# MARYLAND DEPARTMENT OF THE ENVIRONMENT

Land and Materials Administration • Lead Poisoning Prevention Program
1800 Washington Boulevard • Suite 630 • Baltimore Maryland 21230-1719
410-537-3825 • 800-633-6101 x3825 • www.mde.maryland.gov


## GOVERNOR'S LEAD POISONING PREVENTION COMMISSION

Maryland Department of the Environment
1800 Washington Boulevard
Baltimore MD 21230

MDE AERIS Conference Room
November 2, 2017

APPROVED Minutes

**Members in Attendance**
Shana G. Boscak, Anna L. Davis, Mary Beth Haller, Patricia McLaine, Cliff Mitchell, Paula Montgomery, Barbara Moore, Leonidas Newton, Sen. Nathaniel Oaks, Manjula Paul, Christina Peusch, Adam Skolnik

**Members not in Attendance**
Susan Kleinhammer, John Scott

**Guests in Attendance**
Camille Burke (BCHD), Benita Cooper (MIA), Chris Corzine (OAG), Ludeen McCartney-Green (GHHI), Secretary Grumbles (MDE), Rachel Hess Mutinda (MDH), Lisa Horne (DHMH), Dawn Joy (AMA), Myra Knowlton (BCHD), Gruschenka Mojica (MDH), Marché Taylor Templeton (GHHI), Ron Wineholt (AOBA)

**Welcome and Introductions**
Pat McLaine called the meeting to order at 9:35AM with welcome and introductions.

**Approval of Minutes**
A motion was made by Adam Skolnik, seconded by Nathaniel Oaks to accept the October 2017 minutes as amended. All present Commissioners were in favor.

**Old Business**
Lead Poisoning Prevention Week Recap – Paula distributed information on events held around the state: it was a whirlwind week. Activities included a press release for the Annual Report; two contractor forums (on the Eastern Shore and at MDE), with 200 participants; a Proclamation from the Governor; and several banners placed on the MDE website. A roundtable meeting is being planned for the secretaries of Health, Housing and Environment to discuss strategies including funding. Several local health departments had activities that were not on the list including outreach, education, and canvassing; most don't receive money for their lead efforts.

Camille Burke reported that Baltimore City Health Department did testing and conducted community canvassing in about 200 homes in East Baltimore in the 21215 zip code, encouraging residents to get the facts and get children tested; door hangers were left if residents were not home. BCHD will go out again tomorrow and plans to make canvassing a monthly event. GHHI also did outreach to WIC and Head Start focusing on prevention and to local schools. GHHI participated in 16-20 events with 846 people, 611 reached through presentations.

Cliff Mitchell reported that Barbara Moore joined Maryland Department of Health to provide a presentation to the state WIC coordinators. Paula Montgomery reported that MDE took out an ad in the *Latin Opinion* (Hispanic newspaper with a large circulation state-wide) in the paper edition and the social media and web editions focusing on the theme of Lead Week: getting tested, get the facts and get help. MDE also did lots of social media including Facebook and tweeting during Lead Week.

Pat McLaine said she heard back from Senator Grumbles office confirming that he will attend the December 7, 2017 Commission meeting.

**New Business**

MDE Childhood Lead Registry Report for 2016 – Dr. Keyvan made the report. Childhood Lead Registry (CLR) data has been available in computerized format since 1992. Data is maintained in a "historic" Stellar database. This relational database has two sections: reports from 1/1/92 through 12/31/99; reports from 1/1/2000 – the current or "Active" database. The CLR currently has reports on about 1.37 million children, 2.2 million tests, and 961,000 addresses. Reporting by laboratories is daily; logs are generated daily, weekly and monthly. A semi-annual QC check is made of the reporting history by labs to ensure that reporting is complete. A monthly list of reports from Lead Care II analyses is prepared. Annually, the CLR checks a list of labs reporting against the lists of labs licensed by MDH. Some test results are still being submitted by providers.

The CLR produces: daily lists of EBLLs (>=10µg/dL) sent to the counties and Baltimore City; weekly data sent to BCHD, EBLLs 5-9µg/dL to counties requesting (N=10); monthly reports to Medicaid and ImmuNet; quarterly reports to CDC, Medicaid and ImmuNet; Annual reports – the CLR Annual Report and report to CDC; ad-hoc reports – as requested by local jurisdictions, interested parties, Maryland Environmental Public Health Tracking, or for subpoenas.

With regards to case management, the extent of coordination varies by BLL and local jurisdiction. Follow-up includes the local health department nurse case manager, coordination with health care providers, certification with the Rental Registry, referral for environmental inspection and investigations, referrals for other needed support services (including WIC, social services, GHHI, and legal).

Laboratory follow-up includes daily tracking of blood lead reports. The program also maintains the Adult Heavy Metal Registry which receives reports of adult cases of lead and other metal poisonings and provides follow-up on adults with occupational lead exposure. Some follow-up is done with the Maryland Occupational Safety and Health (e.g. workplace investigations); some follow-up is done with individual workers. An annual report is provided to NIOSH.

