the forms.

Paula Montgomery commented that most reporting measures (on page 13) are good. Fifty percent for race is low but above the norm nationally; all other parameters are 100, 94, 100, and 99%. Dr.Keyvan indicated that MDE did follow-up missing guardian name information for BLLs of 10+µg/dL. Race may not be disclosed due to privacy concerns. Pat McLaine commented that the data is good and has improved over time, but it could still be better. . For example, five (5) years ago, basic address information was missing but is now much better. This is part of a bigger issue.

John Krupinsky indicated that he would like to see more attention to getting up to date information on address and contact information. Not having good information makes case management more difficult. Hosanna Asfau-Means from Baltimore City Health Department indicated that MDE has been able to obtain missing guardian information 9 out of 10 times when needed for case management.

Commissioner Pat McLaine commented about the school table on page 12. She suggested adding another column for the number of children in kindergarten in each jurisdiction so that the percentage being screened prior to kindergarten could be estimated. She also suggested that in future years the CLR also report in a similar manner on BLLs 5-9µg/dL by county. Barbara Moore indicated that the data on kindergarten enrollment is retrievable.

Pat McLaine also suggested that the Commission should think about what might be done about ensuring early childhood education for children with confirmed BLLs of 10+µg/dL. Commissioner Cheryl Hall indicated that the Office of Childcare was looking at this.

Commissoner Patrick Connor suggested that the CLR report for 2012 should have breakout by local jurisdiction for BLLs (5-9 and 10+) and age of housing. The 2011 report provides local jurisdiction breakout for 10+µg/dL only (Table Two, page 7) and age of housing data break out for Baltimore City and all counties combined. Pat McLaine indicated she was glad to see the table on page 19 showing first time identified 5-9 BLLs. This represents a 6 fold increase in the number of children identified with BLLs of 10+µg/dL. Earlier estimates, which included new and previously identified children, suggested a 10-fold increase.

Wes Stewart commented about the confidence level for BLLs of 5µg/dL and above. The limits of detection for commercial labs have gone down, but error represents a greater portion of measurement in the lower BLLs. Pat McLaine suggested reviewing the minutes for our July 2012 meeting where these issues were discussed. Although the Commission has requested that personnel from the DHMH labs meet to discuss concerns, we have not yet been able to schedule such a meeting. Pat McLaine referred Commissioners to the copy of a letter sent by the Advisory Committee on Childhood Lead Poisoning Prevention to Kathleen Sibelius, the US Secretary of Health and Human Services, expressing the Committee's concerns about blood lead laboratory issues and offering recommendations for the Clinical Laboratory Improvement Advisory Committee, specifically to tighten performance criteria for BLL testing in proficiency testing programs to $\pm$2µg/dL or $\pm$10%. There will be need for more discussion of laboratory issues this year. Pat McLaine suggested that the Commission may want to consider a legislative recommendation for next year.

Commissioner Patrick Connor commented that limits of detection are a function of the operator as well as the instrument. This also drives the outcome of data. He is very concerned about BLLs. Environmental labs must report the levels of detection and reporting limits for all lab

work (paint, dust) but the standard for BLL reporting is not the same. Limits of detection are different today than years ago; we have no knowledge about how this has changed.

Current Legislation.
Commissioner Edward Landon reviewed three (3) bills; two are lead related and one is for Healthy Homes.

HB 303 - Task force for point of care testing (Delegates Nathan and Pullien). Pat McLaine indicated that she had asked MDE and DHMH to include the Lead Commission as a member of this task force. A hearing on 2/5 was cancelled and rescheduled for 2/12.

HB 389 - Lead-safe income tax credit (Delegates Hogan and Vidal). This is the same bill as last year (HB 544) and in 2011 (HB 527 – hearing but no action). The bill would create a tax credit for qualified lead hazard reduction projects. Hearing is on 2/26. . Similar bills were also submitted in 2006, 2005, 2004, and 1997. HB 1449 did pass in the House in 2006. Similar bills had unfavorable reports and did not make it past the first hearing. Fiscal note is $200,000; vote will likely be unfavorable without a source of revenue.

HB 573 - Healthy Homes initiative (Delegate Glenn). This bill directs the Secretary of the Environment to establish a Healthy Homes initiative with the purpose to protect children and adults from health and safety hazards including lead. Hearing is on 2/20. Commissioner Cheryl Hall inquired what would be the impact on child care. This is not a DHCD or MDE bill. Paula Montgomery commented about HB 879 (which was last year's bill.) Dr. Cliff Mitchell commented that the bill may be responding to CDC's Healthy Homes initiative, for which Federal dollars are no longer available. DHMH has a Healthy Homes program now. Pat McLaine noted that CDC has been talking about a Healthy Homes approach for years and the Baltimore City Health Department has pioneered Healthy Homes programming in Maryland. The Commission has been discussing need for a Healthy Homes approach at MDE for years.

Wes Stewart indicated that the Coalition supports HB 389 which would provide tax credit for window replacement and would like the Commission to also support this bill.

Issue of the Commission supporting current legislation or supporting general principles as we did last year was discussed. Commissioner Karen Stakem Hornig moved that the Commission prepare a general letter of support for issues this year and send the letter to all committees hearing lead legislation. Commissioner Edward Landon seconded the motion. Six Commissioners voted in favor, one opposed, the motion carried. Pat McLaine requested a volunteer to prepare the letter. Tracy Smith will look for additional information including letter sent last year. The specific letter will be subject to approval of Commission members.

Agency updates:

Maryland Insurance Administration - Karen Stakem Hornig presented the Lead group work report to the House Economic Matters Committee. There were virtually no questions from committee members.

HB 754 was dropped and reintroduced. The Commissioners may want to look at this bill.

MDE – Paula Montgomery indicated that MDE is moving forward with RRP. The contractor population is affected and a letter has been sent to the MHIC. Paula may speak at a future MHIC Commission meeting.

DHMH – Dr. Clifford Mitchell reported that DHMH met with the Lead Program at MDE about the new targeting plan. Several different options were considered included universal testing, a revision of the current strategy, a place-based approach, and a fitted model. Rental properties are assumed to be the main source of exposure. DHMH has been making good progress and would like to present the final plan to the Commission at our March meeting. The plan will then be released for public comment. DHMH's goal is to have a strategy adopted by June 2013.

Baltimore City Health Department - No updates

DHCD - No updates

Child Care - No updates

Coalition – Wes Stewart reported that the Department of Energy, HUD, CDC and EPA had released their Healthy Homes Strategic is on the web-site.

HB 754 reintroduces the Qualified Offer, requires tenant testing and a compensation package. The Coalition will oppose this bill.

Wes reported that two Ad Council lead poisoning prevention bill boards have high visibility in our area: the cereal bowl bill board is located near 95 and Eastern Avenue and the paint can bill board can be seen on 895, before Hanover Street.

Commissioner Ed Landon made a motion to adjourn, seconded by Commissioner Cheryl Hall. All commissioners in favor of adjournment.
The meeting was adjourned at 11:40 a.m.