# Maryland Plan to Eliminate

# Childhood Lead Poisoning by 2010

## Update December 7, 2007

## Revised Work Plan May 2008

**Modified July 2008 (Changed LPP Comm. Chair)**

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## I. Mission

**Maryland will have a leading role in the elimination of childhood lead exposure by the year 2010.**

## II. Statement of Purpose

**Maryland's multiple public and private agencies involved in lead poisoning prevention, with financing targeted to the areas most at risk, will cooperate in conducting primary and secondary prevention activities to eliminate all but sporadic cases of childhood lead exposure in young children.**

## EXECUTIVE SUMMARY

The Maryland Plan to Eliminate Childhood Lead Poisoning by 2010, originally developed in 2004, was updated in 2007 to reflect the changes in Maryland data about housing and health and the State Lead Poisoning Prevention Program activities. Participants in the Lead Poisoning Prevention Commission and its Housing and Health Sub-Committees' meetings provided substantial input. Contributors referenced agency reports and the Coalition to End Childhood Lead Poisoning (CECLP) 2010 Comprehensive Action Plan (CAP) Recommendations. The CAP was developed following the 2010 Summit, a weeklong conference convened by the CECLP in December 2005 during which recommendations were obtained from a wide variety of stakeholders.

States must have an updated Elimination Plan to enable application for federal funding such as the Childhood Lead Poisoning Prevention (CLPPP) funding under the federal Centers of Disease Control and Prevention (CDC), Housing and Urban Development (HUD) grants, and the Environmental; Protection Agency (EPA) lead grant programs. Baltimore City Health Department (BCHD) did not develop a plan specifically for the City, but the BCHD administration is developing a Healthy Homes Elimination Plan that will include lead poisoning prevention.

Maryland has aggressive state funding and enforcement statewide, especially in Baltimore City. The State has been implementing a strong primary prevention program since 1996, reinforced by 2004 legislation. Enforcement of lead risk reduction standards focuses on the highest risk housing, pre-1950 rentals, and sets the standard for hazard reduction. The number and percent of children with blood lead levels of $\geq$ 10 µg/dL (EBL) have declined significantly since 1994, especially after increased enforcement efforts beginning in 2000. It is notable that, over time, the proportion of children identified with EBL levels in pre-1950 rental properties has lowered resulting in an almost equal proportion of EBL levels in owner-occupied properties and post-1950 rental units. The State may need additional partners to address this shift.

Lead Poisoning Prevention partners view the Elimination Plan as a work in progress. The updated narrative, Gaps, and the Strategic Work Plan are used as a guide. Revisions and programmatic changes that foster the intended goal of eliminating childhood lead poisoning by 2010 are expected to occur. Lead poisoning prevention is still a major challenge, even more so with shift from predominantly pre-1950 rental housing exposure to exposure in owner-occupied properties and post-1950 rental units.

Summary of the Elimination Plan five components:

Primary Prevention – Control of Hazardous Source

Primary prevention, or the control of the hazardous source of exposure, is necessarily the largest component of an Elimination Plan. Owners of rental property built before 1950 are required to demonstrate registration and inspection certificate compliance with the Maryland lead law prior to registration or renewal with any local city or county rental registry, and prior to use of rent court for repossession of property. The reinforcing legislation of 2004 requires constant

outreach and education to the rent court judges and the counties' and cities' rental registries. Not every jurisdiction maintains a rental registry. The identification of solutions to private housing issues and concerns would require new local partners such as code and permitting officials.

Primary Prevention - Outreach and Education

Traditionally, outreach and education is focused on parents of young children, tenants of pre-1950 housing, and health care providers. Less traditional outreach to local code officials, contractors, housing marketers and loan originators to obtain their cooperation in lead poisoning prevention efforts is needed.

Surveillance of Blood Lead Levels

Data processing programs used for surveillance and case management are underperforming relative to capabilities of new software systems and the needs for data integration. The surveillance system needs to be integrated with the environmental enforcement components of Lead Poisoning Prevention Program for reliable evaluation.

Case Management

Continued State and Local response by Environment, Health, Education, and Housing to an EBL $\geq$10 µg/dL is the preferred first intervention. Electronic recording of case management data and linkage between case management, environmental investigation and blood lead surveillance databases are needed for a good evaluation of the public health response to a child's continuing exposure to lead hazards. Local environmental enforcement entities in the counties need encouragement to investigate the use of local authority to order and enforce local orders for immediate risk reduction of a residence or childcare site that caused a child to have an exposure to lead.

Targeting

The Maryland Targeting Plan for Childhood Lead Poisoning was developed in an effort to increase the blood lead testing rate and was based on many variables including housing and income. Medicaid efforts to improve testing rates should continue, as lower income children are more likely to live in substandard housing. To increase the blood lead testing rate, it is important to identify and address the barriers faced by both the health care providers and parents of young children.

Coordination and Leveraging of Resources

Key partners from health, environment, and housing agencies attend monthly LPP Commission meetings, participate in the Health and Housing Sub-Committees' meetings, and communicate with each other as needed to assure coordination of lead poisoning prevention activities. Neither the State nor local health departments, except Baltimore City, enforce risk reduction measures in owner-occupied and post-1950 rental units. New resources and funding sources are needed for lead hazard reduction, case management and relocation, and in how the local municipalities and counties administer

housing code enforcement, livability code enforcement, and local rental registration enforcement with regard to lead laws and hazard controls. Public state and local health departments have rarely approached locally based private foundations for funding, and public partners, except in Baltimore City, have submitted few agency applications for HUD and EPA funding opportunities.

## 1. Surveillance

State laws regarding childhood blood lead surveillance, Environment Article §6-302 and §6-303 and regulations about Blood Lead Test Reporting (Code of Maryland, COMAR 26.02.01), required laboratories to provide to the Childhood Lead Registry (CLR) all reports of blood lead tests on children 0-18 years of age. In response to a 2001 amendment to the law, and revised regulations in 2002, laboratory reporting completeness and timeliness improved substantially, thereby making it possible to increase the number and percentage of case addresses that could be geo-coded. Maryland Department of the Environment (MDE) enters all laboratory-reported blood lead tests into its Centers for Disease Control and Prevention (CDC) provided database, Systematic Tracking of Elevated Lead Levels & Remediation (STELLAR).

The CLR distributes a wide variety of surveillance reports. The reports include the daily faxed reporting of elevated blood lead levels (EBL) $\geq$ 20 µg/dL and weekly faxed reporting of EBL $\geq$ 10 µg/dL to Local Health Departments used for case management. Other generated reports include the quarterly provision of detailed tables of the aggregate blood lead test results by jurisdiction, and the quarterly electronic datasets for all children tested. This latter report is complied for the benefit of the Maryland Medical Assistance Program (Medicaid) at the Department of Health and Mental Hygiene (DHMH). The DHMH Medicaid program uses this CLR report, previously matched to confidential data files, for submission to the enrollees' HealthChoice Managed Care Organization. Quarterly data reports are also sent to CDC Childhood Lead Poisoning Prevention Program (CLPPP), as required by the CDC cooperative agreement.

According to the blood lead reporting law, laboratories certified by the Office of Health Care Quality (OHCQ) at DHMH, must provide to laboratory draw sites and offices of health care providers a requisition form and instruction how to collect all information required by the CLR. Laboratories are required to obtain all required information and report these values to the CLR. Reporting requirements mandate reporting every 2 weeks whenever possible. The CLR receives reports from a total of 25 laboratories across the nation; 92% of all reports are submitted electronically. The LPP Program CLR Epidemiologist has the responsibility for the consistent processing and maintenance of the blood lead data. The CLR receives approximately 120,000 reports per year.

Compliance for reporting of date of birth, child's first and last name, and blood lead level is 100%. Accurate completion of address information further improved in 2006. More than 92% of blood lead tests were geo-coded at the census tract level. Accurate census tract geo-coding is also used to determine county of residence. By far, the largest problem is <40% compliance rate with reporting information that is necessary

## 1. Surveillance

for local health department case management, i.e., Guardian Name and telephone number. Although 17 of the smaller reporting laboratories on average report 85% of Guardian Name, the two largest reporting laboratories average 58% and 10% for these items. MDE monitors reporting compliance and sends warning letters to laboratory directors as needed.

Now that certain case management actions must be initiated by the local health departments when BLL equals or exceeds 10 µg/dL, the contact information on the laboratory report, such as Guardian Name and telephone number, becomes a critical piece of information for persons in the local health departments who initiate mandated intervention and follow-up activities. Local health departments have an understandably difficult time reaching working parents when only the home telephone number is listed on the laboratory report. For this reason, it has been requested that the CLR encourage the Health Care Providers to obtain current contact information and include it on the laboratory requisition especially the listing of at least two telephone numbers.

Several surveillance quality control oversight mechanisms are in place. The Lead Data Sharing Group, established in 2000, meets quarterly with regular attendance from MDE CLR staff, DHMH representatives involved in the Childhood Lead Screening Program, Medicaid's Division of Data Management & Analysis in the Office of Planning and Finance, the Healthy Kids EPSDT program, and the information technology office at DHMH. New members as of 2006 include representatives from the LPP Commission Health Sub-Committee. These persons also represent the DHMH/MDE EPHT project, the Coalition to End Childhood Lead Poisoning (CECLP), and MCOs. The CLR staff at MDE also submits an annual Quality Assurance (QA) report to the Department.

The CLR has generated and widely distributed an Annual Report on Childhood Blood Lead Surveillance in Maryland since 1995: the 1998 to 2005 reports are on the MDE website. The annual report includes a general narrative with tables, graphs, and maps, and also, since 2003, five detailed supplemental tables by jurisdiction. The CLR Epidemiologist has prepared the annual and ad hoc reports for the Legislative Session and other data summaries in response to other requests. He also provides sets of confidential individual blood lead data based on valid requests. These requests for confidential information have to be justified in writing and approved by the CLR program. Currently, the CLR individual blood lead data can be viewed by selected local health department staff on the DHMH Intranet, a secure and trusted network that can be accessed only by persons who have been granted prior approval and have a unique login ID and password.

The CLR and Medicaid programs distribute reports about the rates of blood lead testing by jurisdiction. Although anecdotal information about barriers to increasing testing in Maryland has been reported to the LPP Commission and to the Lead Screening Program, the lack of good data has hindered the State's ability to clearly analyze and act on identified problems. Agencies and groups who use the blood lead testing rate to

determine the need for program or policy changes are hindered by the fact that the CLR does not receive any reports on the number of blood lead tests ordered by physicians for which a test is never reported.

STELLAR and the associated computer data processing programs used for surveillance and case management are underperforming relative to capabilities of new relational databases. There is also a need for more data integration options than are in STELLAR. STELLAR, a two-decade-old relational database, was principally designed for case management. Its current utility as a surveillance tool, to manipulate data, run queries, and generate charts and other output, is extremely limited. CDC's Lead Program Area Module (Lead PAM), which was under development at CDC, was unexpectedly discontinued by CDC without sufficient notice to CDC funded state childhood lead surveillance programs. The STELLAR system used at MDE is approaching its size limits, and recently documented slow performance and the program's generation of increasingly more error messages are raising concerns about its reliability and short- and long-term longevity. The childhood lead data passes through four separate programs before it can be imported to STELLAR; these tedious processes underscore the conclusion that this data management system is no longer an option.

The blood lead surveillance system needs to be integrated with the environmental enforcement components of the Lead Poisoning Prevention Program for reliable statewide evaluation of the Program's effectiveness. The integration of the blood lead surveillance data with the data in the Lead Rental Property Registry database, Lead Inspection Certificate database, and other environmental databases at both the State and Baltimore City level would reveal important pieces of evaluation information that are not available at this time without extensive manual labor.

**Gaps in Surveillance**

1.1 The compliance of the two largest laboratories is very low in reporting Guardian Name and contact information.

1.2 MDE and local jurisdictions that use STELLAR for case management require current data storage and management resources found in modern relational databases such as MS Access to effectively carry out case management of children with elevated blood lead levels.

1.3 The surveillance system needs to be integrated with the environmental enforcement components of Lead Poisoning Prevention Program for reliable evaluation of program activities.

## 2. Case Management

**Children with EBL**

Environmental investigations are conducted by local health department lead risk assessors in Baltimore City, Prince George's County, and by MDE in all other Maryland jurisdictions. Since 1997, State law regarding case management, Environment Article (EA) §6-304 "Case Management For Children with EBLs", requires providing State level assistance to local health departments for case management of children. MDE provides written guidance for local health department poisoned child case managers, "Case Coordination Guidelines for Lead Poisoned Children" and the "Protocol for Environmental Case Management of Lead Poisoned Children".

Local health departments receive case management resources through State and local early childhood programs such as MCH Title V grants. MDE Outreach Memoranda of Understanding (Outreach MOUs) have supported most counties' local health department case management activities. These activities are supported by lead rental property registration fees since 1998. MDE's CDC Childhood Lead Poisoning Prevention funding has provided support to Baltimore City's lead program since 1991, with decreased funding over time, due to CDC budget decreases.

EA §6-8, "The Reduction of Lead Risk in Housing Law," require local health departments to provide "Official Notice, Report of Elevated Blood Lead Level," commonly referred to as "Notice of EBL" to parents and rental property owners in cases where a child's blood lead level is a venous result $\geq$ 10μg/dL, or 2 capillary tests $\geq$10μg/dL within 12 weeks of each other. Documentation of an EBL is a trigger that subsequently requires rental property owners to provide legally mandated interventions and remediation of offending rental units.

Case managers are responsible to make certain that a child with an EBL receives necessary intervention, such as appropriate medical follow-up, referral to Infant and Toddlers, Healthy Start, and other appropriate responses to resolve psycho-social issues faced by the affected child's family. Medicaid regulations require MCOs to provide case management to their lead exposed patients. Three tertiary care centers with lead specialists are available for consultation or for treatment; these include the Kennedy-Krieger Institute, Mount Washington Hospital in Baltimore City and the Children's National Medical Center in Washington D.C.

As of December 2006 there were 1,274 children receiving case management assistance in Maryland: 843 from Baltimore City and 431 in other counties (Maryland Childhood Blood Lead Surveillance Report, 2006). The MDE LPPP, working from the laboratory reports received by the Childhood Lead Registry, faxes each laboratory report

of an elevated blood lead level (EBL report) to the appropriate local health department contact, as previously stated. Local health departments are required to initiate case management intervention upon receipt of an EBL report. A home visit by the health worker is the preferred first intervention when the BLL ≥ 15 µg/dL. A dampened of takes place if the blood lead level is from 10 to 14 µg/dL. These activities include mailing materials or calling the family as a first step to provide education about the negative health effects in children who have elevated blood lead levels. However, some local health departments provide home visits when the BLL is ≥ 10µg/dL. BCHD provides an environmental investigation when the BLL is ≥ 10µg/dL

Local Health Departments should follow case management policies and procedures recommended by MDE. In point of fact, many EBL cases may remain open for years because one or more of the following reasons:

- difficulty relocating the child to lead-safe housing;
- unable to follow a child with an elevated blood lead level when the family abruptly moves to another residence;
- non-compliance with treatment recommendations;
- legal issues that delay successful enforcement;
- a child having a long-term low level lead exposure that does not reach the action threshold for an EBL. It is know that the longer the exposure continues (especially at lower level) the longer it will take for the elevated blood lead level to decrease;
- physicians failing to conduct follow up testing in accordance with the CDC recommendations or not re-testing the child when the family is in for an office visit; and
- local health departments reluctance to "administratively" close cases that do not meet the State's guidelines for closure, even when there were at least three attempts to make home visits.

**Residences with Children with EBL**

Environmental Sanitarians, certified as Lead Risk Assessors at MDE, Baltimore City, and Prince Georges County conduct an environmental investigation after receiving a referral from a local health department health worker. BCHD has set a policy to conduct an environmental investigation at the BLL ≥ 10 µg/dL. MDE and Prince George's County conduct an environmental investigation with a first time venous level ≥15 µg/dL. Local health and environmental departments must follow MDE guidelines and protocol or comply with MDE-approved guidelines and protocol. Maryland protocol is consistent with Federal recommendations from CDC and Housing and Urban Development (HUD) regulations. These guidelines and policies require that case management continue until discharge criteria conditions are attained.

## 2. Case Management

Case managers' most difficult task is to relocate both tenant and owner-occupant families. The LPP Commission Health and Housing Sub-Committees reviewed options to establish a sustainable and cost effective Temporary Relocation Housing Plan to accommodate families with children having BLLs > 10 µg/dL. The sub-committee report, submitted to the Governor's office in February 2007, recommended a pilot temporary relocation housing project (Attachment 1). Baltimore City Housing received HUD approval to set aside seventy-five Section 8 Housing Vouchers for tenant families of children with EBL for permanent relocation. It will be the first time in more than 5 years that this option is available to case managers with eligible families.

Most children do receive appropriate medical follow-up, but too many of them continue to live in housing with lead hazards. Relocation of a family to a safe residence and/or rehabilitation of these hazardous residences can take many months. Recently MDE started to collect these data on lag times. Case management of lead poisoned children is rarely successful in accomplishing the ultimate goals of either removing the lead hazard from the child's home or relocating the child away from the source of the lead hazard, which usually includes deteriorated lead-based paint. Ideally, the case manager would have the authority and resources needed for the family to improve their living conditions. In reality, there are more barriers than paths to accessing funding to repair the current house or to relocate into safe and affordable housing. Milwaukee and Philadelphia have developed model lead intervention programs, with fewer barriers and more flexible and successful financing strategies that allow for a quick response to fix houses and relocate families.[1]

**Resources for Fixing a Residence in Response to a Child with EBL**

### Resources for Fixing Rental Property – pre-1950

Case managers generally find that when rental property owners come into compliance with EA 6-8 and respond within 30 days to a Notice of EBL, a child's exposure to lead hazards is successfully lowered. Properties in compliance with EA 6-8 are rarely the source of lead hazards for children with EBLs.

Notice of EBL triggers enforcement actions by MDE against non-compliant properties. At a BLL ≥ 30µg/dL MDE initiates a "Fast Track" enforcement procedure to assure a quick response by the non-compliant property owner, but legal proceedings can take, under some circumstances, longer than 30 days. Even when the property owner might be willing to make the necessary repairs quickly, affected families may have difficulty locating temporary affordable housing.

[1] www.afhh.org/building blocks, produced by Alliance for Healthy Homes and the Lead Poisoning Prevention Branch of the Centers for Disease Control and Prevention. "Deploy Enforcement Orders and Grant Incentives in Tandem", "Abate Lead Hazards and Recover Costs when Owner Fail to Act."

## 2. Case Management

The Qualified Offer portion of the Reduction of Lead Risk in Housing Law was intended to have the Property Owner pay for immediate relocation. However, a non-compliant property owner is not eligible to have the law's liability protection. This legal limitation is made more complicated because most EBLs have occurred in non-compliant properties.

Under an MDE contract, the CECLP provides in-home counseling services to families to help in understanding rights and responsibilities included in the Reduction of Lead Risk in Housing Law. The CECLP also coordinates all aspects of the Qualified Offer process. Services to Persons at Risk who are not eligible for or who do not accept the Qualified Offer include the sending of Notices of Defect to the owner of the rental property.

The CECLP 2006 annual report to MDE stated that, of the 718 affected properties referred containing children eligible for a Qualified Offer, only 16% of those properties had received risk reduction certification. Only 96 (13%) of those 718 affected properties were both registered and had met inspection certification requirements.

The CECLP report cumulative Qualified Offer Statistics stated that 105 Qualified Offers were made, and 68 were accepted. The average Qualified Offer total expenditure per household is $3,092. Relocation Benefit payments totaled $180,603 while Medical Benefit payments totaled $4,912. The majority of the Qualified Offers were issued during the initial years of the law, and those beneficiaries have reached age 6 making them no longer eligible to receive Relocation Benefits.

The use of the Qualified Offer Medical and Relocation Benefits is limited. Medical benefits are usually covered and reimbursed by State-run medical programs. Less traditional medical services such as speech therapy, educational tutoring, or behavioral therapy services are offered for free by the school system. The ability to relocate into a higher quality of housing or housing certified as lead safe or lead free is limited by higher approval standards. Families may have poor or insufficient credit history, poor rental history, outstanding utility bills that prevent them from establishing service, and inability to afford the base rent in a safe home without the multiple contributors who will remain in the non-compliant property. These factors and the increased demand and higher market pricing in Baltimore City also contributes to the families moving back into non-compliant housing. The Relocation Benefit ceases at age 6 years. A family may use up all the Relocation Benefit before a child is age 6 years while most if not all of the Medical Benefit remains.

