

GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

Approved Minutes

June 13, 2013

Members in Attendance

Patrick Connor (via conf. phone), Karen Stakem Hornig, Pat McLaine, Clifford Mitchell, Nathaniel Oaks, and Linda Roberts (via conf. phone).

Members not in Attendance

Cheryl Hall, Melbourne Jenkins, Ed Landon, Barbara Moore, and Mary Snyder-Vogel.

Guests in Attendance

Mary Jean Brown – CDC (presenter/via conference phone), Rebecca Morley – NCHH, Michael Shaw – CECLP, Shaketta Denson – CECLP, Michael McKnight – CECLP, Bart Kennedy – Senator Mikulsi's office, H. C. Nzuwah, Hosanna Asfau-Means – BCHD, Dana Schmidt – MMHA, Carolyn Cook – MMHA, Toni Chavis – BMS, Ron Wineholt – AOBA, Clifford Mitchell – DHMH, Debbie Farlow – Worcester Co. HD (via conf phone), Phyllis Burton – Worcester Co. HD (via conf phone), Hope Williams – Representative Cummings office, Horacio Tablada – MDE, Heather Barthel – MDE, Paula Montgomery – MDE, John Krupinsky – MDE staff, John O'Brien – MDE staff, and Tracy Smith – MDE staff.

Introductions

Pat McLaine started the meeting @ 9:32 A.M. with introductions. Pat McLaine noted that the purpose for this meeting was to find out what has happened since Federal cuts were made to the Federal Lead poisoning Prevention Program last year and to discuss what the Commission can do about it. MDE funded the Maryland Program for this year.

Future Meeting Dates

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

Approval of Minutes

Minutes were not voted on at this meeting.

Discussion –

Mary Jean Brown from CDC joined the discussion by telephone with a power point presentation about the Federal strategy for action on healthy housing. CDC has discontinued use of the term “level of concern” which had been in effect since 1991. CDC has accepted the term “reference value”: the 97.5 percentile of the population blood lead (5µg/dL in 2012). The reference value will be recalculated in 2016 after the next four (4) years of NHANES data are in. There is no threshold level and no safe blood lead level. CDC has always been interested in decreasing BLLs and primary prevention is the only way to do this. We need to intensify measures to

decrease exposure and risk for children. BLLs have gotten lower with time. Case management, lead hazard control, cleaner air and water and less lead in consumer products are having an impact. The group at highest risk remains at very high risk: being Black, poor, on Medicaid and living in older housing are all predictors of increased BLL. The disparities for risk of high BLLs are persistent and stubborn.

Five (5) $\mu\text{g}/\text{dL}$ is not the new ten (10); our goal should be for all children to be in lead-safe environments from birth. CDC's budget in 2010 was between \$28 – 30 million; the budget for 2012 was \$2 million. CDC is no longer funding at either the state or local level (thirty-five (35) state and local entities were funded in 2010.) The focus now is a passive surveillance data collection system. CDC can't enforce data reporting now because there are no contractual arrangements. There are no resources for inspection, home visits, court follow-up, etc. CDC does continue to receive data from some states, which is useful for the targeting of resources.

CDC currently has a staff of seven (7), which is down from thirty-eight (38) people in 2010. CDC continues to support an Advisory Committee since the committee's inception in 1973. There is always something new (immigrants, new (sources of) exposures.) HUD has taken over most of the training functions (i.e. risk assessment / hazard reduction.)

Ms. Brown clarified that the number in Table 1 was in the thousand's. There was a question about the stratification for the age of housing. Presumably, lead exposures in 470,000 houses were constructed since 1978 were not from the house. Examples of possible exposures include lead in plumbing fixtures in the District of Columbia and take home lead in upstate New York and in Puerto Rico (i.e. lead brought into cars and on baby seats).

Pat McLaine presented findings from her research on lead and kindergarten reading readiness, recently published in *Pediatrics*. This is an important measure and on average about 25% of children enter kindergarten not ready to learn to read. This is costly to society; the longer schools wait to provide remediation, the more expensive and the less effective it is. A number of studies have found decreases in reading scores associated with blood lead levels of $3\mu\text{g}/\text{dL}$ and higher. Providence has had excellent BLL testing: 88% of the kindergarten children in 3 year period had been tested for lead. But BLLs in Providence were much higher than the NHANES data suggested: 20% of children in the study had at least one BLL $>10\mu\text{g}/\text{dL}$. The study linked blood lead screening data and reading readiness data at the individual level. The average geometric mean (GM) BLL was $4.2\mu\text{g}/\text{dL}$ and only 31% of the children had all BLLs below $5\mu\text{g}/\text{dL}$, compared to 93% for NHANES in the same period of time. Children receiving free lunch had higher average BLLs than children who paid for their lunch. Hispanic children had the lowest average GM BLL (4.0); Black children had the highest GM BLL (5.0). Outcome scores for kindergarten reading readiness were adjusted using progressive adjustment (age, kindergarten year, sex, race, child language, and free/reduced lunch status). Reading readiness scores were lower for children with GM BLLs 5-9 and $10+\mu\text{g}/\text{dL}$. Similar differences were seen for children based on free/reduced lunch status. Compared to children with GM BLLs $0-4\mu\text{g}/\text{dL}$, children with GM BLLs 5-9 and $10+\mu\text{g}/\text{dL}$ scored 4.5 and 10.1 points lower in reading readiness. In addition, only 49% of children with BLLs of $10+\mu\text{g}/\text{dL}$ were successful in achieving fall benchmarks, compared to 68% of children with BLLs of $0-4\mu\text{g}/\text{dL}$. Conclusions were that the risks for failing to be ready to read are associated with BLL; the risk doubles for

poor children. The work supports a finding of no safe lead levels. Public health and public schools can benefit from this data sharing approach.

