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.