### Resources for Fixing Rental Property – post-1950

Owners of rental properties built between 1950 and 1978 can "opt-in" or select entry into EA 6-8 liability protection. Owners of seven thousand nine hundred forty-seven (7,947) of 17,087 of 1950 – 1978 rental properties (45%) made this selection

statewide. Local housing codes vary across jurisdictions. Baltimore City has had a lead-specific housing code (Baltimore City, Housing Code Regulation 5) since 1988, with more than 1,000 enforcement actions completed since 2000. The Mayor and City Council of Baltimore enforce local Health and Housing Codes relating to lead hazards. These complaints request the court to order owners/operators to abate lead containing residences based on guidelines established by EPA and HUD. In fiscal year 2007, the City filed 125 cases and 130 properties were abated of lead hazards. These actions occurred through district court injunction complaints. In 2006, 6% of cases in Baltimore City (24 of 407 cases) and 35% of cases in the remaining Maryland counties (76 of 214 cases) lived in post 1950 rental units. The conclusion, based on anecdotal evidence from case managers statewide, is that rental property owners who did not accept (opt-in) EA 6-8 were slow to make the necessary repairs in comparison to rental property owners who complied with EA 6-8.

### Resources for Fixing Owner-occupied Property

Anecdotal evidence suggests that a family's income is associated with the length of time required to remediate lead hazards following identification of an EBL child. Families with sufficient financial resources are able to quickly correct the lead hazards and reduce their children's exposure. A family without sufficient resources is often not able to correct the lead hazards.

The Lead Hazard Reduction funds in the State and Baltimore City are available to pre-1950 rental property owners when there is a child who has an EBL. Although housing grants and loans programs managed by the Department of Housing and Community Development (DHCD) and Baltimore City Health Department Lead Abatement Action Project Program (LAAP) give priority to housing units with lead poisoned children, many barriers exist that prevent the use of these funds. Owner-occupied properties in which EBL children reside often have had inadequate maintenance and can have structural defects. Such properties are prohibitively expensive to repair; they are excluded under these loan programs. Additional barriers to lead hazard rehabilitation include no property insurance, clear property title, poor credit history, or families not willing to complete the application.

On the Federal level, lead hazard reduction funds are now under the HUD Office of Healthy Homes and Lead Hazard Control. Projects funded by the Healthy Homes program combine funding for the formerly separate elements of lead hazard reduction, mold remediation, integrated pest management (IPM), and allergen reduction in response to lessons learned in the field. CDC is beginning to organize around place and life stage rather than specific disease and conditions, as a move to a more comprehensive focus on healthy homes. Public health field staff and program managers of the housing funding programs have repeatedly found that lead paint is not the only environmental health hazard in homes of most children with EBL. Mold remediation, allergen reduction and integrated pest control are also present. Unfortunately, families who own these homes or

live in these homes as renters have limited economic resources to carry out all necessary interventions. Recently, the LPP Commission Sub-Committees initiated discussions on the need to explore the potential for developing stronger problem-solving strategies with a more diverse set of housing partners, but keeping the Healthy Homes model. To illustrate this approach in Maryland, BCHD is the first and only public agency in the State with a Healthy Homes Division.

**Non-Lead-Based Paint Sources**

In the past year, other sources of lead hazards, such as imported children's jewelry, toys, and non-traditional remedies, have received more attention in Maryland. There have been several cases associated with children with EBLs where lead paint and dust have not been the major hazard source. However, case management documentation of non-lead based paint sources is inconsistent and adequate assessment is not possible at this time. As lead paint controls become more widespread and effective, and more pre-1950 units are replaced with newly constructed housing stock free of lead paint, other background sources will become more significant.

**Gaps in Case Management**

2.1 The barriers to funding remediation need to be addressed with more creative solutions, both with new sources for housing grants and loans, and enforcement.

2.2 A complete evaluation of the environmental public health response and related interventions to a child's continuing exposure to lead hazards is long overdue. Electronic recording of additional case management data and linkage between case management, environmental investigation and the Childhood Lead Registry databases are needed, and should be completed on an ongoing basis.

2.3 Case Management documentation about specific non-lead paint sources is incomplete, making comprehensive assessment inadequate and difficult.

2.4 Additional available funding sources need to be leveraged to their fullest capacity. Local housing departments' funds and Section 8 funds should be made available in all Maryland jurisdictions.

2.5 There continues to be the absence of a functioning system with housing units secured for temporary relocation as recommended by the LPP Housing Sub-Committee. Additional resources are needed to enable emergency placement of all children with EBL $\geq$15 μg/dL within 3-7 days of available blood lead test results.

## 2. Case Management

2.6 Lack of resources to permanently or temporarily relocate tenants to lead certified housing living in non-compliant properties.

## 3. Targeting

### Major Risk Factors

The number of children with blood lead levels ≥10 μg/dL continues to decrease each year but remains an important unresolved problem. Preliminary work to determine the most sensitive indicators of childhood lead poisoning in Maryland show that the percentage of families with children under five years of age who are from families with annual incomes low enough to be included in the Federal Government's definition for poverty (US Bureau of Census) is the next most significant risk factor after pre-1950 housing. In both Baltimore City and the Maryland lower Eastern Shore, there are high percentages of households with annual incomes at or below the poverty level, especially in older communities. The majority of children with lead exposure at high enough levels mandating case management in the State are African-Americans.

### Infrastructure

The Maryland Targeting Plan for Childhood Lead Poisoning was developed in an effort to increase the blood lead testing rate and was based on many variables including housing and income. All of Baltimore City and most of the Lower Eastern Shore are targeted areas where a higher percentage of low-income families on Medicaid are concentrated. Sixty-eight percent of Baltimore City residents and 25% of Lower Eastern Shore residents are from minority populations. Maryland does not require universal testing Statewide, but has statutory requirements for testing in areas identified as at risk. Medicaid's Federal EPSDT requirements do require universal blood lead testing for one and two year olds receiving Medicaid health services. Maryland's screening policies for non-Medicaid children have always been consistent with Federal standards that recommended universal testing in 1991 and recommended targeted testing in 1997.

Maryland law, Health-General Article §18-106, Code of Maryland Regulations (COMAR) 10.11.04, require health care providers of children living in areas designated at risk for lead poisoning as determined by the Maryland Targeting Plan to administer a blood test for lead poisoning at the 12 and 24 month visit. Additionally, when a child enters a public pre kindergarten, kindergarten or first grade, the parent or legal guardian of the child is required to provide documentation from a health care provider certifying that the child has been tested for blood lead if the child currently lives or has lived in an 'At Risk' zip code.

DHMH uses Medicaid Encounter Claims data matched to the CLR to evaluate the rate of testing by Medicaid MCO. MCOs that fail to meet a certain standard as part of the Medicaid Value Based Purchasing initiative are penalized financially. To aid in MCO efforts to meet or exceed standards, Medicaid provides MCOs with the names and demographics of children who did not receive their blood lead test as required.

## 3. Targeting

Baltimore City requires Universal Testing of 1 and 2 years olds and requires reporting to its own Childhood Lead Registry under City Ordinance No. 20, Lead Poisoning Screening

Besides targeting for blood lead testing, the State environmental law requires targeted education and outreach about primary prevention. Environmental Article §6-8 targets pre-1950 rental properties, which is where most of Maryland's childhood lead poisonings occurred prior to 1994. The law requires MDE to fund outreach to tenants and property owners in areas of highest risk to increase awareness in the target population and to educate rental property owners about their responsibility under the State's primary prevention law.

### Current Status of Testing Rate

The most current surveillance data (2006) from MDE's CLR show that the blood lead testing rate of children 0-72 months Statewide averaged 22.2% (18.2% in 2002) with a high of 36.3%in Caroline County, which is entirely within an at risk area. Overall testing has increased Statewide. (Attachment 2, Childhood Blood Lead Surveillance in Maryland 2006 Annual Report) The highest testing rates for children 0-35 months were found in Caroline county (59.7%), Somerset county (51.0%), Dorchester county (47.9%), and Wicomico county (47.2%), each of which has all zip codes designated as at-risk in the Maryland Targeting Plan.

### Gaps in Targeting

3.1 Medicaid efforts to improve testing rates should continue, as lower income children are more likely to live in substandard housing.

3.2 State efforts must continue to concentrate on achieving the Governor's 2000 Initiative's goal of 75% testing of targeted children both Statewide and in Baltimore City.

3.3 Anecdotal evidence suggests that there are barriers to blood lead level testing for both health care providers and families. However, lack of solid data has made it difficult to develop an action plan to help improve testing of targeted children.

## 4. Coordination and Leveraging of Resources

**Partnerships**

Tri-agency (health, environment, housing), coordination has been ongoing since 1988 and again was directed by the Governor's Initiative in 2000. Key partners from each agency attend monthly LPP Commission meetings, participate in the Health and Housing Sub-Committees' meetings, and communicate with each other as needed to assure coordination of lead poisoning prevention activities. The Maryland LPP Commission has made recommendations to the Governor, Legislature and MDE regarding lead poisoning prevention since 1995.

Environment Article §6-807 formed the current Lead Poisoning Prevention Commission in 1994 (Attachment 3, Lead Poisoning Prevention Commission). The Commission has the authority and responsibility to look at regulatory and legislative changes which may be needed; evaluate incentives for increasing the number of lead safe units; and assess ways of expanding blood lead testing in young children. Its 19 appointed members (17 appointed by the Governor and 2 by the General Assembly) represent many affected parties, both in the public and the private sectors, including health care providers, child health advocates, housing advocates, property owners, hazard identification industry, parents, insurers, and several state and local agencies including Health, Housing, Insurance, Child Care, Education, and Environment and the General Assembly. The seats for a representative of a financial institution that makes loans secured by rental property, a parent of a lead poisoned child, a banker, an insurer, and a child care provider have never been successfully filled.

Recent partnerships with the Maryland State Department of Education (MSDE) and Maryland Home Improvement Commission (MHIC) resulted in new significant activities. In October 2006, MDE announced that MSDE made available lead poisoning prevention lessons for use to address the middle and high school core learning goals. MSDE accomplished this with the assistance of EnviroHealth Connections, a cooperative project of the Institute for Urban Environmental Health at the Johns Hopkins Bloomberg School of Public Health and Maryland Public Television. In April, 2007, Housing Sub-Committee discussions with the MHIC Director resulted in a plan to accomplish the following actions:

- Establish a link to MDE's Lead webpage from the MHIC webpage;
- Add a flyer with MDE lead laws about contractors/EPA 406B Renovation Rule information to MHIC's licensing application and licensing renewal packages;
- Set up a meeting with the Maryland Independent Contractors Association (MICA) for presenting lead laws at a large group meeting of contractors;
- Make a presentation on the lead laws affecting contractors at MHIC's 3rd Thursday workshops for contractors, which began June, 2007.

## 4. Coordination and Leveraging

Ongoing coordination and leveraging of resources, especially in Baltimore City, is evident in the oversight and planning functions within the Lead Poisoning Prevention Commission, and within the State and local groups who meet or share data at regularly scheduled events that include:

- MDE holds bi-monthly Enforcement Workgroup meetings that coordinate the agency's enforcement actions.
- MDE, BCHD, and other stakeholders hold meetings at least monthly to coordinate the efficient distribution and use of services.
- Lawyers for MDE, BCHD, DHCD, CECLP, Public Justice Center, and Legal Aid meet quarterly to coordinate around enforcement actions.
- MDE, BCHD and Baltimore Housing have worked together to ensure that all violation notices issued by Baltimore Housing for defective paint in a pre-1950 rental unit also serves as a Notice of Defect, triggering a requirement that the property owner obtain a Risk Reduction certificate within 30 days. Each month Baltimore Housing submits a list of approximately 50 units in which it has issued a notice of defect. MDE initiates enforcement actions against noncompliant units.
- MDE Lead Enforcement officials hold meetings with local county health and housing code officials to discuss incorporating lead laws into local health and housing codes.
- MDE annually conducts information-exchange meetings with a variety of groups, i.e., lead inspectors, lead abatement contractors, and lead training providers, local health department and their housing partners.
- The Lead Data Sharing Group continues quarterly meetings. A wide range of surveillance issues are discussed at these meetings. This committee now has an expanded membership that includes: persons from the Environmental Public Health Tracking Project, representatives from BCHD, DHMH, CECLP, MCOs, and Lead Tertiary Care Centers who also serve on the LPP Health Sub-Committee.
- The MDE Childhood Lead Registry provides quarterly blood lead surveillance data to the DHMH Medicaid Administration. The DHMH Medicaid Administration provides specific information to the MCOs about their clients' blood lead testing reports, or lack thereof, and if a required test of a 1 or 2 year old child was not submitted to a laboratory.
- MDE, DHMH and DHCD sponsor regional meetings between local health, environmental and housing agencies and interested private sector groups to keep involved public and private agency staff informed about lead issues and procedures.
- MDE and CECLP conduct monthly Partnership Meetings that foster a widespread involvement among the partners in collaborative activities.

MDE, local health departments, and CECLP coordinate an Annual Lead Poisoning Prevention Week to coincide with the National Lead Poisoning Prevention Week. It is

held during the third week in October. Over the years, participation in outreach and education efforts have increased and include: DHMH, DHCD, the Office of Child Care , local housing departments, property owner associations, child advocacy organizations, realtor associations, the MHIC, MSDE, private housing organizations, researchers, health care providers, parents, foundations, advocates, Medical Assistance Administrations, MCOs and insurance agencies.

MDE coordinates with the Environmental Protection Agency (EPA) to assure compliance with the Federal Title X Disclosure Rule. EPA has handled only one case in Maryland.

**Financing Case Management**

MDE and the local health departments use multiple sources of Local, State and Federal funding to provide environmental investigations and case management. State Lead Outreach funds and CDC sub-contractor funds are used, but in 2006 CDC made it clear that it will no longer pay for any reimbursable Medicaid services for Medicaid-eligible children. MDE and BCHD pursued discussions with DHMH for Medicaid determination as to eligibility for reimbursement of nursing case management and environmental investigations conducted on Medicaid eligible children 0-36 months of age. As of October 2007, DHMH Medicaid has not submitted the necessary plan to the Federal government to request such reimbursement.

**Financing Lead Hazard Reduction**

Private and public financing are key to primary prevention efforts in housing: the control or replacement of lead paint before children become exposed. This is accomplished through several types of activities: routine maintenance in rental units; turnover maintenance in rental units performed to meet requirements under the Maryland lead law; rehabilitation of older rental units; renovation and rehabilitation of owner-occupied units; large-scale rehabilitation of large multiunit projects for rental or resale; and, demolition of older units. See Table 1, "Lead Risk Reductions 1993 – July 2007."

## Private Funds for Lead Hazard Reduction

Private financing of routine unit lead paint management activities at turnover in pre-1950 rental units is the largest contributor to lead hazard reduction in housing in Maryland. Much of this is in response to Maryland's Reduction of Lead Risk in Housing Law that requires that pre-1950 rental units meet a minimum a standard of care for in-place management of paint. Unit costs vary widely depending on size, construction, and initial condition. Compliance occurs either "voluntarily" with owners meeting treatment standards on their own as required by the law, or in response to enforcement actions by MDE or local jurisdictions. Compliance data are in Table 1.

Private financing of lead hazard control also occurs in owner occupied units and as part of major rehabilitation in multi-unit projects for future resale. There are no inspection or reporting requirements for projects undertaken for the purpose of renovation of owner-occupied units or post 1950 rental units. Therefore, data to report on these activities is not available.

## Maryland State Funds for Lead Hazard Reduction

Maryland DHCD has made grant and low interest loan funds available to residential property owners specifically for lead hazard reduction to assist homeowners and landlords to lessen the risk of lead poisoning and preserve the housing stock. Since 1987, Maryland's Lead Hazard Reduction Loan and Grant Program has approved 970 loans/grants totaling $5.4 million in funds to assist property owners and day care centers with risk reduction work related to lead. In 1995, significant changes were made to the statute and regulations including introducing a grant component; eliminating income restrictions; and permitting modified risk reduction treatments as opposed to full abatement of the property. The program is funded by the State and has no income limits. The funding level for FY08 is $2 million. Grants or Loans provided are based on the applicant's ability to repay State funding for lead hazard reduction. This program can be utilized by either owner occupants or rental property owners if there is not an EBL child.

The Single Family Housing Rehabilitation Programs provide rehabilitation funds for housing or plumbing repairs for single-family owner-occupied properties and one to four unit rental properties. The program is funded by the State and eligibility is determined by income. Funding for FY08 is $3.2 million.

## Federal Funds for Lead Hazard Reduction

HUD's Office of Healthy Homes and Lead Hazard Control currently funds grants to Maryland DHCD, Baltimore City Health Department Lead Abatement Action Program (LAAP), and the CECLP. Funding is awarded competitively and targeted to higher risk low-income owner occupied and rental units.

## Lead Risk Hazard Reductions Data

Counts of units that have received treatment for some version of lead risk reduction are summarized in Table 1. Because treatments usually focus on management in place rather than full removal, and because treatment may include significant repairs of underlying causes such as a leaking roof, units may be included in more than one fund source. State and local lead hazard reduction grants apply to specific requirements and conditions being met. This limits lead hazard reduction assistance to some applicants.

## 4. Coordination and Leveraging

**Table 1**
**Lead Risk Reductions 1993 – July 2007**

| **Location** | **Private**<br>Pre-1950 Rental Units Full Risk Reduction Inspection Certificates (Since 1996) | **Private**<br>Pre-1950 Rental Units<br>Lead Free inspection certificates (Since 1996) | **Federal**<br>HUD Lead grants and CDBG (Since 1993) | **State**<br>Lead Abatement grant and loan funds Breakout not available prior to 2006 (Since 1987) | **State**<br>Governor's Lead Initiative (2000 – 2003) |
|---|---|---|---|---|---|
| **Baltimore City** | 86,159 (Aug.2007) | 71,221 (Aug. 2007) | CECLP<br>757<br>39 in pipeline<br>(1997-Sept.2007) | Data not available | Not applicable |
| | | | MD DHCD (Breakout not available) | Data not available | Not applicable |
| | | | LAAP<br>1,400 completed<br>700 in pipeline<br>(Aug.2007) | 61 (2006-07) | 700 |
| **Other Jurisdictions Statewide** | 72,839 (Aug.2007) | 122,048 | 1,496 completed.<br>50 in pipeline | Data not available | Not applicable |
| **TOTAL** | 158,998 | 193,269 | 4,442 | 1,122 | 700 |

### 4. Coordination and Leveraging

**Financing Outreach and Education**

## Private Funds for Outreach

The CECLP has received private funding for lead poisoning prevention outreach, primarily local foundation grants. Information is not available on amount of funding made available by private funders.

## Maryland State and Baltimore City Funds for Outreach

MDE, DHMH, and BCHD fund and promote a variety of activities for different populations and different purposes. MDE's Lead Poisoning Prevention Fund consisting of $750,000 per year, established by the Maryland Reduction of Lead Risk in Housing law, supports State and local outreach in addition to covering operating costs of implementing the law. MDE funding for annual Outreach MOU grants to 21 of the 23 local health departments and to Baltimore City to support outreach and case management decreased from $600,000 in FY1999 to $508,000 in FY2007. In FY1999 local health received $30,000, in FY2007 it was given $18,000. In FY1999 Baltimore City received $200,000 and in FY 2007 $148,000. Locally based outreach was directed to tenants, rental owners, owner occupants, parents, and health care providers. This fund source also pays for printing for the outreach materials targeted at parents, tenants, rental owners, and owner occupants. MDE annual funding to a non-profit organization for outreach and assistance for tenants and property owners at approximately $250,000 per year, this is the amount that has gone to the CECLP.

DHMH Center for Maternal and Child Health promotes blood lead testing, a WIC pilot project, and an Improved Pregnancy Outcomes program that includes specific lead poisoning prevention activities. The Medicaid Division of Outreach and Care Coordination's Healthy Start Program funds care for children 0 – 2 years old born to women on Medicaid Managed Care. Medicaid funds are used by MCOs and local health department Administrative Care Organizations (the local health department single point of entry for adults and children) to provide outreach that includes lead poisoning prevention topics. BCHD implemented new cross-training projects with other maternal, infant, and child health home visiting programs that resulted in an increase in direct lead poisoning prevention education through home visits to the highest risk population in Baltimore City.