In 2016, the CLR received and processed 137,219 reports, including BLLs on 129,697 children aged 0-18 years, from 101 labs. Eight large laboratories process 76.7% of the tests (N=about 105,000). The other 93 are clinical providers using Lead Care II equipment, accounting for 23.3% of tests (N=31,925). The average time from the blood draw to the result being entered in

the CLR is about 5 days. Blood lead level results of 10µg/dL and higher must be faxed and reported within 24 hours.

Quality of data – the amended laws and regulations of 2001 and 2001 (COMAR 26.02.01) list all the demographic data that must be reported to the CLR electronically. Most of the data elements are reported at levels of 90% complete and higher, including child's name, test date, blood lead level, and sample type. With few exceptions, the information on the report is accepted as is with no further check on accuracy of the data. Race data (51.6% complete) and name of guardian (57.2% complete) are exceptions. The level of detection for point of care testing is 3.3µg/dL.

Testing in Maryland increased significantly in 2016. Results show gradual declines over time in all BLLs of 10µg/dL and higher and BLLs in the 5-9µg/dL range, suggesting that children are becoming less lead burdened. In 2016, most BLLs were less than 4µg/dL.

Source of lead exposure for children in the 1990s was thought to be primarily lead based paint. In 2016, lead based paint accounted for less than half of sources identified in investigations that include lead dust, soil, personal products, hobby, spices, cosmetics and other sources.

With regards to the impact of state initiatives on lead testing, the Maryland Lead Testing Target Strategy of 2015 replaced the earlier targeting strategy of 2004 with universal testing. The state was declared as an at-risk area and requirements mandated that all children living in the state be tested at one and two years of age and at any time there is suspicion of lead exposure. In addition, the Task Force on Point of Care Testing encouraged the use of POC testing and recommended the Laboratories Administration allow a waiver. This resulted in a large increase in the number of laboratories reporting and an increase in the number of BLL reports received in hard copy. POC testing has increased tremendously: from 10 labs in 2011 to 51 in 2015 and 76 in 2016. All POC labs fax BLL reports which must be typed in by hand. There is no mechanism for Stellar to accept these reports.

The CLR looked at the impact of POC testing on provider practice. Among 37 practices that changed to use POC, one half of the practices increased the number of tests they reported by 262%; overall, in the 37 practices, the number of tests reported increased by 100%. In addition, the percent of children tested for lead at ages one and two has increased from 42.2% in 2010 to 44.6% in 2016. There has been a significant decrease in the number of children found with BLLs of 10µg/dL and higher; the percentage of Maryland children with BLL of 10µg/dL and higher is now below the national average. The number of new cases with BLLs above 10µg/dL went from 379 in 2009 to 270 in 2016. Although the numbers are dropping, there are variations and inconsistencies. Some of the increase in number of tests is because children with positive POC results need to be re-tested.

Asked if follow-up of capillary BLLs of 10µg/dL was sufficient, Dr. Keyvan indicated no: follow-up of such results was less than 25% in 2016 compared to 35% in 2015. Ron Wineholt asked about BLL results below 3.3µg/dL; POC testing is not able to measure a BLL below the 3.3µg/dL level of detection. Barbara Moore asked if any pregnant women had been identified

with the Adult Lead Registry; Dr. Keyvan indicated that he was not aware of any pregnant woman and that almost all the reports (99%) were for men. A Commissioner asked if more detailed information on sources would be made available. With regards to venous re-test, Dr. Keyvan noted that by law, a capillary of 10µg/dL or higher must be retested but some clinics are testing with a venous BLL when the capillary result is 5µg/dL and higher. Shana Boscak asked whether there was oversight of the POC machines. Cliff Mitchell said yes; in Maryland, the POC testing received a CLIA waiver. Machines have to be registered with MDH and have to regularly test and report result the results on blinded QC samples to one of the Proficiency Testing laboratories. Shana Boscak said her experience was that the test result from the POC machine was 4 points off the venous test. Cliff Mitchell said that was not uncommon and that capillary tests often have false positive results.

Cliff Mitchell made the next presentation showing the change in the average annual percentage of 1 and 2 year old children who were tested from 2010 to 2015. Baltimore City and Baltimore County had lower percentages of change. Other counties had more than a 50% change, meaning a large increase in the number of tests performed. Generally counties with previously lower testing rates (Howard, Carroll and Frederick) had the biggest increases, which is what MDH was hoping to find.

With regards to next steps, MDH is trying to identify where the greatest opportunities are to do more outreach. Where can MDH prioritize or increase efforts? Where might counties find more cases? Pat McLaine asked for a copy of the tables shared in the meeting and pledged that the Commission will provide feedback to MDH. Cliff Mitchell will send an email requesting input to the Commissioners.