Rebecca Morley and Michael McKnight (Green and Healthy Homes Initiative) provided an update on the national overview of the impact of federal funding cuts on state and local CLPPs. Most states reported problems, many with maintaining basic surveillance functions. Environmental Health tracking grants (Maryland has one) will be cut 30% in the next fiscal year, so this support for state lead programs will also be reduced.

Horacio Tablada reported that Federal funding for Maryland had gone from \$1.4 million to \$1.2 million to \$800K to \$600K to \$0. In the past, MDE had funded the counties generally. But after the loss of federal funds, MDE funded only Baltimore City and Wicomico and the Lower Eastern Shore. MDE made the case and restored funding to use to continue to support the program for one year with hopes that CDC funding cuts would be restored. John Krupinsky reported that there was minimal support for outreach and education except in Baltimore City. Primary prevention has been through the Reduction of Lead Risk in Housing law, including enforcement efforts in Wicomico and the Lower Eastern shore. In Baltimore, outreach has been done using the lead and healthy homes “party” model, to bring information to communities at risk; John reported that 10-15 people had attended such parties. Baltimore City has also been coordinating outreach and education for children with 5-9µg/dL BLLs as part of HUD program. BCHD does mail outs and makes phone calls if they can’t physically get in. On the lower Eastern Shore, HD staff provided education to health care providers on BLLs 5-9µg/dL and also targeted property owners and homeowners. The program ends July 1, 2013. John Krupinsky also reported he had surveyed local HDs regarding their providing case management services; of 24 HDs contacted, 17 report that they provided telephone consultation for 5-9 BLLs and 4 provide home visits. 4 Health departments indicated they had no resources to provide any case management at this level. For case management of children with BLLs 10-14, 9 HD indicated they could provide phone calls but no home visits; 2 HDs reported having only 2 CPH nurses total on staff. At BLLs of 15+, only 4 counties could do a telephone call for CM. In terms of environmental investigation, BCHD inspects at a BLL of 5µ/dL; PG inspects at a level of 10µg/dL; MDE provides inspections for all other counties at BLL of 10µg/dL.

Cliff Mitchell reported the DHMH funds 7 local jurisdictions at \$1 million; most of funds go to Baltimore City HD, then to Prince Georges County. None of the funding to the other 5 jurisdictions is large enough to fund a FTE (ranges from \$17-30K). Other HDs want to know what the state would recommend, want to know how long doctors should follow a child. Funding is now based on general funds, part of the match to qualify for Title 5 funding. DHMH is formalizing its targeting plan.

Shaketa Denson reported on the Housing Choice Vouchers (Section 8). 75 were allocated in 2007, but Baltimore City now has 200 vouchers. Only 11 vouchers are left at this point. The Coalition has been providing home visits and case management to families for 3 years.

Regarding key elected representatives in Maryland, Dr. Andy Harris holds weight on the Republican side and is a physician. It would be important for him to understand the problems of childhood lead poisoning in Maryland. The suggestion was made to make the personal political,

so that the situation we face is real for all lawmakers. It might be possible to earmark administrative money for home visits. A suggestion was made that home visit guidelines are restrictive. Can DHMH tailor the assessment to funding? What is the average caseload for Baltimore City and Counties? Baltimore has no PHNs – but does have 5 community health investigators. Recommendation was made that the Commission update our letters, requesting support for this issue. The US Conference of Mayors has requested funding at the \$50 million level. NACCHO could also support funding increase for the CDC Lead Program.

Patrick Connor asked if there were any issues about gaining access in Baltimore City if the BLL was $<10\mu\text{g/dL}$. Hosana Asfau-Means replied that the 5-9 program was voluntary but that program staff had to go in if the level was $10+\mu\text{g/dL}$.

Patrick Connor asked if a rental property was identified with a child having a BLL $5-9\mu\text{g/dL}$, why wouldn't the HD go to the property? Regulation 5 defines an EBL as what CDC has set. Hosana indicated that BCHD lawyer Myra Knowlton could discuss this issue at a future Commission meeting.

Patrick Connor also indicated that he would like to explore the ability to charge for services, particularly charging the property owner for environmental investigation. If we are tight for funding, and also providing services, why aren't we charging? Why don't we have local regulations specifying the charge (for example, EI = \$675, dust testing = \$375).

Ken Strong indicated that BCHD Housing representatives will attend the July meeting.

Motion was made to end the meeting; the meeting ended at 11:35.