## Federal Funds for Outreach

CDC's Childhood Lead Poisoning Prevention (CLPPP) funding to Maryland and BCHD supports technical consultation to local health departments regarding primary prevention outreach and education activities. MDE is currently using some CDC CLPPP funds for more intense primary prevention activities in local health departments on the

Eastern Shore through a Regional Lead Poisoning Prevention Project with Wicomico County Health Department. HUD grants to state and local agencies have also included funding for outreach and education efforts.

In 2007, the CECLP successfully competed for an EPA Outreach grant for $243,000 that will fund outreach activities with Coppin State University to be conducted in neighborhoods surrounding the University.

## Health and Housing Code Support of Lead Poisoning Prevention

Currently, local municipalities and counties in Maryland that grant permits for the rehabilitation of pre-1978 residences and schools do not require assurances that families be protected from the risk of lead poisoning due to the renovation or rehabilitation activities that disturb lead based paint. The International Code Council, a membership association dedicated to building safety and fire prevention, develops the codes used to construct residential and commercial buildings, including homes and schools. Most U.S. cities, counties and states that adopt codes choose the International Codes developed by the International Code Council which does not deal with environmental issues. However, they do recommend that permits be acquired through local codes for demolition and construction operation of homes and schools. This is where local codes can address safe handling of lead-based paint. Of the more than one hundred fifty local jurisdictions in Maryland that govern the safety of their housing, it is possible that very few local codes insure that lead based paint is safely handled during renovation or rehabilitation activities.

## Banking and Lending Institution Support of Lead Poisoning Prevention

Banks and lending institutions that underwrite loans for rehabilitation of pre-1978 residences in Maryland do not require assurances that lead exposures of families to the risk of lead poisoning be minimized during rehabilitation activities that disturb lead based paint.

## Real Estate Companies and Agents Support of Lead Poisoning Prevention

The Federal Disclosure Rule already requires real estate agents to assure that sellers inform buyers about the presence of lead based paint, and buyers are given a copy of the EPA booklet, “Protect Your Family From Lead In Your Home.”

## 4. Coordination and Leveraging

### Gaps for Coordination and Leveraging of Resources

4.1 Disparities exist in how the local municipalities and counties administer housing code, livability code, and local rental registration enforcement with regard to lead laws and hazard controls.

4.2 One-unit property owners usually do not belong to property owner associations and are not aware of the Maryland lead law.

4.3 Neither the State nor local health departments, except Baltimore City, enforce risk reduction measures in owner-occupied and post-1950 rental units.

4.4 Public state and local health departments have rarely approached locally based private foundations for funding. Public partners have submitted few agency applications for HUD and EPA funding opportunities. The State has no lead grant manager.

4.5 Budget restrictions have significantly reduced availability of MDE funding for contracts for outreach and education.

4.6 Federal funding potential for lead hazard reduction and outreach could be better accessed. HUD's 2007 SuperNOFA for the Lead Outreach Program offered in April 2007 provided funding to raise public awareness and deliver HUD-approved training about lead-based paint. However, only BCHD and CECLP submitted successful applications.

4.7 Federal funding potential for reimbursement of case management activities could be tapped by an application to the Federal government from the DHMH Medicaid Administration.

4.8 The LPP Commission seats for all eleven representatives should be filled.

4.9 Banks and lending institutions that underwrite loans for rehabilitation of pre-1978 houses do not require a borrower to know about the risks of lead or the need for lead safe work practices.

## 5A. Primary Prevention Source Control

**Residential Lead Paint**

Most cases of childhood lead exposure (BLL ≥10 μg/dL) in Maryland are associated with deteriorated or damaged residential lead paint, originating from pre-1950 housing. According to the US Census Bureau, 2005 American Community Survey, there are more than 368,000 residential housing units built before 1950 (95% likely to contain lead paint) and 897,000 housing units built between 1950-1979 (75% likely to have lead paint). The main factors contributing to the decline of blood lead levels are the movement of families away from older housing into more recently built city or suburban housing and state efforts to make older houses safer.

**Maryland Housing Units by Type of Occupancy and the Year Structure Built**

| Occupancy and Year | 2000 Housing[1] | | | 2005 Housing[2] | |
|---|---|---|---|---|---|
| **Structure Built** | **Number** | **Percent** | | **Number** | **Percent** |
| Owner occupied | 1,341,594 | 100.0 | | 1,438,614 | 100.0 |
| 1980+ | 507,485 | 37.8 | | 613,226 | 42.7 |
| 1950-1979 | 576,420 | 43.0 | | 580,816 | 40.3 |
| Pre- 1950 | 257,689 | 19.2 | | 244,572 | 17.0 |
| | | | | | |
| Renter Occupied | 639,265 | 100.0 | | 647,033 | 100.0 |
| 1980+ | 171,397 | 26.8 | | 206,488 | 31.9 |
| 1950-1979 | 333,338 | 52.1 | | 316,312 | 48.9 |
| Pre- 1950 | 134,530 | 21.0 | | 124,233 | 19.2 |

1. US Census Bureau, US census of population and housing of 2000.
2. US Census Bureau, 2005 American Community Survey.

Although the State of Maryland has experienced growth in new housing, many established urban areas contain an abundance of older housing (Attachment 4,Map 1). In Baltimore City, 129 (64.8%) of the 199 residential census tracts have concentrations of pre-1950 housing ≥50%. More than 58% housing units on the Lower Eastern Shore were built before 1979. More than 66% of houses Statewide were built before 1979.

Due to the high contribution of residential paint to childhood lead exposure, much of Maryland's source control infrastructure is aimed at residential lead paint. The basic elements of Maryland's lead laws for primary prevention are discussed below.

## 5A. Primary Prevention – Source Control

**State Law**

. **Reduction of Lead Risk in Housing Law, Title 6 Subtitle 8 of Environment Article (EA 6-8) 1994, with 1996 implementing regulations COMAR 26.16.01-04.** This law applies to all pre-1950 rental units except those certified as lead free. It affects 1950 – 1978 rental units only for property owners who opted in, and it has no effect on owner-occupied homes. It established a mandatory standard of care including lead risk reduction treatments and independent inspection in vacant units before each change in tenants, distribution of educational materials and inspection certificate to new tenants, and registration with State Lead Rental Property Registry. The property owner must provide educational materials to the tenant (EPA brochure "Protect Your Family from Lead in Your Home" and the "Maryland Tenant's Rights Notice") at each change in occupancy, and every two years thereafter.

Landlords must also respond to a Notice of Defect or Notice of EBL (elevated blood lead) with additional interim controls and inspections in occupied units. On February 24, 2006, the lead law required that every pre-1950 rental unit had undergone at least one inspection. Private inspectors issued over 158,998 Full Risk Reduction certificates between 1996 and August 2007.

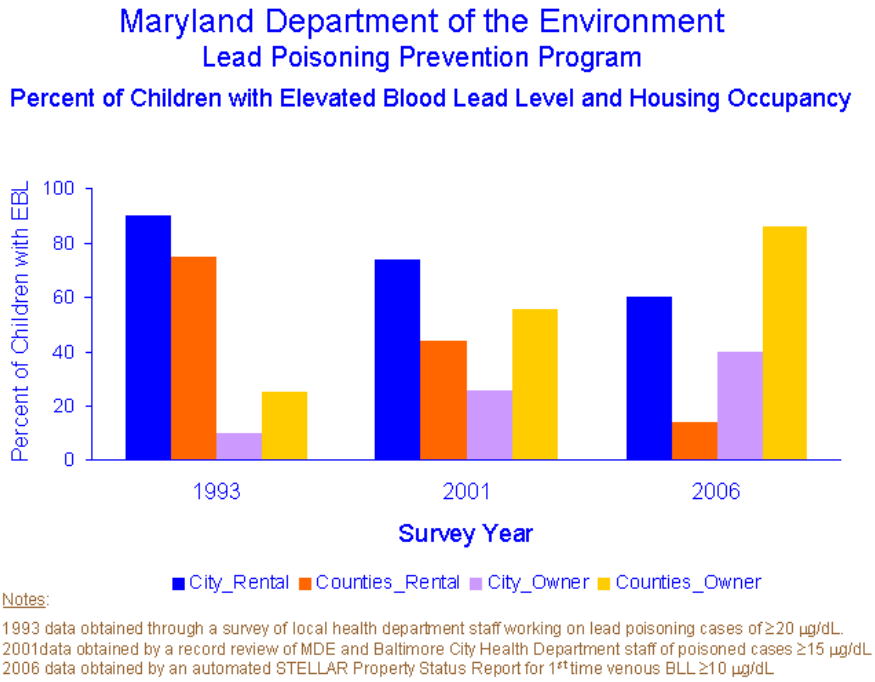
Reinforcing legislation, i.e., Procedures for Rent Court, Real Property Article Section 8, subsection 401(b) and (c), and Procedures for Regulation of Properties for Rent or Lease, Article 24-Political Subdivisions – Miscellaneous Provisions as Section 18, Subsections 101 through Section 18-104 became effective in October 2004. Owners of rental property built before 1950 are required to demonstrate registration and inspection certificate compliance with the Maryland lead law prior to registration or renewal with any local city or county rental registry and prior to use of rent court for repossession of property. Obtaining cooperation from the rent court judges and from the counties' and cities' rental registries is an ongoing effort. Not every jurisdiction maintains a rental registry. The CECLP and MDE educate rent court judges and attorneys, and MDE obtained cooperation from the rental registries in Baltimore City, Howard and Montgomery counties, and the cities of Cambridge, Easton, Frederick, Hagerstown, and Salisbury.

Since the Reduction of Lead Risk in Housing Law was enacted, MDE has initiated over 3,000 enforcement actions, collected over $1,500,000 in penalties, and ensured that 10,794 properties were brought into compliance. There are 440,545 pre-1980 rental units in Maryland according to the US Census Bureau 2005 American Community Survey, of which 193,269 are certified lead free and 158,998 have a full risk reduction certificate. As of February 24, 2006 when the 100% Rule became effective, 89% of the affected units were in compliance with the 100% rule, meaning that each unit had at least 1 Full Risk Reduction Treatment.

**2010 Plan to Eliminate Childhood Lead Poisoning**
**III. Progress Report**

## 5A. Primary Prevention – Source Control

The number and percent of children with blood lead levels of ≥ 10 µg/dL have declined significantly since 1994, especially after increased enforcement efforts started in 2000. Over the past fourteen years, there have been increases in the proportion of children identified with elevated blood lead levels in city and counties owner-occupied properties and parallel decreases in city and counties post-1950 rental units. Ownership




of houses identified as the primary source for a lead poisoned child was 90% rental in Baltimore City in 1992, and 60% rental in 2006. In Maryland's counties, ownership of houses identified as the primary source for a lead poisoned child was 75% rental in 1992, and 14% rental in 2006 (See graph above). The primary residences of most children with blood lead levels of ≥10 µg/dL are not in units that have been treated and certified as meeting the standard of care.

**"Point of Sale Notice" Environment Article 6-848.1 "Paint Retailers Information on Lead Risk Reduction"**. Maryland law passed in 2003 requires that an informational poster be visible at the point of sale of paint for residential use. The poster must contain warning of the hazards of disturbing lead-based paint during renovations, and reference the use of lead-safe work practices. Implementation was combined with an agreement between many States' attorneys general and the National Paint and Coatings Association that requires posters and paint can labeling. In 2006, MDE conducted a second distribution of the posters through a mass mailing to paint stores and other stores with paint departments. Posters are available upon request.

**Procedures for Abating Lead Containing Substances from Buildings, regulations COMAR 26.02.07, 1988, revised 1996 and 2003.** Maryland passed the nation's first State-level regulations for safe work practices for lead abatement, and first lead dust-clearance levels to be met after lead hazard reduction work**.** The original regulations also included a training requirement. Work performed to meet the requirements of the "Reduction of Lead Risk in Housing Law" or other declared lead-abatement (lead hazard reduction) projects must be performed using specified safe practices. These also apply in all residential property including owner-occupied and childcare centers, only if the work is designated as lead hazard reduction work. Enforcement is by MDE inspectors statewide and a cooperative effort with BCHD in Baltimore City. Renovation and remodeling performed in owner-occupied homes and 1950-1978 rental units, including child care centers, not affected by the Reduction of Lead Risk in Housing Law remain unregulated unless the work is designated as lead abatement.

**Accreditation and Training for Lead Paint Abatement Services Titles 6 and 7 of Environment Article and regulations in COMAR 26.16.01, 1995, 1998** The MDE Managing for Results FY 07 Annual report indicates that, as of June 30, 2007, there were 3,023 Lead Inspectors, Lead Risk Assessors, Supervisors, Instructors, courses of instruction and contractors involved in lead related activities in Maryland. MDE's Lead Accreditation and Enforcement Division in fiscal year 2007 conducted 2,625 field and administrative audits of accredited inspectors and contractors to assure implementation of protocols and work practices. MDE Lead Accreditation & Oversight Section conducted 300 oversight inspections of accredited service providers in fiscal year 2007. In October 2006, five hundred thirty-six (536) residential and commercial contractors had current accreditations. Two licenses have been revoked for significant violations.

**Local Housing And Health Codes**

Local housing codes vary across jurisdictions. Baltimore City has had a lead-specific housing code (Baltimore City, Housing Code Regulation 5) since 1988. MDE and BCHD have a working agreement whereby the City focuses enforcement efforts on owner-occupied units and the State enforces EA 6-8 on pre-1950 rental units. If the City

orders abatement in a pre-1950 rental unit, the City also performs clearance testing and issues a risk reduction certificate, which meets State law.

Baltimore Housing coordinates legal casework with BCHD and the CECLP attorneys, especially regarding enforcement of Lead Rental Property Registration. Since 2005, Baltimore Housing Violation Notices have contained a statement about the requirement for pre-1950 rental property registration under EA 6-8. More recently, informational materials, "What a Tenant Needs to Know " and "What a Property Owner Needs to Know," are provided to the landlord and tenant following the issuance of a defective paint notice.

Inclusion of paint condition or lead paint in routine housing code enforcement would broaden the likelihood of identifying and safely correcting hazardous conditions before a child is poisoned, in both rental and owner-occupied housing. Since 2005, Baltimore Housing puts the following paragraph on all permits:

- "Please be advised that there is a presumption of lead-based paint in properties constructed prior to 1950. Protect workers and tenants by using the lead-safe work practices found in the code of Maryland Regulations Section 26.02.07 "

In addition, on a monthly basis Baltimore Housing provides to MDE with a list of properties with Violation Notices related to chipping/peeling/flaking paint problems for enforcement of EA 6-8. As of April 2007, 659 referrals were received, 478 cases were opened, and 415 actions were taken on cases that were opened (145 Advisory Letters, 29 Registration Letters, 154 Notices of Violation sent, 52 Administrative Complaint Order & Penalties, 35 Executed Consent Order Agreements).

**Federal Law**

**Implementation and enforcement of** the Lead Disclosure Rule, Section 1018 of the Residential Lead-Based Paint Hazard Reduction Act of 1992, also known as Title X, is by EPA and HUD with assistance from MDE. Maryland's Lead Poisoning Prevention program has coordinated with both Region III and national EPA when EPA has pursued enforcement cases regarding 1018 Disclosure Rule compliance. These cases to date have been focused in Baltimore City and Montgomery County. EPA completed one case in Maryland.

HUD's 1999 "Lead-Safe Housing Rule" (24 CFR Part 35, subparts B-R) as amended June 21, 2004, requires notification, evaluation and reduction of lead-based paint hazards in Federally owned residential property and housing receiving Federal assistance. The requirements apply to housing built before 1978. Guidance documents were published in 2004. The HUD Section 8 offices in Maryland are required to deny Section 8 subsidy to pre-1950 property owners who are not in compliance with EA 6-8.

## 5A. Primary Prevention – Source Control

### Federal Grants For Primary Prevention (Healthy Homes)

CDC's Lead Poisoning Prevention Branch is preparing to transition to a broader healthy homes program, and has provided funds for a collaborative pilot project between October 2007 and October 2008 to determine if Baltimore City Health Department Healthy Homes could be improved by addressing multiple housing conditions.

The goal of this project is to develop, implement and evaluate a cost effective, outcome-focused, replicable model to expand an urban childhood lead poisoning prevention program into a comprehensive program to reduce lead exposure, asthma risks, injury risks and hazards, carbon monoxide poisoning and fire morbidity and mortality. The pilot project will cross train existing staff on healthy housing approaches and conduct and assess the efficacy of at least fifty coordinated environmental home assessments in high-risk communities in Baltimore. Assessments and interventions will address priority public health hazards among the following categories: 1) Lead exposure (chipping, peeling & flaking lead-based paint, cultural, renovation & occupational sources; 2) Carbon monoxide exposure; 3) fire hazards and the adequacy of smoke alarms; 4) Moisture, mold, and allergen triggers; 5) Presence of rodents and roaches and approaches to pest control; 6) Presence of and access to hazardous or harmful household products; 7) Smoking; 8) Adequacy of ventilation, heating, and cooling; 9) Visible physical hazards; and 9) Residential soil contamination.

### Non-Lead-Based Paint

Other sources of childhood lead exposure, such as lead in drinking water, ceramics, traditional medicines, occupational "take-home" or adult hobbies, and lead-containing vinyl products contribute to general background exposure. In early 2006, awareness of this fact heightened when a 4-year-old Minnesota child died 4 days after he ingested a metallic charm containing lead. Baltimore City and Maryland took primary prevention actions against other lead sources in 2006. BCHD passed a regulation created under the Commissioner's authorization to regulate nuisances - Health Code 2-101, banning the sale of children's jewelry with a lead level over 600 parts per million, and MDE and BCHD issued a joint press release detailing the lead hazard of surma/kohl. Baltimore City prohibited the sale of the surma/kohl. An MDE referral to the Attorney General's office stopped the distributor from future distribution in Maryland

### Gaps in Primary Prevention Source Control

Maryland has a strong infrastructure of laws supporting primary prevention, with substantial implementation and compliance Statewide. Elimination of childhood lead poisoning will require increased source control and compliance Statewide especially in high-risk areas. Identified needs associated with the laws listed above include:

## 5A. Primary Prevention – Source Control

**5A.1. The Reduction of Lead Risk in Housing law is not yet fully implemented by rental owners of pre-1950 units.** Efforts are needed to obtain more registration under State law and more private sector inspections at unit turnover. This may require more staff for MDE enforcement.

**5A.2. Safe work practices are not consistently used during renovation by owner occupants.** More outreach to owner-occupants doing home renovation, and funding to support education and training for homeowners and rental owners to do their own work are needed.

**5A.3. Accredited lead abatement contractors and inspectors are not consistently available in some regions of the State.** Many contractors and inspectors have been trained Statewide but there is still a need for more contractors and inspectors if 100% implementation of the MD lead law is to occur.

**5A.4. Courts, landlords, tenants, and local housing agencies are not yet fully aware of the new rent court and local registration statutes which began on October 1, 2004.** Legislation from the 2004 requires outreach to courts, local jurisdictions, and owners re new requirements.

**5A.5. Except in Baltimore City, local housing code enforcement rarely addresses lead paint hazards** Increased coordination with local housing code is important to build lead poisoning prevention into routine housing safety

**5A.6. Continued coordination with Region III and National EPA enforcement is needed.** Implementation of Federal 1018 Notice requirements by owners is not consistent.

## 5B. Primary Prevention Outreach and Education

Three State level departments, 22 local health departments, and one non-profit organization together provide outreach and education to nine different target groups (Attachment 5, Table One, Awareness). MDE requires certain targeted outreach and reports from funded agencies regarding the types of activities and numbers of people reached. MDE's LPP staff and the Assistant Attorney Generals assigned to MDE provide outreach activities directed to pre-1950 property owners.

MDE's CDC-funded Regional Primary Prevention Project is a new project on the Eastern Shore that focuses on outreach and education to public and private agency personnel who are in a position to influence primary prevention actions in the region. Through interactions with the small municipality offices that serve those who plan to rehabilitate old housing, the Regional Coordinator has identified new opportunities to educate owner-occupants and contractors about the need for lead safe work practices in pre-1978 housing are lost. This observation, along with anecdotal evidence from the LHD case managers that a higher proportion of their cases are due to renovations by people who have no knowledge about the need for lead safe work practices, indicate that new avenues for outreach and education are needed specifically for those who do not need MDE accreditation for their work with lead-based paint.

