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

Pat McLaine opened the public hearing on DHMH approach to the new CDC Lead recommendations opened at 9:40 AM and reviewed rules for testimony.

Clifford Mitchell (Department of Health and Mental Hygiene) briefly reviewed the seven comments received by DHMH prior to the close of the comment period. These informal comments, received by phone and by email, include the following:

- One commenter asked whether the State "has enough employees to follow up with the children who are born to determine whether they have been or should have been tested for lead paint poisoning."
- One commenter, from a local health department, felt there were not enough resources to case manage children with levels between 5 and 9 mcg/dL in the same fashion as currently done for levels of 10 mcg/dL and greater. The commenter favored an alternate approach, in which the local health department would provide educational materials to providers and parents and serve as a resource but not provide active case management. The commenter also suggested that for previous lead tests in the past five years between 5 and 9 mcg/dL, letters could be sent home to parents through the school system. The commenter also suggested that school nurses should be able to access the lead registry.
- One commenter favored the option of more active case management for children with levels between 5 and 9 mcg/dL, stating that MDE should notify the local health department, which would then identify and contact the family and expedite contact with a treating pediatrician. This commenter also favored looking back at historical blood lead tests of the past 5-6 years, or those who have not yet entered puberty.
- One commenter from a local health department noted that they no longer have the resources to do case management for any children other than those with blood lead levels of 10 mcg/dL or greater. This commenter favored "look back" for only three years, if MDE were to do it at all.
- One commenter indicated that local health departments lacked the resources to do case management for the blood lead levels of 5 – 9 mcg/dL, and pointed out that children are best served by a "medical home" model, where the primary care provider provides the follow up.

Ruth Ann Norton (Coalition to End Childhood Lead Poisoning) emphasized that we should look to the science, rather than fear of litigation, in establishing policies. There is no safe level of lead, and more recent studies on adults show increased risks for them as well. Recent studies of children with level of 2 – 7 mcg/dl show the most dramatic impact on cognition. We should redouble assets to invest in primary prevention with an aggressive campaign focused on primary prevention. We should emphasize source removal and reduction. There is a need to improve online public information, including: updated leadsafehomes.info website with individual property unit data on lead; lead housing violations in searchable format; and the integration of inspection and compliance data. All of these should tie reduction values to 5 mcg/dL. We should pursue Medicaid funding to help pay for the case management as well as environmental inspection and approve reimbursement for intervention in housing. All laws should be amended to match the new reference levels. Families should have access to nursing case management by registered nurses, health education for affected children, and appropriate follow up. We

also need relocation and other resources to serve children outside of Baltimore City. Baltimore City's lead Housing Choice voucher program should be replicated throughout the state. We also need an increase in resources for training of primary care providers, as well as more resources for training.

All cases 5 µg/dL and above going back 2 years should be investigated and provided case management services. If lead hazards are identified in a unit in a mulst-family complex, the same response should be applied to all other units.

Urged development of window replacement program, increased access to state and grant programs with easy access to increased training for rntal property owners on the RRP and CDC guidelines. Increase targeting of Western Maryland and the Eastern Shore. Urges demonstration programs. Develop interactive education program on maintenance of lead-safe housing. Adapt new reference level, change laws, increase resources, invest in lead-hazard control.

Kathy Howard (Maryland Multi-Housing, Apartment Office Building Association) talked about the multi-housing industry's concerns about a "look back" mechanism. The big concern is because of the success of the program up to now. Extending this level backwards for 21 years would be a huge burden, on property owners and poses a big regulatory burden on DHMH. This is a resource issue. A look back of 2 years for environmental investigation and case management would be the feasible, with educational materials made available beyond 2 years. BLLs of 5 mcg/dL should be based on a venous, not capillary, test; any regulatory action should require confirmed venous tests. There are also question about which addresses are being attached to the lab results. We need to look at all potential sources (home, soil, water, playground, cookware, medication, etc.), not just rental housing. We must also look at owner occupied issues. We also need to look at lab protocols to make sure they are able to detect levels below 5µg/dL and that proper testing supplies are used. Need good regulation of testing so we are acting on reliable results.

Cynthia Erville (Fluoride Action Network) urged the elimination of fluoridation in order to retain IQ. She recommended looking at vitamin supplements, especially those with zinc supplements, to use with children with EBBLs. She recommended use of special pitchers to filter water that would not remove calcium and magnesium, as most commercial water filtration pitchers do. She also talked about risks to pregnant women.

Ken Strong (Baltimore City Housing Authority) made 5 recommendations. (1) Invest in community health education so families know what they can do now to stay safe. He pointed out that this is similar to the idea of keeping poisons and medicine in the home out of hands of children. (2) Intensify and invest in surveillance testing and reporting. More resources are needed, not less. (3) Intensify and invest in our response to ID cases. When there is an elevated blood lead level identified, a health professional should go to the home, provide an in-home assessment and education, ID category of the response needed. More investment is needed in assessment and in intervention. Need to start at state level to find resources for all local HDS to mount an immediate response. Clean-up provides immediate health benefit, and this 1st level response can help prevent further poisoning. (4) Fund interventions. Reductions in BLLs have been demonstrated and lead hazard control is a public health success story. Prevention makes sense. (5) Work

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.