Paula Montgomery presented the Medical and Environmental Case Management report on behalf of the Land and Materials Management Administration. This is the first time that this report has been presented as part of the Annual Report. Case management guidelines require medical case management when a child is identified with a first time venous BLL or two capillary BLLs of 10µg/dL or higher. Case management consists of comprehensive medical and environmental case management services including outreach and education of the family, investigation of the sources of exposure, referrals to services, etc. The environmental investigation is conducted to identify all potential lead hazards in the child's environment and to make recommendations for lead hazard remediation. If the family lives in a rental property built before 1978, MDE sends a Notice of EBLL to the rental property owner which triggers moderate risk reduction except in Lead Free and Limited Lead Free properties.

A total of 238 new cases were confirmed in 2016, 23 fewer cases than in 2015. 131 new cases were identified in Maryland counties, an increase of 10 cases compared to 2015. The majority of families (64%) lived in rental properties. Out of the 131 new cases, contact was made with 93% (122) of cases, 116 completed inspections, 14 refused and 1 could not be located. Twenty of these cases in Maryland counties were related to recent immigration to the US and resettlement in Prince Georges County. The number of new cases in Baltimore City in 2016 decreased by 33 cases compared to 2015; 75% were in rental properties, 70% in pre-1950 and 5% in 1950-1977

properties; 15% of cases were in owner-occupied properties. Of 107 confirmed cases in Baltimore City, 95% completed the medical home visits and 82% completed environmental investigation.

In Maryland counties, 182 sources were identified among 116 properties with inspection complete: 44 had lead based paint or dust, 110 other lead sources were identified including soil, in 28 cases inspectors were unable to determine the source. Among Baltimore City cases, 90 properties had lead-based paint, 9 properties had sources other than paint (including soil) and in 12 cases, the inspector was unable to determine the lead source.

Overall for the entire state and 238 cases, medical case management was completed for 92% of cases and environmental case management was completed for 85% of cases. Findings include: 1. Lead-based paint is a significant source of lead-poisoning in Maryland. 2. Investigation is needed into what can be done about the unregulated source of spices. 3. The program needs to reach immigrant and refugee populations that resettle. 4. Breaking cultural barriers is important. 5. Outreach to families visiting non-industrial countries should be considered. The number and percent of source unknown is significant because there are barriers to getting people to talk with inspectors and home visitors.

Pat McLaine said she appreciated the focus on case management; this helps us figure out where we can improve on our follow-up and how well prevention efforts are working. Barbara Moore asked where people could safely buy spices; is there a list of international markets that carry safe spices? Paula Montgomery said there are challenges in identifying statewide sources. MDH and MDE worked on a special project looking at spices this year and are looking at the data.

Adam Skolnik noted that this data shows that rentals built from 1950-78 are a minor part of the problem compared to spices and other things. In the future, we need to do the research before the legislature puts onerous regulations on those who are not part of the problem; the costs are passed on to renters. Do we need to look at regulations on importing spices? [Note: information presented showed that in 2016, 5% of new cases in Baltimore City and 35% of new cases in Maryland counties resided in rental housing built between 1950 and 1978.] Paula Montgomery commented that owners of properties built 1950-1977 have done a great job getting rid of the lead; this has worked well and is a win-win situation. Paula Montgomery was asked if MDE was also looking at compliance of properties prior to kids being poisoned.

Manjula Paul asked if MDE identified child care centers in the list of lead sources identified in the case management report. Paula Montgomery indicated that no child care centers were identified in these cases; if a child was identified in child care, that care was unlicensed.

Requests were made to look at the data based on the number of properties rather than number of sources identified. Concerns were expressed about the 14 refusals; were all refusals owner-occupied properties – Paula Montgomery did not know. Barbara Moore suggested that some families may refuse because they are in the country illegally. Mary Beth Haller asked whether

counties could get search warrants if there was a refusal to allow entry to investigate. In Baltimore City, if the BLL is 10µg/dL and above and the family refuses entry, BCHD continues to follow the child. If the lead level goes up, BCHD gets protective services involved. What do other counties do? The problem remains unidentified and more children can get exposed if a property is not properly assessed for lead hazards. MDE and Baltimore City staff will look into compliance with state lead laws.

Paula Montgomery indicated that BCHD sends a team to the house, made up of the investigator and the inspector. In the counties, the nurse can't always accompany the MDE inspector to the family's home.

**Future Meeting Dates**
The next Lead Commission Meeting is scheduled for Thursday, December 7, 2017 at MDE in the AERIS Conference Room – Front Lobby, 9:30 – 11:30 AM.

**Agency Updates** – deferred until December due to lack of time.

**Public Comment** – no public comment offered.

**Adjournment**
A motion was made by Adam Skolnik to adjourn the meeting, seconded by Paula Montgomery. The motion was approved unanimously and the meeting was adjourned at 11:37 AM.