MDE has contracts with CECLP and local health departments to provide outreach activities. The primary targets of outreach are pre-1950 rental property owners and tenants, families of children ages 0 months to 6 years and pregnant women regardless of home-ownership status. Each year, the attorneys at MDE and CECLP train judges and lawyers; persons in the local health departments and the CECLP provide outreach and education to tenants and homeowners, especially young families in high-risk areas. The educational materials used in these trainings are specific to the "Reduction of Lead Risk in Housing" law. These materials were developed and distributed by MDE, the CECLP, and local health departments.

In FY 2004 and 2005, Health Sub-Committee members conducted annual field reviews to ascertain the availability of educational materials in Baltimore City and four counties in the three (3) regions of the State, which are Central, Western Maryland and the Eastern Shore. Team members requested materials of lead poisoning prevention from Section 8 Housing offices, private rental offices, libraries, paint and hardware stores, health clinics, Social Services offices, early intervention and elementary school sites, Child Care Resource Centers, and pediatric and obstetric offices. The survey was not repeated in FY 2006. The survey found that private rental housing agencies, hardware stores, and pediatricians/obstetricians' offices had material available, but elementary schools, libraries, and Social Services offices rarely had materials available.

Of the approximately 20 different educational items identified, the field reviewers

most commonly found the EPA booklet, "Protect Your Family From Lead In Your Home", followed by the four (4) original MDE brochures[2] often with obsolete telephone numbers. The MDE poster, "Are Your Planning to Buy, Rent, or Renovate a Home Built before 1978?" is required to be placed so that it is visible in paint stores and in the paint departments of hardware stores. Spot checks revealed a low compliance rate, estimated at less than fifty percent.

During the FY 2006, 17 local associations and health departments in high risk areas advertised and hosted Property Owner and Realtors Forums focused on the Maryland lead law to which property owner associations, local contractors and inspectors, realtor, and local government officials were invited. In FY 2006, MDE and CECLP, under an outreach contract with MDE, made 17 presentations in these meetings reaching 5-175 people per meeting and another unknown number through the televising of one of the meetings on a local cable channel.

Six community colleges (Wor-Wic, Chesapeake, Catonsville, Cecil, Hagerstown, and Allegany) offer lead paint abatement worker training in their course catalogs. Other types of outreach to educate do-it-yourself homeowners and to recruit more contractors into classes to obtain MDE certification are limited to MDE and EPA booths at the occasional home and garden show or contractors' conventions. In general outreach funded by MDE, local health department partners provided activities and made presentations, distributed posters and flyers, included advertisements in radio and newspapers, posted billboards, etc. For FY 2006, the local health departments reached an estimated 888,478 persons in 237 activities. A Summary Report and the County Health Departments' National Lead Poisoning Prevention Awareness Week Activities for the October 21-27, 2007 Calendar are attached (Attachment 6). Activity reports by jurisdiction are available from MDE.

The CECLP is funded by MDE to provide outreach activities under the Lead Poisoning Prevention Outreach and Assistance for Tenants and Property Owners Contract. Their extensive owner trainings, representations in court, calls/clients received on their toll-free telephone number, individual compliance assistance to rental property owner, attorneys, and realtors, materials distributions, Lead Safe Housing Registry distribution, and maintenance of their website with Tenant Rental Property Owner information on EA 6-8 are reported in a Yearly Statistics activity report to MDE. In summary, in 2006, the CECLP Intake Coordinator tracked assistance to 1,297 callers, CECLP staffed a total of 37 presentations/training/health fairs with direct assistance provided to 1,666 tenants and property owners in the general public and another 33 presentations/training/health fairs to tenants and property owners involved in Qualified

[2] "Preventing Lead Poisoning – What Every Parent Should Know"
"Be Lead-Smart – Before Your Baby is Born"
"Keep Your Home Lead-Safe"
"Preventing Lead Poisoning: Food and Good Nutrition"

## 5B. Primary Prevention – Outreach and Education

Offer issue, and provided education and facilitation to 1,032 tenants and property owners to make and respond to Notices of Defect and Notices of EBL.

Public access to web-based registration and inspection certificates was included as a goal in the Maryland Plan to Eliminate Childhood Lead Poisoning by 2010 which was released in July 2004. MDE has not been able to identify funding to place searchable, address-specific Lead Rental Property Registrations and Lead Inspection Certificates data on MDE's website for use by prospective tenants, buyers, housing advocates, Judges and staff of Rent Court, and the general public. A HUD funded website designed for the purpose was not maintained for Maryland and Baltimore City data. MDE announces enforcement actions against rental property owners on its website. As of October 2007, BCHD posts on its website a searchable database of addresses with lead violations for the public.

**Gaps in Primary Prevention Outreach and Education**

5B.1. One of the weaknesses in Maryland's current outreach and education program is the lack of an outreach evaluation plan or a consistent or sustained media campaign comprehensive plan. Except for distribution of the paint store poster to paint and hardware stores and basic direction to local health departments and CECLP in the MDE funding agreements, the State does not encourage or require a specific activity for the State funds expended. MDE and other state agencies who conduct outreach and education do not have a comprehensive plan for statewide lead poisoning prevention educational efforts that involves mass media, the use of attention-grabbing, targeted messages for the specific audiences, and regular updating of brochures and other information. A comprehensive plan should addresses the following:

i. Identify key target groups;
ii. Propose how best to involve public and private sectors and mass media;
iii. Develop key target messages;
iv. Evaluate the effectiveness of educational efforts throughout the State; and,
v. Assess existing educational materials, including on-line educational materials, for
    1) scientific accuracy and literacy levels;
    2) Continuity/compliance with regard to current policies and laws;
    3) Propose changes based on review.

5B.2. Evaluation of the effectiveness of outreach and education activities has not been conducted.

## 5B. Primary Prevention – Outreach and Education

5B.3. There is little evidence that MDE and other state agencies pool resources for education and outreach or coordinate efforts to maximize the effectiveness of scarce resources.

5B.4. MDE should improve online public information resources, including website access to lead violation history, lead rental registration status, and lead inspection certificates on its website.

5B.5. Property owners who access rehabilitation funds receive no education about lead poisoning prevention and lead safe work practices.

5B.6. Renovations by people, who have no knowledge about the need for lead safe work practices, indicate that new avenues for outreach and education are needed, specifically for those who do not need MDE accreditation for their work with lead-based paint.

5B.7. The largest obstacle to assuring safe work practices in owner-occupied homes and non-pre-1950 rental child care centers is lack of knowledge. Most general contractors, day workers and do-it-yourself home renovators lack knowledge about lead safe work practices. The public in general lacks knowledge about the dangers of childhood lead poisoning from disturbed or deteriorated lead-based paint in their homes and centers. Property owners and contractors who apply for permits for work in pre-1978 homes receive no education about lead poisoning prevention and lead safe work practices, except for the lead safe work practices statement in Baltimore City Housing's permit document. (See the section on Leveraging and Coordination for the status about outreach and education to contractors not seeking MDE accreditation.)

## 1. Surveillance

### Goal Fiscal Year 2008

Local health and environmental staff will have easy access to a web-based surveillance/case management system to document and retrieve reliable information about blood lead surveillance and case management activities.

### Objective Fiscal Year 2008

By June 30, 2008, MDE will complete transition from STELLAR to an MDE and DHMH-compatible and user friendly database system that allows for ease of import and export of data to include tracking the causes of EBLs and case management activities, and accommodates the needs of Baltimore City Healthy Homes tracking, CDC, DHMH, and other MDE Lead Program databases.

| **MAJOR 2008 ACTIVITIES - SURVEILLANCE** | **Respons. Staff-** | **Time Frame** | **Fiscal Impact** | **Measure Of Effectiveness-Impact-Outcome** | **Evaluation-Data Source-Frequency Of Reports** |
|---|---|---|---|---|---|
| MDE and BCHD with assistance from CDC will investigate surveillance and case management software alternatives currently used in other states. (Gap 1.2, 1.5) | MDE<br>S Seligson<br>BCHD<br>S Norman | Sept. 2007 | CDC to make funds available | MDE and Local Health Departments will use a web-based database for CLR surveillance and case mgmt activities. | LPP Commission agenda and minutes will include a summary of problems and progress. |
| Maintain quality assurance and control measures on the operation of the childhood lead registry. (Gap 1.1) | MDE<br>S Seligson | Ongoing | | | |
| Conduct enforcement of lab reporting regulations for complete data reporting to the childhood blood lead registry. (Gap 1.1) | MDE<br>S Seligson | Ongoing | | Improved completeness of all elements of laboratory reports | Annual CLR report. |

## 1. Surveillance

### Goal Fiscal Year 2009

Local health and environmental staff will increase their efforts in lead poisoning prevention with easy access to reliable information about BLLs in their jurisdictions.

### Objective Fiscal Year 2009

By June 30, 2009, the Childhood Lead Registry child specific data will be available to local health departments on a web-site.

| MAJOR 2009 ACTIVITIES - SURVEILLANCE | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| MDE LPP Program with MDE IT will develop a plan for operating the CDC-provided software for the CLR on a web-based platform for Beta testing. (Gap 1.2, 1.5, 2.2) | MDE<br>E Keyvan | December 2008 | CDC to make funds available | Resources to monitor childhood exposure to lead and testing rates, by census tract, will be readily available. | Reports will be provided quarterly to LPP Commission Health Sub-Committee and minutes will reflect a summary of problems and progress. |
| MDE will implement a plan to put the CLR on a web-based platform. (Gap 1.2, 1.5) | MDE<br>S Seligson | March 2009 | None | | |
| MDE will begin sharing annual CLR data with the DHMH EPHT project according to the Trading Partners Agreement, and DHMH EPHT project will make aggregate CLR data available on a public website. (Gaps 1.2, 5B.4) | MDE<br>E Keyvan<br>DHMH<br>C Mitchell | June 2009 | CDC to make funds available | Aggregate CLR report available on public website | |

**1. Surveillance**

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| Analyze the feasibility and develop a cost-effective plan to implement an integrated one-stop searchable public database that provides LPP-related information by address, such as basic DAT information, State and local violations, lead inspection certificates, and MDE registration status in an integrated manner. (Gap 1.4) | MDE<br>A Bowles | Dec 2008 | None | Necessary preliminary step to development of a system (One-Stop) that will make basic housing safety status available to the public and necessary enforcement data available to legal system | MDE will report quarterly progress to LPP Commission |
| Develop the One-Stop Primary Prevention database (searchable public database that provides LPP-related information by address, such as basic DAT information, State and local violations, lead inspection certificates, and MDE registration status in an integrated manner) and complete testing. (Gap 1.4) | MDE<br>A Bowles | June 2009 | To Be Determined | Final step to development of a public one-stop database. | |

## 1. Surveillance

### Goal Fiscal Year 2010

Advocates, the general public, local health and environmental staff will increase their efforts in lead poisoning prevention with easy access to reliable information about blood lead levels in their jurisdictions.

### Objective Fiscal Year 2010

By June 30, 2010, the Childhood Lead Registry aggregate data will be available to the public through the Environmental Public Health Tracking Project.

| MAJOR 2010 ACTIVITIES - SURVEILLANCE | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| BCHD and MDE will implement data entry of the required CDC case management reporting fields into the web-based CLR database. (Gaps 1.2, 2.3) | MDE<br>J Krupinsky<br>BCHD<br>S Norman | December 2009 | Existing funding | Complete appropriate fields in database | Quarterly submission of clean data to CDC |
| MDE will train other LHDs to use the CLR database for documenting case management activity and intervention information. (Gap 1.2) | MDE<br>J Krupinsky | June 2010 | Existing funding | Improved capacity to monitor childhood lead exposure and lead testing rates. | Annual Case Management Report to LPP Commission |
| Continue annual development and distribution of surveillance reports. | MDE<br>E Keyvan | June 2010 | Existing funding | Information to monitor childhood exposure to lead and testing rates, by census tract, will be publicly available. | LPP Commission Health Sub-Committee and minutes will reflect a summary of problems and progress. |
| MaintainStatewide CLR and case management interventions in a single web-based application. (Gaps 1.2) | MDE<br>E Keyvan | June 2010 | Existing funding | | |

**1. Surveillance**

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| Maintain EPHT aggregate CLR data available to DHMH for use on a public website. (Gaps 1.2, 5B.4) | MDE<br>E Keyvan<br>DHMH<br>C Mitchell | June 2010 | Existing funding | | |
| Make operational on a public site the One Stop Primary Prevention database (searchable public database that provides LPP-related information by address, such as basic DAT information, State and local violations, lead inspection certificates, and MDE registration status in an integrated manner). (Gap 1.4, 4.11) | MDE<br>A Bowles | June 2010 | To Be Determined | Resources will be available that allow public access and legal staff access to the necessary primary prevention and enforcement data. | MDE will report progress quarterly to LPP Commission |

## 2. Case Management

### Goal Fiscal Year 2008 Case Management

State and local authorities will have the necessary laws and resources to support prompt environmental treatment of a residence, child day care or early childhood learning facility in response to the identification of a child with an exposure to lead caused by lead paint hazards.

### Objective Fiscal Year 2008 Case Management

Statewide successful public health interventions that assure that a child with a blood lead level at 20 µg/dL is no longer exposed to an unsafe lead environment will be completed within 3 months of the identification of the lead exposure.

| MAJOR 2008 ACTIVITIES – CASE MANAGEMENT | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| Begin study of definition for "Fast Track" handling of EBL cases taking into consideration that, under the MDE definition, resources are not sufficient to lower to level of 20 as recommended by Health Sub-Comm for EA 6-8 enforcement procedures. | LPP Comm.<br>E Lomboy | June 2008 | None | EBL case managed children will have lower follow-up blood lead levels, and units with an environmental investigation will have lessened lead hazards. | Periodic QA reports out of STELLAR. |
| Continue State and Local response to an EBL >=10 (Environment, Health, Education, Housing) | MDE<br>S Seligson | Ongoing | Existing funding | | |
| The Commission will make recommendations based on a review of MDE Case Management reports regarding 1) the time between identification of EBL at 20 µg/dL or higher and the time at which the child resides a "safe-environment", 2) the barriers which preclude a child from residing in a safe environment within 90 day time period, 3) the change in ratio of lead exposure in owner-occupied vs Affected units. (Gap 2.2, 4.3) | LPP Comm.<br>E Lomboy<br>Health Sub-Comm.<br>M Vogel | June 2008 | None | | |
| Review reports about the success and limitations of the use of the Qualified Offers. (Gap 2.7) | LPP Comm<br>Housing Sub-Comm<br>P Connor | June 2008 | None | EBL case managed children will have lower follow-up blood lead levels, | Periodic QA reports out of STELLAR. |

**2. Case Management**

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| MSDE (specifically Infants and Toddler, Child Find and Head Start) will consider input from the Health Sub-Committee and adopt a policy that results in effective screening, monitoring and intervention services until age 6 for children with an elevated blood lead level 10µg/dL or greater.. | LPP Health Sub-Comm. M Vogel | June 2008 | Existing funding | | |
| Recommend that State and Local Housing policy makers include in their Annual Plan inclusion of EBL (>= 10 µg/dL) as a disability under the Section 8 program at the State level so that EBL children receive priority for Housing Choice Vouchers. (Gap 2.4) | LPP Comm E Lomboy | June 2008 | None | | |
| Encourage local environmental enforcement entities to investigate the use of local authority to order and enforce local orders for immediate risk reduction of a residence or child care site that caused a child to have an exposure to lead. (Gap 4.1) | MDE A Bowles | June 2008 | None | EBL case managed children will have lower follow-up blood lead levels, and units with an environmental investigation will have lessened lead hazards. | Periodic QA reports out of STELLAR. |
| Programs that offer Lead Hazard Reduction funds will continue to target units known to have poisoned children. | LPP Comm. Housing Sub-Comm P Connor | June 2008 | None | | |
| HIGH PRIORITY: Medical Assistance reimbursement for case management of lead poisoned children will be obtained. (Gap 4.7) | DHMH S Tucker BCHD M Shea | June 2008 | Existing BCHD funds for the required 50% Medicaid Match | | |

## 2. Case Management

### Goal Fiscal Year 2009 Case Management Goal

State and local authorities will have the necessary laws and resources to support prompt environmental treatment of a residence, child day care or early childhood learning facility in response to the identification of a child with an exposure to lead caused by lead paint hazards.

### Objective Fiscal Year 2009 Case Management Objective

Statewide successful public health interventions that assure that a child with a blood lead level at 15 µg/dL is no longer exposed to an unsafe lead environment will be completed within 3 months of the identification of the lead exposure.

| MAJOR 2009 ACTIVITIES – CASE MANAGEMENT | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| Obtain Medical Assistance (MA) reimbursement for case management of lead poisoned children. (Gap 4.7) | DHMH<br>S Tucker<br>BCHD<br>M Shea | September 2008 | Approx. $40,000 new funds from Medicaid | Half of the BCHD costs for environmental investigations will be reimbursed. | Annual budget report from BCHD |
| Based on a study for Qualified Offer use, make recommendations to the Governor. (Gap 2.7) | LPP Comm<br>E Lomboy | October 2008 | None | LPP Comm. report to the Governor | LPP Comm. Meeting minutes |
| Identify and implement a practical method to provide health care providers with parent educational materials to give to families with a child with a BLL below 10µg/dL. | MDE<br>J Krupinsky<br>LHDs | December 2008 | Existing funding | Health care providers will assist in education of parents about living safely with lead hazards. | Annual Report with Outreach MOU statistics |
| Evaluate BCHD's use of Baltimore Housing's HUD-approved practice of giving preference for Housing Choice Vouchers to families with EBL children. (Gap 2.4) | MDE<br>A Bowles | December 2008 | None | Eligible families will move to safe environments. | Report from MDE to LPP Comm. Regarding PHA activity. |
| Study need for development of a nonprofit lead hazard reduction crew to ES, Central MD and Western MD. (Gap 5A.14) | LPP Comm<br>E Lomboy | December 2008 | None | LPP Comm. report to the Governor | LPP Comm. Meeting minutes |

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**2. Case Management**

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| Complete the study of and report recommendations regarding enforcement procedures for Fast Track handling of enforcement for EBL cases taking into consideration that under the MDE definition, resources are not sufficient to lower to level of 20 as recommended by Health Sub-Comm. for EA 6-8 enforcement procedures. | MDE<br>A Bowles<br>BCHD<br>S Norman | December 2008 | None | Timelier drop in blood lead levels of children exposed to lead. | Quarterly QA reports out of STELLAR. |
| The Commission will make recommendations based on a review of an MDE Case Management tracking report regarding the time between identification of EBL at 15 µg/dL or higher and the time at which the child resides a "safe-environment", and the barriers which preclude a child from residing in a safe environment within 90 day time period. | LPP Comm.<br>Health Sub-Comm.<br>M Vogel | June 2009 | None | | |
| Continue State and Local response to an EBL >=10 (Environment, Health, Education, Housing) | MDE<br>S Seligson | Ongoing | None | | |
| Continue to encourage local environmental enforcement entities in the counties to investigate the use of local authority to order and enforce local orders for immediate risk reduction of a residence or childcare site that caused a child to have an exposure to lead. (Gap 4.1) | MDE<br>A Bowles | June 2009 | | | |
| Continue to monitor programs that offer Lead Hazard Reduction funds to ensure targeting of units known to have poisoned children. | LPP Comm.<br>Housing Sub-Comm<br>P Connor | | | | |
| Study affordable housing as related to statewide housing voucher or rent subsidy programs and make recommendations to the Governor. | LPP Comm<br>E Lomboy | | | | |
| Seek funding, and identify a sustainable funding source of $500,000/year for a pilot project in Baltimore City for 20 existing units, under the management of a Gate Keeper, to be made available for temporary relocation for families of EBL children. (Gap 2.8) | LPP Comm.<br>E Lomboy | June 2009 | $500,000 | LPP Comm. report to the Governor | LPP Comm. Meeting minutes |

**2. Case Management**

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|---|---|---|---|---|---|
| DHCD use Lead Hazard Reduction Loan and Grant Program funds and Single Family Housing Rehabilitation Programs funds as flexibly as possible to remove EBL children, temporarily or permanently, from known hazards in their homes. (Gap 2.8) | DHCD<br>E Landon | | Existing funding | Eligible families will move to safe environments. | Annual case management reports |

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## 2. Case Management

### Goal Fiscal Year 2010 Case Management

State and local authorities will have the necessary laws and resources to support prompt environmental treatment of a residence, child day care or early childhood learning facility in response to the identification of a child with an exposure to lead caused by lead paint hazards.

### Objective Fiscal Year 2010 Case Management

Statewide successful public health interventions that assure that a child with a blood lead level at 10 μg/dL is no longer exposed to an unsafe lead environment will be completed within 3 months of the identification of the lead exposure.

| MAJOR 2010 ACTIVITIES – CASE MANAGEMENT | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| Encourage local environmental enforcement entities in the counties to investigate the use of local authority to order and enforce local orders for immediate risk reduction of a residence or child care site that caused a child to have an exposure to lead. (Gap 4.1) | MDE<br>A Bowles | June 2010 | None | Timelier drop in blood lead levels of children exposed to lead. | Quarterly QA reports out of STELLAR, and annual case management reports. |
| Continue State and Local response to an EBL >=10 (Environment, Health, Education, Housing) | MDE<br>S Seligson | | | | |
| Evaluate the success of obtaining Medical Assistance (MA) reimbursement for case management of lead poisoned children. (Gap 4.7) | BCHD<br>M Shea | September 2009 | To be determined | Report will indicate that half of the BCHD costs for environmental investigations were be reimbursed. | Annual budget report from BCHD |

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## 3. Targeting

### Goal Fiscal Year 2008 Targeting

Institutionalization of appropriate lead screening and blood lead testing will be advanced.

### Objective Fiscal Year 2008 Targeting:

By June 30, 2008 there will be a statewide increase in testing of all 1-2 years olds by 5%. (Health Choice/Medicaid testing rates will increase by 2%): Baselines: CLR ad hoc report on all 1 and 2 year old children = 38.5%; DHMH MA report on Medicaid 1 and 2 year old children = 48.9%)

| **MAJOR 2008 ACTIVITIES - TARGETING** | **Respons. Staff-** | **Time Frame** | **Fiscal Impact** | **Measure Of Effectiveness-Impact-Outcome** | **Evaluation-Data Source-Frequency Of Reports** |
|---|---|---|---|---|---|
| The Commission will review the evaluations of the WIC pilot projects conducted in 2007. (Gap 3.3) | Health Sub-Comm<br>M Vogel | June 2008 | Existing funding | Increase in rate of testing of high-risk children. | Annual reports from the CLR and from DHMH' linked CLR/MA data will indicate a higher rate of testing of 1 and 2 year olds. |
| Dependent on the WIC Pilot Project evaluation report, DHMH will work with WIC to continue lead testing in WIC sites. (Gap 3.3) | DHMH<br>M LaCasse | June 2008 | To be determined | | Report on WIC Pilot Project. |
| The Commission will enlist at least one partner from either Med Chi or the Maryland Chapter of the American Academy of Pediatrics to work with the Health Sub-Committee to identify, report and make recommendations on the barriers to increase screening rates. (Gap 3.1, 3.2) | Health Sub-Comm<br>M Vogel | June 2008 | None | | Report on effort to increase testing with AAP partners. |
| DHMH will support filter paper or hand-held analyzer and consider revising statute that prohibits hand held analyzer in a non-medical lab setting. (Gap 3.2) | DHMH<br>M LaCasse | June 2008 | None | Increase in rate of testing of high-risk children. | Report on use of filter paper, and handheld analyzer. |

**3. Targeting**

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|---|---|---|---|---|---|
| DHMH will continue to audit MCO (not physician as recommended by Health Sub-Comm.) testing rates and encourage testing. (Gap 3.4) | DHMH<br>M LaCasse | | None | | Report on EPSDT audit of MCOs. |
| The LPP Commission Health Sub-Committee will review reports from MSDE regarding child registration requirement for appropriate lead testing and make recommendations. (Gap 3.3) | Health Sub-Committee<br>M Vogel | June 2008 | None | | Report on MSDE monitoring of daycare enrollment requirement for blood lead test. |
| Identify and publicly thank/congratulate LHDs with successful testing programs. (Gap 3.2) | LPP Comm<br>E. Lomboy | June 2008 | None | | LPP Commission meeting minutes will indicate letters sent. |

## 3. Targeting

**Goal Fiscal Year 2009 Targeting**

Institutionalization of appropriate lead screening and blood lead tes5ting will be advanced.

**Objective Fiscal Year 2009 Targeting**

By June 30, 2009 there will be a statewide increase in testing of all 1-2 years olds by 5%. (Health Choice/Medicaid testing rates will increase by 2%): Baselines: CLR ad hoc report on all 1 and 2 year old children = 38.5%; DHMH MA report on Medicaid 1 and 2 year old children = 48.9%)

| MAJOR 2009 ACTIVITIES - TARGETING | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| The immunization registries, ImmuNet and BIRP, will seek funding to incorporate childhood blood lead data into their registries for use by health care providers. (Gap 3.3) | DHMH<br>G Reed<br>BCHD<br>A Bailowitz | Sept. 2008 | $40,000 annually for each registry. | Increase in rate of testing of high-risk children. | Annual report from immunization registries regarding number of users |
| DHMH will continue its funding for LHD promotion of lead testing. (Gap 4.5) | DHMH<br>M Lacasse | June 2009 | None | Increase in rate of testing of high-risk children. | Annual reports from the CLR and from DHMH's linked CLR/MA data will indicate a higher rate of testing of 1 and 2 year olds. |
| DHMH will partner with the Maryland Chapter of the American Academy of Pediatrics to address one of the barriers identified by the MD Chapter of AAP partners to increase screening rates. (Gap 3.3) | DHMH<br>M Lacasse<br>MD AAP<br>E Levey | June 2009 | None | | |
| Study issues related to sufficiency of reimbursement to health care providers and WIC clinics, and recommend actions to improve feasibility by blood testing at point of care. (Gap 3.3) | Health Sub-Comm<br>M. Vogel<br>DHMH<br>M. LaCasse | June 2009 | None | LPP Commission will prepare appropriate recommendations to the Governor. | Annual Report to the Governor by LPP Commission. |
| Study issues related to feasibility of requiring parent to show evidence of obtaining child's blood lead test for continuation of DSS benefits. (Gap 3.3 | Health Sub-Comm<br>M. Vogel | June 2009 | None | LPP Commission will prepare appropriate recommendations to the Governor. | |

**3. Targeting**

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|---|---|---|---|---|---|
| DHMH will continue to audit MCO testing rates and encourage testing. (Gap 3.4) | DHMH<br>M LaCasse | June 2009 | None | Increase in rate of testing of high-risk children. | Report on EPSDT audit of MCOs. |
| The LPP Commission Health Sub-Committee will review reports from MSDE regarding child registration requirement for appropriate lead testing and make recommendations. (Gap 3.3) | Health Sub-Committee<br>M Vogel | June 2009 | None | LPP Commission will prepare appropriate recommendations to the Governor. | Report on MSDE monitoring of daycare enrollment requirement for blood lead |
| Identify and publicly thank/congratulate LHDs with successful testing programs. (Gap 3.2) | LPP Comm.<br>E Lomboy | June 2009 | None | Increase in rate of testing of high-risk children. | Meeting minutes of LPP Comm. |

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## 3. Targeting

**Goal Fiscal Year 2010 Targeting**

State and local departments will cooperate in targeting special problem areas with lower than average rates of appropriate blood lead testing.

**Objective Fiscal Year 2010 Targeting**

By June 30, 2010 there will be a statewide increase in testing of all 1-2 years olds by 5%. (Health Choice/Medicaid testing rates will increase by 2%): Baselines: CLR ad hoc report on all 1 and 2 year old children = 38.5%; DHMH MA report on Medicaid 1 and 2 year old children = 48.9%)

| MAJOR 2010 ACTIVITIES - TARGETING | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| DHMH will continue its funding for LHD promotion of lead testing. (Gap 4.5) | DHMH M LaCasse | June 2011 | None | Increase in rate of testing of high-risk children. | Annual reports from the CLR and from DHMH regarding the match to Medicaid data with comparison of annual Medicaid versus non-Medicaid blood lead screening rates will indicate a higher rate of testing of 1 and 2 year olds. |
| DHMH will continue to partner with the Maryland Chapter of the American Academy of Pediatrics to address the remaining identified barriers to increase screening rates; the questionable usefulness of the current targeting plan by Zip Code for targeting orders for blood lead testing; and, the proposed idea to combine lead test orders with the orders for CBC tests since both are related to cognitive development. (Gap 3.2, 3.3) | Health Sub-Comm. M Vogel | | | | |
| DHMH will continue to audit MCO testing rates and encourage testing. (Gap 3.4) | DHMH M LaCasse | June 2009 | None | Increase in rate of testing of high-risk children. | Report on EPSDT audit of MCOs. |
| The LPP Commission Health Sub-Committee will review reports from MSDE regarding child registration requirement for appropriate lead testing and make recommendations. (Gap 3.3) | Health Sub-Committee M Vogel | June 2009 | None | LPP Commission will prepare appropriate recommendations to the Governor. | Report on MSDE monitoring of daycare enrollment requirement for blood lead |
| Identify and publicly thank/congratulate LHDs with successful testing programs. (Gap 3.2) | LPP Comm. E Lomboy | June 2009 | None | Increase in rate of testing of high-risk children. | Meeting minutes of LPP Comm. |

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## 4. Coordination and Leveraging

**Goal Fiscal Year 2008 Coordination and Leveraging**
All systems involved in residential housing, especially the judicial, reality, and residential home improvement contractor systems, will be knowledgeable about the lead primary and secondary prevention laws, regulations and resources.

**Objective Fiscal Year 2008 Coordination and Leveraging**
By June 30, 2008, key partners will enlist the assistance of new partners and identify additional resources for education and outreach activities.

| MAJOR 2008 ACTIVITIES - COORDINATION | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| Explore the relationship between lead exposure and educational outcomes with the potential of asking the Governor to appoint a Commissioner from MSDE. | Health Sub-Comm. M Vogel | June 2008 | None | New partners will be involved in activities regarding lead poisoning prevention issues. | Minutes of LPP Commission and Sub-Committee meetings. |
| The LPP Commission will identify new potential lead hazard reduction and relocation funding sources, 1 each in the State government, City government, and in the private sector (Gap 4.4) | LPP Comm E Lomboy | | | | |
| LPP Commission will evaluate use of outreach and education funding (Gap 4.4, 4.5) | Health and Housing Sub-Committees P Connor | June 2008 | None | LPP Commission will prepare appropriate recommendations to the Governor. | |
| Develop a plan for online electronic registration and inspection certification (Gap 5B.4) | MDE A Bowles | June 2008 | None | New partners will be involved in activities regarding lead poisoning prevention issues. | Minutes of LPP Commission and Sub-Committee meetings. |

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## 4. Coordination and Leveraging

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|---|---|---|---|---|---|
| Discuss early intervention needs of children with EBLs with representatives from State and local, including Baltimore City, Infants and Toddlers Programs. | LPP Comm<br>Health Sub-Comm<br>M Vogel | June 2008 | None | New partners will be involved in activities regarding lead poisoning prevention issues. | Minutes of LPP Commission and Sub-Committee meetings. |
| One additional highest risk jurisdiction will make application for Federal funding to increase primary prevention. (Baseline: Baltimore City, Baltimore County) (Gap 4.4, 4.5, 4.6) | MDE<br>S Seligson | June 2008 | None | Application submitted to EPA or HUD.<br>Lower rates of EBL in Baltimore City and lower eastern shore. | CLR surveillance reports. |
| Lead Hazard Control programs will provide timely services making optimum use of funds regardless of funding source. | DHCD<br>E Hagan<br>LAAP<br>E Lomboy | June 2008 | None | Lead hazard control services will be provided in a timely manner. | Reports to LPP Commission by DHCD and LAAP. |
| The LPP Commission will suggest names to Governor for an appointee to the LPP Commission from a financial institution. (Gap 4.8) | LPP Comm<br>E Lomboy | June 2008 | None | LPP Commission appointment will be filled. | Minutes of LPP Commission and Sub-Committee meetings. |

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## 4. Coordination and Leveraging

**Goal Fiscal Year 2009 Coordination and Leveraging**
All systems involved in residential housing, especially the judicial, reality, and residential home improvement contractor systems, will be knowledgeable about the lead primary and secondary prevention laws, regulations and resources.

**Objective Fiscal Year 2009 Coordination and Leveraging**
By June 30, 2009 Maryland citizens will have access to a consolidated point of contact for lead information with a common 800 for callers who will be directed to the appropriate agency, organization, resources, or materials.2009. Similar referral information will be provided to person who request information through e-mails.

| MAJOR 2009 ACTIVITIES – COORDINATION | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| The LPP Commission will identify new potential lead hazard reduction and relocation funding sources, 1 each in the State government, City government, and in the private sector (Gap 4.4) | LPP Comm.<br>E Lomboy | June 2009 | None | New partners will be involved in activities regarding lead poisoning prevention issues. | Minutes of LPP Commission and Sub-Committee meetings. |
| LPP Commission will make recommendations to governor regarding improved use of outreach and education funding (Gap 4.5) | Health and Housing Sub-Committees<br>M Vogel<br>P Connor | June 2009 | None | LPP Commission will prepare appropriate recommendations to the Governor. | Minutes of LPP Commission and Sub-Committee meetings. |
| Plan and develop on-line registration and fee payment as an additional method for initial registration as required under the Reduction of Lead Risk in Housing law. (Gap 5B.4) | MDE<br>A Bowles | | None | MDE RFP in place for procuring outside software development services | Report to LPP Comm. |

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## 4. Coordination and Leveraging

| | | | | | |
|---|---|---|---|---|---|
| Implement a plan for internet based online electronic registration and inspection certification (Gap 5B.4) | MDE<br>A Bowles | June 2009 | To be determined | New partners will be involved in activities regarding lead poisoning prevention issues. | Minutes of LPP Commission and Sub-Committee meetings. |
| Develop a plan for a consolidated point of contact for lead information with a common 800 number for callers or persons who send e-mails to the appropriate agency, organization, resources, or materials. | MDE<br>A Bowles | June 2009 | None | Lower rates of EBL in Baltimore City and Lower Eastern Shore. | |
| One additional highest risk jurisdiction will make application for Federal funding to increase primary prevention. (Baseline: Baltimore City, Baltimore County) (Gaps 4.4, 4.5, 4.6) | MDE<br>S Seligson | | | Submission of a new application to EPA or HUD. | Annual CLR reports. |
| The LPP Commission will maintain full membership including a representative of a financial institution. (Gap 4.8) | LPP Comm.<br>E Lomboy | | | New partners will be involved in activities regarding lead poisoning prevention issues. | Report to LPP Comm. |
| Evaluate potential for a lead safe window replacement initiative with new partners from housing affordability and energy conservation groups. (Gap 4.10) | LPP Comm.<br>E Lomboy | June 2009 | None | LPP Commission will prepare appropriate recommendations to the Governor. | Minutes of LPP Commission. |
| Promote landlord licensing and cooperation of rental registration agency with EA 6-8 referrals in jurisdictions with high number of pre-1978 rental units and population living in poverty (Baltimore City, select municipalities in Prince George's County and Montgomery County). (Gap 5A.11) | MDE<br>A Bowles | June 2009 | | New partners will be involved in activities regarding lead poisoning prevention issues. | Minutes of LPP Commission and Sub-Committee meetings. |

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## 4. Coordination and Leveraging

| | | | | | |
|---|---|---|---|---|---|
| The LPP Commission will secure commitment from financial institutions to establish incentives for loans for lead hazard reduction | LPP Comm. E Lomboy | June 2009 | None | New partners will be involved in lead poisoning prevention issues. | Minutes of LPP Commission and Sub-Committee meetings. |

**Maryland 2010 Plan to Eliminate Childhood Lead Poisoning**
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## 4. Coordination and Leveraging

**Goal Fiscal Year 2010 Coordination and Leveraging**
All systems involved in residential housing, especially the judicial, reality, and residential home improvement contractor systems, will be knowledgeable about the lead primary and secondary prevention laws, regulations and resources.

**Objective Fiscal Year 2010 Coordination and Leveraging**
By June 30, 2009 Lead Hazard Reduction Programs, relocation programs, and outreach programs will have resources sufficient to meet hazard reduction needs.

| MAJOR 2010 ACTIVITIES – COORDINATION | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| Continue to evaluate and make recommendations to governor regarding the following:<br>improved use of outreach and education funding;<br>success of registration for rental property owners, especially small property owners;<br>availabilityand use of funding for relocation;<br>availability of funding for lead hazard reduction;<br>use of lead safe work practices by home improvement contractors; and,<br>sources of other educational efforts state-wide. (Gap 4.5) | LPP Comm.<br>E Lomboy | June 2010 | None | Lower rates of EBL in Baltimore City and Lower Eastern Shore. | CLR quarterly reports. |
| Evaluate success of online electronic registration and inspection certification. (Gap 5B.4) | MDE<br>A Bowles | | | Report will indicate more complete and timelier reports. | LPP Commission meeting minutes |

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## 5A. Primary Prevention – Source Control

### Goal Fiscal Year 2008 Primary Prevention – Source Control

All owners will use lead safe work practices and procedures to renovate or maintain their pre-1978 residential properties at the appropriate standard of care.

### Objective Fiscal Year 2008 Primary Prevention – Source Control

By June 30, 2008, MDE will increase the number of pre-1950 rental units in Baltimore City and the Lower Eastern Shore that are registered under the MD Reduction of Lead Risk in Housing law by 5%.

| MAJOR 2008 ACTIVITIES – SOURCE CONTROL | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| Develop and oversee a mail out of registration forms to 5,000 potential unregistered pre-1950 rental property owners in Baltimore City and lower Eastern Shore making improved use of a cleaner LRPR database match with the MD Assessment & Taxation database. (Gap 5A.1) | MDE<br>T Phillips | June 2008 | Existing funding | Numbers of registered properties and numbers of inspection certificates will increase by 5% | MD MFR Managing for Results data review by LPP Commission. |
| Fill vacancies and add 2 inspectors in MDE Lead Enforcement Division. (5A.12) | MDE<br>A Bowles | | | | |
| Review reports of compliance rates regarding registration, visual and dust-lead testing and accreditation courses/providers/students and make recommendations. (Gap 5A.1, 5A.3) | LPP Comm Hous Sub-Comm<br>P Connor | | | | |
| Identify private housing issues and concerns and invite new partners such as code and permitting officials into the discussions. (Gap 5A.5) | LPP Comm Hous Sub-Comm<br>P Connor | | | | |

**5A. Primary Prevention – Source Control**

| | | | | | |
|---|---|---|---|---|---|
| Determine mechanism to focus on regulation of more activity done by contractors doing work for compensation in pre-1978 housing by amending the lead statute to extend MDE authority to contractors doing lead work in pre-1978 housing to match the EPA Repair, Renovation, and painting Rule. (Gap 5A.2) | MDE<br>A Bowles | June 2008 | None | Expand authority of EA 6-10 to include more contractor activity with potential to release lead dust hazards | MDE report to LPP Commission |
| Monitor source of lead exposure based on case management database (Gap 2.3) | MDE<br>J Krupinsky | June 2008 | None | Identification of sources associated with lead poisoned children | Annual report of findings to LPP Commission |

## 5A. Primary Prevention – Source Control

**Goal Fiscal Year 2009 Primary Prevention – Source Control**

All owners will use lead safe work practices and procedures to renovate or maintain their pre-1978 residential properties at the appropriate standard of care.

**Objective Fiscal Year 2009 Primary Prevention – Source Control**

By June 30, 2009, MDE will increase the number of pre-1950 rental units that are registered under the MD Reduction of Lead Risk in Housing law by 5%.

| MAJOR 2009 ACTIVITIES – SOURCE CONTROL | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| Summer study of Mandatory Lead Dust Testing for pre-1978 Rental Units with intent of developing a bill proposal upon which all interested parties agree for submission in 2009 Legislative Session. (Gap 5A.7) | MDE<br>A Bowles | October 2008 | None | Legislators will have a well-prepared proposed bill | MDE report to LPP Commission. |
| Finalize, with input from local jurisdiction housing officials, protocols for lead safe demolition standards (EBDI standards) for all demolition projects of older housing Statewide. | MDE<br>A Bowles | October 2008 | None | Input provided by local housing officials. | Report to LPP Comm. |
| Determine mechanism to focus on regulation of more activity done by contractors doing work for compensation in pre-1978 housing by amending the lead statute to extend MDE authority to contractors doing lead work in pre-1978 housing to match the EPA Repair, Renovation, and painting Rule. (Gap 5A.2) | MDE<br>A Bowles | January 2009 | None | Expanding the authority of statute or authority to include contractor activities with potential to release lead dust hazards will result in remodelers and renovators increased use of lead safe work practices. | Case management reports from Childhood and Adult Lead Registries. |

**5A. Primary Prevention – Source Control**

| | | | | | |
|---|---|---|---|---|---|
| Study of adoption of mandatory dust testing prior to sale or rental of all pre-1978 property. (Gap 5A.16) | LPP Comm<br>E Lomboy | January 2009 | None | Recommendation to the Governor regarding need for prompt clean up prior to exposure to known hazards. | Legislatures will consider a bill for prospective pre-1978 residential purchasers to receive lead toxicity reports prior to settlement |
| Legislative passage of Lead Dust Testing for pre-1978 Rental Units. (Gap 5A.7) | MDE<br>A Bowles | March 2009 | None | Dust clearance method of inspection = 100% | Public disclosure of lead toxicity with each inspection |
| Increase court action efficiency by computerizing the District Court's rent court system to allow online viewing of dockets regarding failure to pay rent. (Gap 5A.4) | Baltimore Housing | June 2009 | To be determined | Numbers of registered properties and numbers of inspection certificates will increase by 5% | MD MFR Managing for Results routine data |
| Review EA 6-8 compliance in child day care facilities (MSDE report). | Health Sub-Comm.<br>M Vogel | June 2009 | None | Improved compliance in childcare facilities. | MSDE report |
| Monitor the progress of the acceptance/ publishing/ implementation of the new EPA Rule for Renovation and Remodeling to become effective April 2010. (Gap 5A.8) | MDE<br>A Bowles | June 2009 | None | New partners will be involved in activities regarding lead poisoning prevention issues. | Report to LPP Commission |
| Monitor source of lead exposure based on case management database (Gap 2.3) | MDE<br>PMontgomery | Ongoing | None | Identification of sources associated with lead poisoned children | Annual report of findings to LPP Commission |

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## 5A. Primary Prevention – Source Control

### Goal Fiscal Year 2010 Primary Prevention – Source Control

Lead Hazard Reduction Programs, relocation programs, and outreach programs will have resources sufficient to meet housing hazard reduction needs.

### Objective Fiscal Year 2010 Primary Prevention – Source Control

By June 30, 2010, MDE will increase the number of pre-1950 rental units that are registered under the MD Reduction of Lead Risk in Housing law by 5%.

| MAJOR 2010 ACTIVITIES – SOURCE CONTROL | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| Continue to monitor source of lead exposure based on case management database (Gap 2.3) | MDE PMontgomery | Ongoing | None | Identification of sources associated with lead poisoned children | Annual report of findings to LPP Commission |
| Evaluation of services and efforts to control sources to-date, and determine if additional efforts are needed to control lead sources going forward. (Gap 2.2) | LPP Comm. E Lomboy | December 2009 | None | Identification of extent of resources for lead hazard reduction. | Annual report of findings to LPP Commission. |
| Focus on decreasing exposure in do-it-yourself renovations in pre-1978 owner occupant and post-1950 rental residences based on standards for lead safe remodeling and renovation. | MDE A Bowles | June 2010 | None | Enforcement action related to phase-in of EPA Renovation and Remodeling Rule | Annual report of activity with EPA to LPP Commission. |
| Encourage adoption of protocols for lead safe demolition standards for all demolition projects of older housing statewide. | MDE A Bowles | June 2010 | None | Demolition projects in municipalities will not spread dust. | Annual report of activity with municipalities to LPP Commission. |

### 5B. Primary Prevention – Outreach and Education

## Goal Fiscal Year 2008 Primary Prevention – Outreach and Education

Public education and outreach activities, based on consistent and audience-specific information for lead poisoning prevention, will reach specified target audiences including caregivers, tenants, property owners, health care providers, educators, homeowners, contractors, and renovators.

## Objective Fiscal Year 2008 Primary Prevention – Outreach and Education

By June 30, 2008, State resources for outreach will be expended for statewide and local activities that have demonstrated effectiveness in improving local EBL rates.

| MAJOR 2008 ACTIVITIES – OUTREACH | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| Cross train all perinatal and early childhood home visitors to conduct environmental visual inspections and make appropriate referrals in at risk areas | BCHD<br>S Norman | June 2008 | Funded by CDC grant or None | Increase in the following:<br>Total number of referrals for enforcement;<br>Number of personnel trained, by category;<br>Number of referrals from perinatal and early childhood home visitors. | Maryland Managing for Results MFR data and special reports to LPP Commission |
| Outreach MOU specifications torequire training for individuals who will educate tenants or pre-1950 rental property owners about the use of Notice of Defect (NOD), and referral of NODs to MDE. | MDE<br>S Seligson | June 2008 | Existing funding | | |
| Local health departments continue to make referrals for enforcement by using the Notice of Defect | LHDs | June 2008 | None | | Annual summary report of Notices of Defect |
| Obtain the cooperation of three local Section 8 housing agencies regarding their education and enforcement of compliance of Section 8 owners with EA 6-8.<br>(Gap 5A.1) | LPP Comm.<br>E Lomboy | June 2008 | None | Number of Section 8 properties in compliance before/after initiative. | Annual Outreach report in Managing MD for Results. |

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**5B. Primary Prevention – Outreach and Education**

| | | | | | |
|---|---|---|---|---|---|
| Provide cross training to LHDs and individuals who will educate tenants or pre-1950 rental property owners. | MDE<br>J Krupinsky | June 2008 | None | Increase in number of individuals trained | Annual report in Managing MD for Results. |
| Conduct outreach to code officials in local jurisdictions to obtain their cooperation to report to MDE those property owners in their respective jurisdictions who are non-compliant with state lead laws regarding pre-1950 rental unit registration and inspection. (Gaps 4.2, 5A.1, 5A.4) | MDE<br>A Bowles | June 2008 | None | Increase in number of jurisdictions reporting non-compliant properties to MDE. | Annual report in Managing MD for Results. |
| Review LHD outreach reports and make recommendations regarding best practices with the highest return for the effort in use of resources for outreach. (Gap 5B.2) | LPP Comm Health & Hous Sub-Comms<br>P Connor<br>M Vogel | June 2008 | None | LPP Commission will prepare appropriate recommendations to the Governor. | Minutes of LPP Commission and Sub-Committee meetings. |
| Develop a plan for education and outreach that includes procedures of updating, making accurate, consistent, culturally correct and current supplies of outreach and education materials that are distributed by any state or local agency that is receiving funding for outreach; coordinate use of mass media. (Gaps 5B.a, 5B.3) | MDE<br>S Seligson<br>DHMH<br>M LaCasse | June 2008 | None | Written plan for education and outreach. | Report to LPP Comm. |
| Continue to provide trainings to judicial staff, and property owner and realty associations. | MDE<br>A Bowles | June 2008 | None | Number of trained individuals by category | Report to LPP Comm. |
| Change application of lead safe standard to apply to all pre-1978 housing units at time of qualification for lead safe to allow a definition useful for marketing at time of sale for private and rental market (Gap 4.14) | MDE<br>A Bowles | June 2008 | None | Written report regarding revised definition of lead safe standard | Report to LPP Comm. |

**5B. Primary Prevention – Outreach and Education**

| | | | | | |
|---|---|---|---|---|---|
| Educate property owners, young families, and housing officials in the highest risk urban and rural areas of the State regarding their responsibilities in reducing lead hazards in residences or choosing to live in residences without lead hazards. (Gap 5A.1) | Eastern Shore Regional Primary Prevention Manager<br>D Webster<br>BCHD<br>M Shea | June 2008 | Existing funding | Lower rates of EBL in Baltimore City and lower eastern shore. | |
| MDE will report to Maryland State Department of Education (MSDE) the use of lead poisoning prevention curriculum by middle and high school teachers. | MDE<br>A Bowles | June 2008 | None | | CLR surveillance reports. |
| Initiate projects to reach small property owners with registration requirements. (Gap 4.2, 5A.2) | MDE<br>A Bowles | June 2008 | None | Number registered properties before/after initiative. | LRP Registry report. |
| Initiate projects to reach home improvement contractors with lead safe work practice requirements. (Gap 4.2, 5A.2) | MDE<br>A Bowles | June 2008 | None | Number of contractors reached | MDE Outreach reports |
| LPP Commission will review and make recommendations to governor regarding improved use of outreach and education funding (Gap 4.4, 4.5) | Health and Housing Sub-Committees<br>P Connor<br>M Vogel | June 2008 | None | LPP Commission will prepare appropriate recommendations to the Governor. | Minutes of LPP Commission and Sub-Committee meetings. |
| Monitor source of lead exposure based on case management database. (Gap 2.2, 2.3) | MDE<br>PMontgomery | Ongoing | Existing funding | Identification of sources associated with lead poisoned children | Annual report of findings to LPP Commission |

**5B. Primary Prevention – Outreach and Education**

## Goal Fiscal Year 2009 Primary Prevention – Outreach and Education

Public education and outreach activities, based on consistent and audience-specific information for lead poisoning prevention, will reach specified target audiences including caregivers, tenants, property owners, health care providers, educators, homeowners, contractors, and renovators.

## Objective Fiscal Year 2009 Primary Prevention – Outreach and Education

By June 30, 2009, State resources for outreach will be expended for statewide and local activities that have demonstrated effectiveness in improving local EBL rates.

| MAJOR 2009 ACTIVITIES - OUTREACH | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| Initiate a workgroup around person(s) from a financial institution to analyze how loan and mortgage companies could assist in primary prevention activities such as use of Lead Safe Work Practices and incentives for lead hazard reduction. (Gap 4.8) | LPP Commissioners | October 2008 | None | New partners will develop recommendations to institutionalize primary prevention requirements in new areas. | Reports to LPP Comm. from new partners. |
| Continue to cross train new pre-natal and early childhood home visitors to conduct environmental visual inspections in at risk areas | BCHD S Norman | June 2009 | Funded by CDC grant or None | Increase in the following: Total number of referrals for enforcement; Number of personnel trained, by category; Number of referrals from perinatal and early childhood home visitors | Annual MFR report |
| Identify lead hazards in homes of 400 very low-income pregnant/post partum women enrolled in government-funded programs. | BCHD S Norman | June 2009 | Existing funding | | |
| Local health departments continue to make referrals for enforcement by using the Notice of Defect. | LHDs | June 2009 | None | | |

**5B. Primary Prevention – Outreach and Education**

| | | | | | |
|---|---|---|---|---|---|
| Obtain the cooperation of an additional three local Section 8 housing agencies regarding their education and enforcement of compliance of Section 8 owners with EA 6-8. (Gap 5A.1) | LPP Comm.<br>E Lomboy | June 2009 | None | Increase in the number of Registered Properties and Lead Inspection Certificates | |
| Increase participation by local code officials to report to MDE those property owners in their respective jurisdictions who are non-compliant with state lead laws regarding pre-1950 rental unit registration and inspection. (Gaps 4.2, 5A.1, 5A.4) | MDE<br>A Bowles | June 2009 | None | Increase in number of jurisdictions reporting non-compliant properties to MDE. | |
| Review LHD outreach reports and make recommendations regarding best practices with the highest return for the effort in use of resources for outreach. (Gap 5B.2) | LPP Comm.<br>Health&Housing Sub-Comm.<br>P Connor<br>M Vogel | September 2008 | None | LPP Commission will prepare appropriate recommendations to the Governor | Minutes of LPP Commission and Sub-Committee meetings |
| Focus use of Outreach MOU resources to best practices (Gap 5B.1) | MDE<br>A Bowles | June 2009 | None | LPP Commission will send appropriate recommendations to the Governor | Minutes of LPP Commission and Sub-Committee meetings |
| Implement the plan for education and outreach and conduct, as appropriate, procedures of updating, making accurate, consistent, culturally correct and current supplies of outreach and education materials that are distributed by any state agency that is receiving funding for outreach; coordinate use of mass media. (Gap 5b.3) | MDE<br>A Bowles<br>DHMH<br>M LaCasse | June 2009 | None | Written plan for education and outreach will be implemented. | Report to LPP Comm. |

**5B. Primary Prevention – Outreach and Education**

| | | | | | |
|---|---|---|---|---|---|
| Provide trainings to judicial staff, and property owner and realty association | MDE<br>A Bowles | June 2009 | None | Report of number of judicial staff, property owners, and realty association staff trained. | Report to LPP Comm. |
| Review MDE/DHMH comprehensive plan for statewide outreach and make recommendations. (Gap 5B.1, 5B.3) | Health&Housing Sub-Comm<br>M Vogel<br>P Connor | June 2009 | None | LPP Commission will provide appropriate recommendations to Departments | Minutes of LPP Commission and Sub-Committee meetings. |
| Develop comprehensive plan for statewide educational efforts to include partnerships with professional associations, i.e., ACOG, AAP, etc.(Gap 5B.3) | MDE<br>S Seligson<br>DHMH<br>M LaCasse | June 2009 | None | List of educational events with professional organizations | Minutes of LPP Commission and Sub-Committee meetings. |
| Educate property owners, young families, and housing officials in the highest risk urban and rural areas of the State regarding their responsibilities in reducing lead hazards in residences or choosing to live in residences without lead hazards. (Gap 5A.1) | Eastern Shore Regional Primary Prevention Manager<br>D. Webster<br>BCHD<br>M. Shea | June 2009 | Existing funding | Numbers of persons reached: property owners; families; housing officials. | Minutes of LPP Commission and Sub-Committee meetings. |
| MDE and Maryland State Department of Education (MSDE) will reinforce the use of lead poisoning prevention curriculum by middle and high school teachers. | MDE<br>A Bowles | Ongoing | None | Lower rates of EBL in Baltimore City and lower eastern shore. | CLR surveillance reports. |

**5B. Primary Prevention – Outreach and Education**

## Fiscal Year 2010 Primary Prevention Goal– Outreach and Education

Public education and outreach activities, based on consistent and audience-specific information for lead poisoning prevention, will reach specified target audiences including caregivers, tenants, property owners, health care providers, educators, homeowners, contractors, and renovators.

## Fiscal Year 2010 Primary Prevention Objective– Outreach and Education

By June 30, 2009, State resources for outreach will be expended for statewide and local activities that have demonstrated effectiveness in improving local EBL rates.

| MAJOR 2010 ACTIVITIES - OUTREACH | Respons. Staff- | Time Frame | Fiscal Impact | Measure Of Effectiveness-Impact-Outcome | Evaluation-Data Source-Frequency Of Reports |
|---|---|---|---|---|---|
| Continue to cross train new pre-natal and early childhood home visitors to conduct environmental visual inspections in at risk areas | BCHD<br>S Norman | June 2010 | Funded by CDC grant<br>Or<br>None | Increase in the following:<br>Total number of referrals for enforcement;<br>Number of personnel trained, by category;<br>Number of referrals from perinatal and early childhood home visitors | Annual MFR report |
| Identify hazards in homes of 400 very low-income pregnant/post partum women enrolled in government-funded programs. | BCHD<br>S Norman | June 2010 | Existing funding | | |
| Local health departments continue to make referrals for enforcement by using the Notice of Defect | LHDs | June 2010 | None | | |
| Obtain the cooperation of three additional local Section 8 housing agencies regarding their education and enforcement of compliance of Section 8 owners with EA 6-8. (Gap 5A.1) | LPP Comm.<br>E Lomboy | June 2010 | None | Increase in the number of Registered Properties and Lead Inspection Certificates | Annual MFR report |

**5B. Primary Prevention – Outreach and Education**

| | | | | | |
|---|---|---|---|---|---|
| Increase participation by local code officials to obtain their cooperation to report to MDE those property owners in their respective jurisdictions who are non-compliant with state lead laws regarding pre-1950 rental unit registration and inspection. (Gaps 4.2, 5A.1, 5A.4) | MDE<br>A Bowles | June 2010 | None | Increase in the number of Registered Properties and Lead Inspection Certificates | Annual MFR report |
| Review LHD outreach reports and make recommendations regarding best practices with the highest return for the effort in use of resources for outreach. (Gap 5B.2) | LPP Comm. Health&Housing Sub-Comm.<br>P Connor<br>M Vogel | June 2010 | None | LPP Commission will provide appropriate recommendations to Departments | Minutes of LPP Commission and Sub-Committee meetings |
| Focus use of Outreach MOU resources to best practices. | MDE<br>S Seligson | Ongoing | None | Comparison of numbers of different populations reached | Annual MFR reports. |
| Educate property owners, young families, and housing officials in the highest risk urban and rural areas of the State regarding their responsibilities in reducing lead hazards in residences or choosing to live in residences without lead hazards. (Gap 5A.1) | Eastern Shore Regional Primary Prevention Manager<br>D. Webster<br>BCHD<br>M. Shea | June 2010 | Existing funding | Numbers of persons reached: property owners; families; housing officials. | Minutes of LPP Commission and Sub-Committee meetings. |
| Implement annual plan for the procedures of updating, making accurate and consistent, and refreshing supplies of outreach and education materials that are distributed by any state agency that is receiving funding for outreach. | MDE<br>S Seligson<br>DHMH<br>M LaCasse | Ongoing | None | Written plan for education and outreach will be implemented. | Report to LPP Comm. |

**5B. Primary Prevention – Outreach and Education**

| | | | | | |
|---|---|---|---|---|---|
| Provide trainings to judicial staff, and property owner and realty association | MDE<br>A Bowles | Ongoing | Existing funding | Report of number of judicial staff, property owners, and realty association staff trained. | Report to LPP Comm. |
| MDE and Maryland State Department of Education (MSDE) will reinforce the use of lead poisoning prevention curriculum by middle and high school teachers. | MDE<br>A Bowles | Ongoing | None | Lower rates of EBL in Baltimore City and mid- lower eastern shore. | CLR surveillance reports. |

## Evaluation

**Who will conduct the evaluation?**

Key partners perform evaluation of the lead poisoning prevention activities and outcomes for which they hold responsibility and authority as part of ongoing routine program evaluation. State agencies evaluate performance or outcome measure as part of Maryland's "Managing for Results" (MFR) reporting. MFR is Maryland's system for planning, continuous improvement, and measurement of performance and results. MFR reports go to the Legislature and Governor for consideration in the annual budget and legislative processes. Lead poisoning prevention measures are included in Maryland's Managing for Results reports.

The LPP Commission already reviews several components of lead poisoning prevention in its annual rotation of scheduled reports. The LPP Commission's health and housing sub-committees receive and compile data from the key partners and prepare reports.

The LPP Commission will expand its oversight by integrating ongoing assessments and reviews of the progress of each of the components of the Elimination Plan into the routine oversight duties of the LPP Commission. The sub-committees will receive and compile data from the following sources and will prepare summary reports for the LPP Commission. Committee assignments for oversight will roughly follow the Elimination Plan's components. The Health Sub-committee's components will be Surveillance, Case Management and Targeting while the Housing Sub-committee's components will be Coordination and Leveraging of Resources and Primary Prevention.

**What data sources and other information will be used to assess progress?**

1. Annual Blood Lead Surveillance Reports and detailed supplemental reports from the Childhood Lead Registry (CLR)
2. Managing Maryland for Results (MFR): Maryland Department of the Environment, DHMH Medicaid, and DHMH Center for Maternal and Child Health report about lead poisoning prevention efforts quarterly.
3. Medicaid/CLR match report
4. DHMH Medicaid report to managed care organizations
5. Annual Reports about Case Management from the STELLAR databases
6. Reports of HUD-funded projects
    a. State DHCD reports
    b. Baltimore City Health Department Lead Abatement Action Project (LAAP)
7. Baltimore City Health Department CityStat and LeadStat reports
8. MDE MFR quarterly reports about the number of units registered
9. MDE MFR quarterly reports about the number of units with inspection certificates

**How the information will be used?**

The LPP Commission members will receive reports from the sub-committee chairs and discuss the findings and recommendations. The LPP Commissioners will use the information as a basis for making recommendations to the Governor, Legislature, and State agencies.

**Timeline for conducting and presenting annual evaluations to the workgroup?**

## Evaluation

The LPP Commission will function as the ongoing workgroup for the Elimination Plan. MDE, which staffs the LPP Commission, will assist with the preparation and distribution of reports of findings and recommendations at the request of the LPP Commission Chair.

**Timeline for conducting and presenting annual evaluations to CDC?**

MDE will provide a report on activities, progress toward objectives, and discussion of barriers with revisions to the plan to CDC in the annual CLPPP grant application.

**How the evaluation results will be used to improve progress towards elimination?**

The LPP Commissioners have the responsibility to make recommendations to the Governor.

# ATTACHMENTS

**ATTACHMENT 1**

**Task**

Review options for establishing a sustainable and cost effective *Temporary Relocation Housing Plan* to accommodate families with children having environmental intervention blood lead levels or Elevated Blood Lead ("EBL").

## Objective

To provide through a structured program housing to families in need on a temporary basis (i.e. less than 100 calendar days)

## Comments

Over the last several years the regulatory, housing and child advocate communities have identified the lack of readily available temporary housing as an impediment to relocating families with EBL children to permanent housing. This Sub-Committee reviewed the need for temporary housing when:

1. Private property owners are required by local agencies to make repairs to their home in order to reduce childhood lead exposures;
2. Rental property owners are required by local agencies to make repairs to their rental dwelling units in order to reduce childhood lead exposures;
3. Rental property owners of Affected Properties are (a) required by local agencies to make repairs to their rental dwelling units in order to reduce childhood lead exposures, (b) The rental property owner is compliant with Title 6 – Toxic, Carcinogenic, and Flammable Substances; Subtitle 8 – Reduction of Lead Risk in Housing; Part V – Qualified Offer; and (c) the family is scheduled to return to that Affected Property and/or rental dwelling unit;
4. Rental property owners of Affected Properties are (a) required by local agencies to make repairs to their rental dwelling units in order to reduce childhood lead exposures, (b) the rental property owner is compliant with Title 6 – Toxic, Carcinogenic, and Flammable Substances; Subtitle 8 – Reduction of Lead Risk in Housing; Part V – Qualified Offer; and (c) the family is <u>not</u> scheduled to return to that Affected Property and/or rental dwelling unit;
5. Rental property owners of Affected Properties are (a) required by local agencies to make repairs to their rental dwelling units in order to reduce childhood lead exposures, (b) the rental property owner is <u>not</u> compliant

with Title 6 – Toxic, Carcinogenic, and Flammable Substances; Subtitle 8 – Reduction of Lead Risk in Housing; and (c) the family is not scheduled to return to that Affected Property and/or rental dwelling unit.

In an effort to better understand the current opportunities to find sustainable and cost effective temporary housing the Committee determined that several key questions would need to be addressed:

1. Do property management firms and/or rental property owners typically permit their lessee to sub-lease the premises?
2. If the answer to Question 1 is "no," how would the Gate Keeper work with the property management firm and/or rental property owner to sub-lease the premises?
3. What requirements would the property management firm and/or rental property owner impose upon the Gate Keeper in order to have the rights to sub-lease the premises?
4. What level of documentation, if any, would the property management firm and/or rental property owner require of the Gate Keeper to prove compliance with the provision noted in Question 3?
5. Where are (general area) the trade association's membership apartments located in Baltimore City and then through the state of Maryland?
6. Would any members of the trade association have the desire and skills to serve as the Gate Keeper?
7. Once in place, assuming everything works out, what level of involvement would the property management firm and/or rental property owner desire with the lessee and the sub-lessee?
8. What is the typical rent by area?
9. What is the typical utility cost by area?

Unrelated to these key "property" questions, the sub-committee determined that it would like to also know from property owners:

1. What factors or situations motivate a rental property to accept Housing Choice Vouchers?
2. What factors or situation prevent or discourage a rental property from accepting Housing Choice Vouchers?

The Housing Sub-Committee, in conjunction with the Health Sub-Committee, also recognized the need for a "Gate Keeper" or manager of the referral agencies that would need access to this Temporary Housing Network. This discussion resulted in:

1. The need to know who or which firms/agencies would be able to handle this type of assignment.
2. The need to know who is already handling this type of assignment.
3. The need to know what obstacles have been identified or can be anticipated with this type of assignment.

Preliminary Conclusions

Temporary rental housing can be a reality. While we continue to experience the increasing trend of compliant rental properties and the decreasing number of children with elevated blood lead levels, the need for temporary housing will remain a reality for the foreseeable future. However, our preliminary research suggests that a cost-effective and sustainable program can be implemented. What we learned so far:

**Rental Housing Providers:**

1. Already have in place very similar "temporary housing" arrangements with both private and public organizations. Therefore, we have existing "experience" with the concept of temporary housing and a track record of performance.
2. Have available housing stock throughout the state of Maryland that can meet both the need and the demand.
3. Have both lead-free and "lead-safe" communities that can be made available.
4. Have available rental dwelling units with rents and utility costs compatible to the families' existing costs. Many rental housing providers have compliant properties within the discussed target areas.
5. Expressed interest in exploring further the opportunity of having annual leases with the "Gate Keeper" in order to make temporary housing available to those in need.

**Gate Keepers:**

1. Need to be explored further.
2. Need to be experienced in working with families having EBL children.
3. Need to be clear about the process of moving in and moving out families with EBL children. Both the property owner and family need to understand the construction process (lead treatment schedule) in order to have a successful temporary housing program.
4. Funding sources and limits need to be clear:
    a. Private property owners may or may not be able to afford to re-imburse the Gate Keeper for the temporary housing;
    b. Rental property owners should pay for the temporary housing service;

c. Accepted Qualified Offers should be able to pay for the temporary housing service;

d. Non-compliant rental property owners (i.e. not eligible to make a Qualified Offer) remain a key obstacle in the process. This "group" would require funding not directly related to the family or the rental property owner. Recovery of funds from the rental property owner, while an option, was not viewed as being likely.

## Recommendations

Establish a pilot program in Baltimore City (east and west). This pilot program will lay the foundation for a statewide program.

Do not divert funding to build or renovate "temporary relocation housing." The housing stock exists and we need to develop a process that maximizes its use.

Establish a Gate Keeper to manage the temporary housing process, including both sides of the equation (rental property owner and family).

Identify a sustainable funding source to maintain this program.

ATTACHMENT 2

# MARYLAND DEPARTMENT OF THE ENVIRONMENT

Lead Poisoning Prevention Program

## Childhood Blood Lead Surveillance in Maryland

## 2006 Annual Report

***July, 2007***

**MARYLAND CHILDHOOD LEAD REGISTRY**

**2006 ANNUAL SURVEILLANCE REPORT**

**EXECUTIVE SUMMARY**

The Maryland Department of the Environment's statewide Childhood Lead Registry (CLR) performs childhood blood lead surveillance for Maryland. The CLR receives the reports of all blood lead tests done on Maryland children 0-18 years of age, and the CLR provides blood lead test results to Medicaid and local health departments as needed for case management and planning.

Since 1995, the CLR has released a comprehensive annual report on statewide childhood blood lead testing. This current report presents the childhood blood lead test results for calendar year 2006 (CY 2006). All numbers are based on blood lead testing (venous or capillary) on children. The CLR does not receive any reports on lead screening based on the lead risk assessment questionnaire. With few exceptions all numbers referred to children 0-72 months.

## CY 2006 Surveillance Highlights:

- A total of 121,968 blood lead tests from 115,969 children 0-18 years were received and processed by the CLR in 2006, of which 108,517 tests were from 102,974 children 0-72 months. The overall blood lead testing for children 0-72 months was 22.2% for 2006.

- The highest testing rates for children 0-72 months were found in Caroline county (36.3%); followed by Wicomico county (35.1%), Baltimore City (33.7%), and Somerset county (32.4%).

- The highest testing rates for children 0-35 months were found in Caroline county (59.7%), Somerset county (51.0%), Dorchester county (47.9%), and Wicomico county (47.2%).

- Accurate completion of address information further improved in 2006. More than 92.0% of blood lead tests were geocodable at the census tract level, which later was used for county assignment. Child's zip code address was the basis of county assignment for those records with an incomplete address.

- The Childhood Lead Registry is maintained in the "Systematic Tracking of Elevated Lead Levels and Remediation" (STELLAR) surveillance system, obtained from Centers for Disease Control and Prevention (CDC) Lead Poisoning Prevention Program. In 2006, 91.6% of blood lead tests were reported electronically. The average reporting time, from the time sample is drawn to time the result enters the CLR database is about 7 days. The average time for elevated blood lead results (≥10 μg/dL) is approximately 30 hours.

- Out of 102,974 children 0-72 months tested for lead statewide in 2006, 1,274 (1.2%) were found to have blood lead level ≥10 µg/dL (prevalence) of whom 936 had their very first EBL test (incidence) in 2006.

## Overview

Lead is one of the most significant and widespread environmental hazards for children in Maryland. Children are at the greatest risk from birth to age six while their neurological systems are being developed. Exposure to lead can cause long-term neurological damage that may be associated with learning and behavioral problems and with decreased intelligence.

**Sources of Childhood Lead Exposure**

Lead paint dust from deteriorated lead paint or from renovation is the major source of exposure for children in Maryland. According to the US Census Bureau, 2005 American Community Survey there are more than 368,000 residential houses built before 1950 (95% likely to contain lead paint) and 897,000 houses built between 1950-1979 (75% likely to have lead paint.

Water, air, and soil, may provide low-level, "background" exposure, but rarely may cause childhood lead poisoning.

Imported products, parental occupations, hobbies, and imported traditional medicines occasionally may cause lead exposure among children.

There is some concern that in-utero exposure to lead may affect fetal development. This can be of more significance among certain subgroup

## Terms and Definitions

There is no evidence of a blood lead level below which there are no health effects. The Centers for Disease Control and Prevention (CDC) concurs that the evidence shows that there is no threshold level for blood lead that can be considered "safe". CDC's current blood lead level of concern of 10 µg/dL is based on: 1) lack of successful clinical or public health interventions with BLLs below 10 µg/dL, 2) likelihood of misclassification errors due to uncertainty associated with laboratory testing at levels <10 µg/dL, and 3) the need to prioritize public health resources for children with BLL ≥10 µg/dL. Based on these facts, the CLR dropped the term "Lead Poisoning" as was initially defined: "a venous blood lead level ≥25 µg/dL" and later dropped the level to 20 µg/dL. Instead, to better reflect the extent of the work and to direct program activities to the "more at-risk" areas, from 2005 forward new terms 'incidence' and 'prevalence' with the following definitions were included in annual report.

EBL (Elevated Blood Lead level): A blood lead level ≥10 µg/dL, currently defined by CDC as "Level of Concern". The highest venous, in the absence of venous test the highest capillary test was the bases of determination.

Prevalence: Any child with an EBL for the calendar year is the basis of this selection. Prevalence reflects the existing load of children with EBL who may be new to the program or may have been carried-over from previous years (continuously or after some remission.)

Incidence: Any child with the very first EBL is basis of this selection. The child may have not been tested for lead in the past or all his/her tests were below 10 µg/dL. Incidence reflects the load of the children with EBL who may have never been tested for lead before or the result of all their blood lead tests were all below 10 µg/dL. Incidence is a better indicator for primary prevention. It is expected that the expansion of primary prevention activities results in less exposure and fewer new cases. The old cases, because of the extent and severity of their past exposure may continue to have EBL for months or even years.

To locate the new cases, the list of children with an EBL in calendar year 1995 was set as a base and then list of children with EBL from 1996 was matched against it (using full last and first name, and date of birth as matching criteria). Children from 1996 who were not matched (not found in the list) were assumed to be new cases for CY1996, and were added to the list. Next the list of EBL children from 1997 was matched against the cumulative list of 1995 and 1996 to find new cases for CY1997 who were then added to the list. The process was repeated for each calendar year up to 2006.

## Statistical Report

In calendar year 2006, a total of 102,974 children 0-72 months were tested for lead exposure statewide. Table One provides a summary of statewide statistics of blood lead testing in 2006.

Table One

**Calendar Year (CY) 2006 Statistical Report[1]**

| Item | Number | Percent (%) |
|---|---|---|
| Number of tests | 123,013[2] | |
| Number of children | 102,974 | 100.0 |
| **Age** | | |
| Under One | 11,702 | 11.4 |
| One Year | 34,065 | 33.1 |
| Two Years | 25,186 | 24.5 |
| Three Years | 11,687 | 11.3 |
| Four Years | 11,893 | 11.5 |
| Five Years | 8,441 | 8.2 |
| **Sex** | | |
| Female | 49,386 | 48.0 |
| Male | 51,123 | 49.6 |
| Undetermined | 2,465 | 2.4 |
| **Highest Blood Lead Level (µg/dL)** | | |
| 0-4 | 93,058 | 90.4 |
| 5-9 | 8,642 | 8.4 |
| 10-14 | 890 | 0.9 |
| 15-19 | 230 | 0.2 |
| ≥20 | 154 | 0.1 |
| Mean BLL (Geometric mean) | 2.49 | |
| **Blood Specimen** | | |
| Capillary | 16,422 | 15.9 |
| Venous | 78,258 | 76.0 |
| Undetermined[3] | 8,294 | 8.1 |

1. For detailed analysis and breakdown of numbers refer to Supplementary Data Tables 1-5.
2. The 123,013 tests were from 115,969 children 0-18 years, of whom 102,974 were 0-72 months old. Data in this statistical table are based on children 0-72 months.
3. In supplemental data tables blood tests with sample type unknown were counted as capillary.

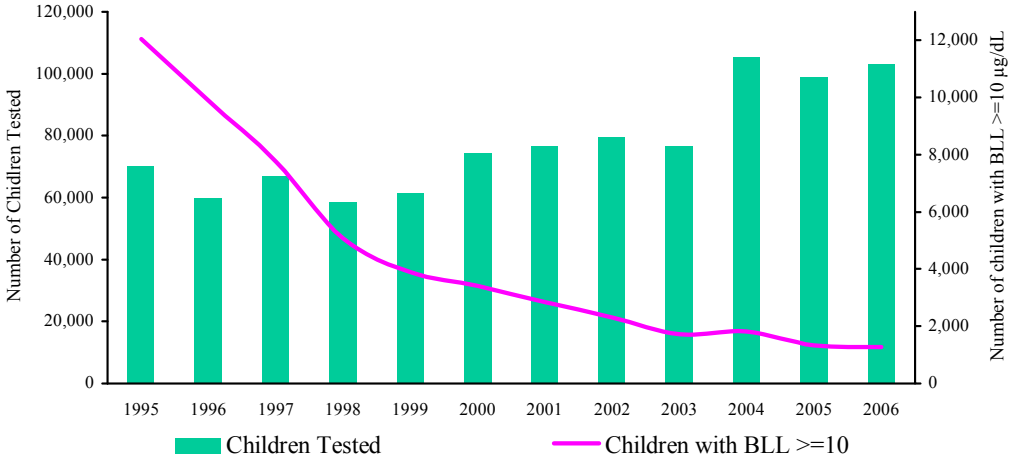
**ATTACHMENT 1**

## Findings

There has been a steady decline in childhood lead exposure in Maryland over the past decade at all levels of exposure. The reduction has occurred both statewide (Figure One) and in areas of highest risk such as Baltimore City.

# Figure One

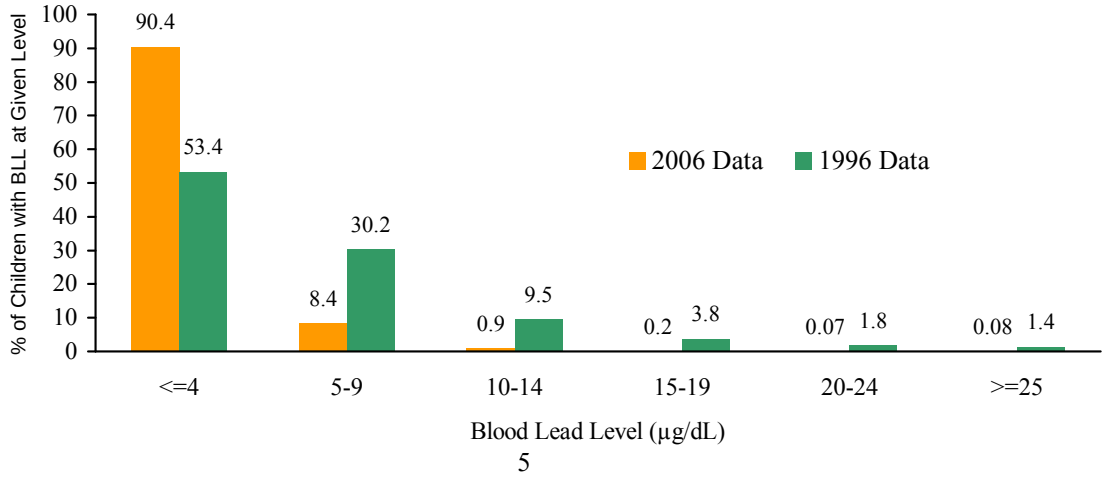
**Number of Children 0-72 Months Tested for Lead and Number Reported to Have Blood Lead Level >10 µg/dL : 1995-2006**




**The drop in the extent and severity of childhood lead poisoning are not only pronounced in the decrease in the number of children with blood lead level ≥10 µg/dL, but also in further shift to the left of those children with blood lead level <10 µg/dL (Figure Two).**

**Figure Two**

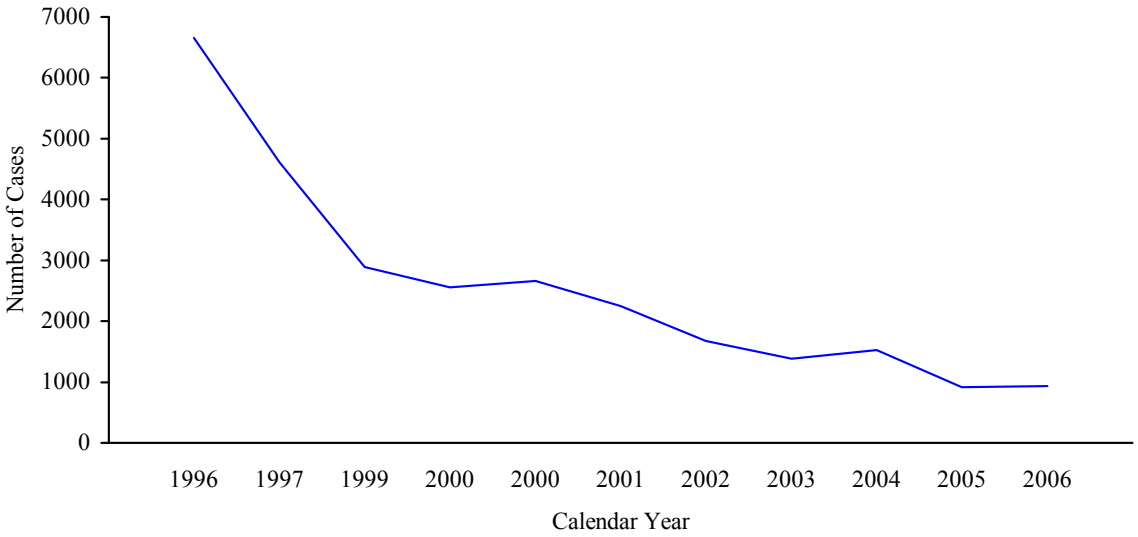
**Blood Lead Distributions of Children 0-72 Months Tested for Lead (1996 and 2006)**



**ATTACHMENT 1**

**There has been steady decline in both number and severity of new cases (incidence) of EBL (Figure Three, Map One, Maps Two a and b).**

**Figure Three**
**Number of New Cases (Incidence) of EBL*: 1996:2006**




**Map One**
**Distribution of New (Incidence) Cases of EBL by Blood Lead Level**
**Children 0-72 Months, Baltimore City**

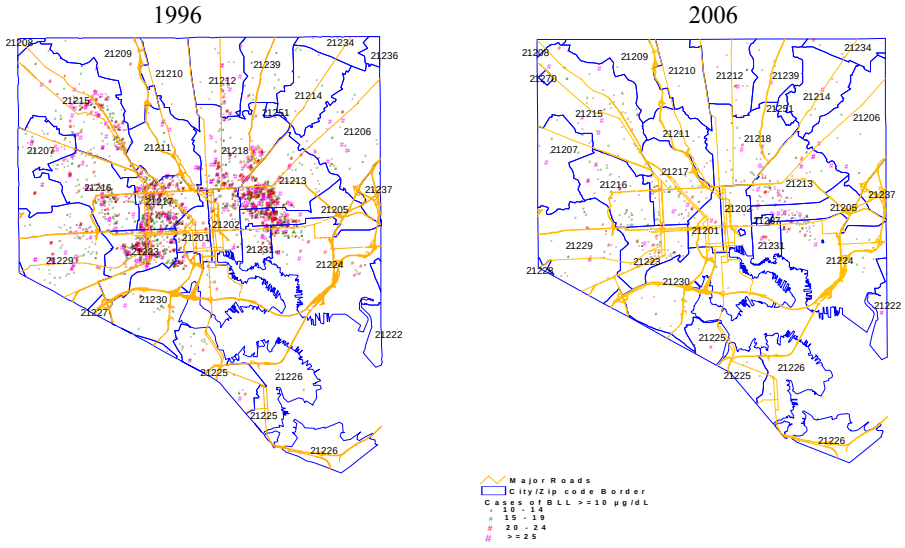


Table Two provides the breakdown of blood lead testing and the status of children with respect to lead exposure by jurisdiction in 2006.

**Table Two**

## Blood Lead Testing of Children 0-72 Months by Jurisdiction in 2006

| County | Population of Chidlren[1] | Children Tested | | Prevalent Cases[2] | | Incident Cases[3] | |
|---|---|---|---|---|---|---|---|
| | | Number | Percent | Number | Percent | Number | Percent |
| Allegany | 4,904 | 1,172 | 23.9 | 22 | 1.9 | 17 | 1.5 |
| Anne Arundel | 43,306 | 6,422 | 14.8 | 20 | 0.3 | 16 | 0.2 |
| Baltimore | 59,148 | 15,344 | 25.9 | 85 | 0.6 | 69 | 0.4 |
| Baltimore City | 54,547 | 18,363 | 33.7 | 843 | 4.6 | 573 | 3.1 |
| Calvert | 6,737 | 749 | 11.1 | 9 | 1.2 | 9 | 1.2 |
| Caroline | 2,463 | 893 | 36.3 | 7 | 0.8 | 3 | 0.3 |
| Carroll | 13,400 | 1,378 | 10.3 | 7 | 0.5 | 5 | 0.4 |
| Cecil | 7,808 | 1,058 | 13.5 | 6 | 0.6 | 6 | 0.6 |
| Charles | 11,404 | 1,919 | 16.8 | 1 | 0.1 | 1 | 0.1 |
| Dorchester | 2,177 | 684 | 31.4 | 11 | 1.6 | 8 | 1.2 |
| Frederick | 18,484 | 3,108 | 16.8 | 10 | 0.3 | 7 | 0.2 |
| Garrett | 2,406 | 495 | 20.6 | 5 | 1.0 | 3 | 0.6 |
| Harford | 20,721 | 3,041 | 14.7 | 15 | 0.5 | 14 | 0.5 |
| Howard | 24,092 | 2,188 | 9.1 | 8 | 0.4 | 6 | 0.3 |
| Kent | 1,184 | 257 | 21.7 | 4 | 1.6 | 4 | 1.6 |
| Montgomery | 78,408 | 17,411 | 22.2 | 53 | 0.3 | 48 | 0.3 |
| Prince George's | 75,996 | 18,561 | 24.4 | 71 | 0.4 | 66 | 0.4 |
| Queen Anne's | 3,425 | 659 | 19.2 | 4 | 0.6 | 4 | 0.6 |
| Saint Mary's | 8,285 | 1,517 | 18.3 | 11 | 0.7 | 11 | 0.7 |
| Somerset | 1,560 | 506 | 32.4 | 9 | 1.8 | 5 | 1.0 |
| Talbot | 2,326 | 636 | 27.3 | 5 | 0.8 | 5 | 0.8 |
| Washington | 10,593 | 3,012 | 28.4 | 18 | 0.6 | 15 | 0.5 |
| Wicomico | 6,955 | 2,440 | 35.1 | 22 | 0.9 | 16 | 0.7 |
| Worcester | 3,002 | 962 | 32.0 | 7 | 0.7 | 5 | 0.5 |
| County Unknown | | 199 | | 21 | | 20 | |
| **Statewide** | **463,331** | **102,974** | **22.2** | **1,274** | **1.2** | **936** | **0.9** |

1. Adapted from the Census Bureau: "State Interim Population Projections by Age and Sex: 2000-2030" http://www.census.gov/population/www/projections/projectionsagesex.html.
2. All children with at least one blood lead test ≥10 µg/dL in 2006.
3. Children with the very first blood lead test ≥10 µg/dL in 2006. These children were either not tested in the past or their blood lead levels were below 10 µg/dL.

Appendix A provides numbers of children by age groups of 0-35 months and 36-72 months, and Appendix B provides summary results for the past eight (8) years at the State, Baltimore City and Counties levels. For detailed breakdown of blood lead data the reader is referred to supplementary data tables: Supplements 1-5.

Statewide activities to reduce (eliminate) childhood lead poisoning

**State of Maryland has implemented laws and regulations, and has in place activities to reduce and eliminate childhood lead poisoning.**

Primary Prevention**: Much of the decline in blood lead levels is the result of implementation and enforcement of Maryland's "Reduction of Lead Risk in Housing" law. The law requires each pre-1950 rental dwelling to be issued a Full Risk Reduction certificate at turnover. In 2001, at least 50% of the owner's affected properties were required to be in compliance with the Full Risk Reduction Standard, 100% compliance was required in 2006. Effective October 1, 2004, the law requires rent court Judges and local housing registry officials to not accept cases and applications from pre-1950 rental property owners who can not present lead certificates that indicate that their rental properties are in compliance with the Reduction of Lead Risk in Housing law.**

***State laws and regulations with impact on childhood lead poisoning***

- ✓ Requirements to perform lead hazard reduction at each turnover in rental housing built before 1950. [Environment Article (EA) §6-8]
- ✓ Outreach programs to parents, health care providers, and property owners, especially in at-risk areas. [EA§ 6-8, Health Article §18-106]

**Other factors contributing to the decline of blood lead levels are the movement of families away from older housing into more recently built city or suburban housing (Table Three), and outreach and education to families and health care providers.**

Table Three
Housing Units by Type of Occupancy and the Year Structure Built

| Year | 1990 Housing[1] | | | 2000 Housing [2] | | | 2005 Housing[3] | |
|---|---|---|---|---|---|---|---|---|
| Structure Built | Number | Percent | | Number | Percent | | Number | Percent |
| Owner occupied | 1,137,307 | 100.0 | | 1,341,594 | 100.0 | | 1,438,614 | 100.0 |
| 1980+ | 263,208 | 23.1 | | 507,485 | 37.8 | | 613,226 | 42.7 |
| 1950-1979 | 599,545 | 52.7 | | 576,420 | 43.0 | | 580,816 | 40.3 |
| Pre- 1950 | 274,554 | 24.1 | | 257,689 | 19.2 | | 244,572 | 17.0 |
| | | | | | | | | |
| Renter Occupied | 612,090 | 100.0 | | 639,265 | 100.0 | | 647,033 | 100.0 |
| 1980+ | 105,684 | 17.3 | | 171,397 | 26.8 | | 206,488 | 31.9 |
| 1950-1979 | 347,299 | 56.7 | | 333,338 | 52.1 | | 316,312 | 48.9 |
| Pre- 1950 | 159,107 | 26.0 | | 134,530 | 21.0 | | 124,233 | 19.2 |

1. **US Census Bureau, US census of population and housing of 1990.**
2. **US. Census Bureau, US census of population and housing of 2000.**
3. **US. Census Bureau, American Community Survey of 2005**

Secondary Prevention**: Maryland requires that children living in "at-risk" areas be tested at ages one and two years. The State has a targeted testing plan that identifies "at-risk areas." Universal blood lead testing applies to Baltimore City children (Ordinance 20 effective July 2000) and children on Medicaid (required by EPSDT). The percentage of one**

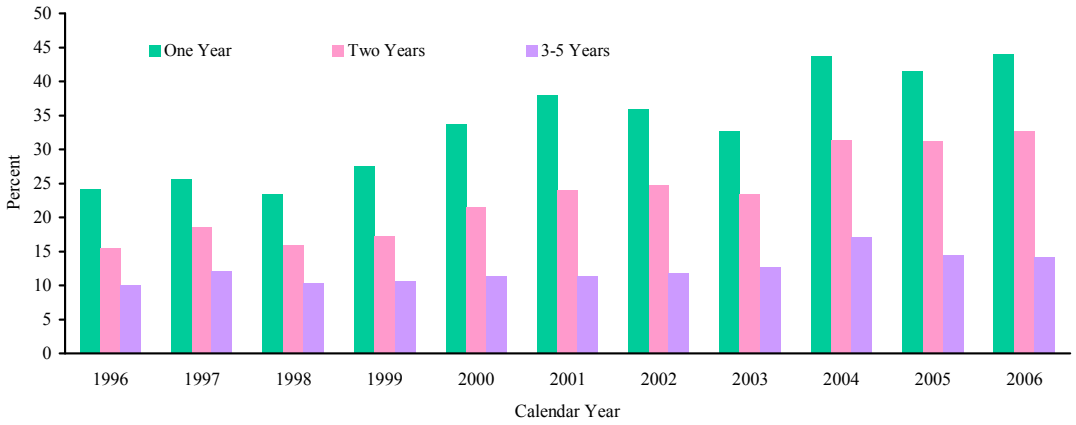
**and two year old children tested for lead has increased substantially since 2004 (Figure Four).**

**Identifying Children with Lead Exposure**

The critical issue in childhood lead poisoning is early detection. Because there are no specific clinical symptoms, a blood lead test is the most reliable technique to identify children with elevated blood lead levels. If there is any suspicion that a child is exposed to lead, a health care provider should do a blood lead test.

## Figure Four

**Percent of Children One and Two Years Old Tested for Lead vs. Children of Other**




**Tertiary Prevention**: Maryland's Lead Poisoning Prevention Program has well-established case management guidance and environmental investigation protocols for follow-up of children with elevated blood lead level. As of February 24, 2006, one venous or two capillary blood lead tests ≥10 µg/dL trigger the Notice of EBL under the Reduction of Lead Risk in Housing Law. A venous blood lead test ≥10 µg/dL in Baltimore city or a venous blood lead test ≥15 µg/dL in Maryland counties initiates environmental investigation.

### Data Quality

The CLR is maintained in the "Systematic Tracking of Elevated Lead Levels and Remediation" (STELLAR) surveillance system, obtained from CDC Lead Poisoning Prevention Program. CLR staff makes all efforts to further improve data quality with respect to completeness, timeliness, and accuracy. Staff keep track of laboratory reporting to make sure laboratories are reporting all blood lead tests no later than biweekly. The law requires blood lead results ≥20 µg/dL to be reported (fax) within 24 hours after result is known. However, upon CLR request, laboratories agreed to report (fax) the result of all blood lead test ≥10 µg/dL within 24 hours For all blood lead tests ≥10 µg/dL, staff check the completeness of data in particular with respect to child's and guardian's name, address, and telephone number.

In 2006, more than 91.6% of blood lead tests were reported to registry electronically. The average reporting time, from the time sample is drawn to time the result enters the CLR database is approximately 7 days. The average time for elevated blood lead results (≥10 µg/dL) is approximately 30 hours. Table Four provides summary reports for completeness of data as required by law.

**Table Four**
**Completeness of Data for 2006**

| Item | % Complete |
|---|---|
| Child's name | 100 |
| Date of Birth | 100 |
| Sex/Gender | 97.7 |
| Race/Ethnicity | 44.9 |
| Guardian's name | 38.5 |
| Sample type | 98.2 |
| Blood lead level | 100 |
| Address (geocoded) | 92.2 |

**Blood Lead Laboratory Reporting Requirement**

The amended law and regulations* of 2001 and 2002 require that:

1-The following child's demographic data should be included in each blood lead test reported:

- Date of Birth
- Sex
- Race
- Address
- Test date
- Sample type
- Blood lead level

2-Blood lead results ≥20 µg/dL to be reported (fax) within 24 hours after result is known. All other results to be reported every two weeks.

3-Reporting format should comply with the format designed and provided by the Registry.

4-Data should be provided electronically.

* EA 6-303, Blood lead test reporting (COMAR 26.02.01, Blood lead test reporting)

## Appendix A
## Blood Lead Testing of Children 0-72 Months by Major Age Group and Jurisdiction in 2006

| Age Group | Population of Children | Children Tested Number | Children Tested Percent | Prevalent Cases Number | Prevalent Cases Percent | Incident Cases Number | Incident Cases Percent |
|---|---|---|---|---|---|---|---|
| | | | Allegany County | | | | |
| 0-35 Months | 2,503 | 970 | 38.8 | 16 | 1.6 | 14 | 1.4 |
| 36-72 Months | 2,401 | 202 | 8.4 | 6 | 3.0 | 3 | 1.5 |
| Total | 4,904 | 1,172 | 23.9 | 22 | 1.9 | 17 | 1.5 |
| | | | Anne Arundel County | | | | |
| 0-35 Months | 21,947 | 4,799 | 21.9 | 14 | 0.3 | 12 | 0.3 |
| 36-72 Months | 21,359 | 1,623 | 7.6 | 6 | 0.4 | 4 | 0.2 |
| Total | 43,306 | 6,422 | 14.8 | 20 | 0.3 | 16 | 0.2 |
| | | | Baltimore County | | | | |
| 0-35 Months | 29,735 | 11,126 | 37.4 | 64 | 0.6 | 58 | 0.5 |
| 36-72 Months | 29,413 | 4,218 | 14.3 | 21 | 0.5 | 11 | 0.3 |
| Total | 59,148 | 15,344 | 25.9 | 85 | 0.6 | 69 | 0.4 |
| | | | Baltimore City | | | | |
| 0-35 Months | 28,024 | 12,690 | 45.3 | 537 | 4.2 | 438 | 3.5 |
| 36-72 Months | 26,523 | 5,673 | 21.4 | 306 | 5.4 | 135 | 2.4 |
| Total | 54,547 | 18,363 | 33.7 | 843 | 4.6 | 573 | 3.1 |
| | | | Calvert County | | | | |
| 0-35 Months | 3,266 | 582 | 17.8 | 9 | 1.5 | 9 | 1.5 |
| 36-72 Months | 3,470 | 167 | 4.8 | 0 | 0.0 | | 0.0 |
| Total | 6,737 | 749 | 11.1 | 9 | 1.2 | 9 | 1.2 |
| | | | Caroline County | | | | |
| 0-35 Months | 1,147 | 685 | 59.7 | 6 | 0.9 | 2 | 0.3 |
| 36-72 Months | 1,316 | 208 | 15.8 | 1 | 0.5 | 1 | 0.5 |
| Total | 2,463 | 893 | 36.3 | 7 | 0.8 | 3 | 0.3 |
| | | | Carroll County | | | | |
| 0-35 Months | 6,483 | 983 | 15.2 | 5 | 0.5 | 5 | 0.5 |
| 36-72 Months | 6,917 | 395 | 5.7 | 2 | 0.5 | | 0.0 |
| Total | 13,400 | 1,378 | 10.3 | 7 | 0.5 | 5 | 0.4 |
| | | | Cecil County | | | | |
| 0-35 Months | 3,883 | 726 | 18.7 | 4 | 0.6 | 4 | 0.6 |
| 36-72 Months | 3,925 | 332 | 8.5 | 2 | 0.6 | 2 | 0.6 |
| Total | 7,808 | 1,058 | 13.5 | 6 | 0.6 | 6 | 0.6 |

**Appendix A (continued)**
**Blood Lead Testing of Children 0-72 Months by Major Age Group and Jurisdiction in 2006**

| Age Group | Population of Children | Children Tested Number | Children Tested Percent | Prevalent Cases Number | Prevalent Cases Percent | Incident Cases Number | Incident Cases Percent |
|---|---|---|---|---|---|---|---|
| | | | Charles County | | | | |
| 0-35 Months | 5,628 | 1,306 | 23.2 | 1 | 0.1 | 1 | 0.1 |
| 36-72 Months | 5,776 | 613 | 10.6 | 0 | 0.0 | | 0.0 |
| Total | 11,404 | 1,919 | 16.8 | 1 | 0.1 | 1 | 0.1 |
| | | | Dorchester County | | | | |
| 0-35 Months | 1,082 | 518 | 47.9 | 10 | 1.9 | 8 | 1.5 |
| 36-72 Months | 1,096 | 166 | 15.2 | 1 | 0.6 | | 0.0 |
| Total | 2,177 | 684 | 31.4 | 11 | 1.6 | 8 | 1.2 |
| | | | Frederick County | | | | |
| 0-35 Months | 9,136 | 2,062 | 22.6 | 8 | 0.4 | 7 | 0.3 |
| 36-72 Months | 9,348 | 1,046 | 11.2 | 2 | 0.2 | | 0.0 |
| Total | 18,484 | 3,108 | 16.8 | 10 | 0.3 | 7 | 0.2 |
| | | | Garrett County | | | | |
| 0-35 Months | 1,194 | 360 | 30.2 | 3 | 0.8 | 2 | 0.6 |
| 36-72 Months | 1,212 | 135 | 11.1 | 2 | 1.5 | 1 | 0.7 |
| Total | 2,406 | 495 | 20.6 | 5 | 1.0 | 3 | 0.6 |
| | | | Harford County | | | | |
| 0-35 Months | 10,224 | 2,109 | 20.6 | 12 | 0.6 | 12 | 0.6 |
| 36-72 Months | 10,497 | 932 | 8.9 | 3 | 0.3 | 2 | 0.2 |
| Total | 20,721 | 3,041 | 14.7 | 15 | 0.5 | 14 | 0.5 |
| | | | Howard County | | | | |
| 0-35 Months | 11,739 | 1,485 | 12.7 | 4 | 0.3 | 3 | 0.2 |
| 36-72 Months | 12,353 | 703 | 5.7 | 4 | 0.6 | 3 | 0.4 |
| Total | 24,092 | 2,188 | 9.1 | 8 | 0.4 | 6 | 0.3 |
| | | | Kent County | | | | |
| 0-35 Months | 611 | 214 | 35.0 | 3 | 1.4 | 3 | 1.4 |
| 36-72 Months | 573 | 43 | 7.5 | 1 | 2.3 | 1 | 2.3 |
| Total | 1,184 | 257 | 21.7 | 4 | 1.6 | 4 | 1.6 |
| | | | Montgomery County | | | | |
| 0-35 Months | 39,777 | 11,710 | 29.4 | 33 | 0.3 | 32 | 0.3 |
| 36-72 Months | 38,631 | 5,701 | 14.8 | 20 | 0.4 | 16 | 0.3 |
| Total | 78,408 | 17,411 | 22.2 | 53 | 0.3 | 48 | 0.3 |

**Appendix A (continued)**
**Blood Lead Testing of Children 0-72 Months by Major Age Group and Jurisdiction in 2006**

| Age Group | Population of Children | Children Tested Number | Children Tested Percent | Prevalent Cases Number | Prevalent Cases Percent | Incident Cases Number | Incident Cases Percent |
|---|---|---|---|---|---|---|---|
| | | | Prince George's County | | | | |
| 0-35 Months | 38,073 | 11,715 | 30.8 | 46 | 0.4 | 42 | 0.4 |
| 36-72 Months | 37,923 | 6,846 | 18.1 | 25 | 0.4 | 24 | 0.4 |
| Total | 75,996 | 18,561 | 24.4 | 71 | 0.4 | 66 | 0.4 |
| | | | Queen Anne's County | | | | |
| 0-35 Months | 1,700 | 485 | 28.5 | 3 | 0.6 | 3 | 0.6 |
| 36-72 Months | 1,725 | 174 | 10.1 | 1 | 0.6 | 1 | 0.6 |
| Total | 3,425 | 659 | 19.2 | 4 | 0.6 | 4 | 0.6 |
| | | | Saint Mary's County | | | | |
| 0-35 Months | 4,106 | 1,226 | 29.9 | 6 | 0.5 | 6 | 0.5 |
| 36-72 Months | 4,179 | 291 | 7.0 | 5 | 1.7 | 5 | 1.7 |
| Total | 8,285 | 1,517 | 18.3 | 11 | 0.7 | 11 | 0.7 |
| | | | Somerset County | | | | |
| 0-35 Months | 776 | 396 | 51.0 | 9 | 2.3 | 5 | 1.3 |
| 36-72 Months | 784 | 110 | 14.0 | 0 | 0.0 | | 0.0 |
| Total | 1,560 | 506 | 32.4 | 9 | 1.8 | 5 | 1.0 |
| | | | Talbot County | | | | |
| 0-35 Months | 1,107 | 501 | 45.2 | 5 | 1.0 | 5 | 1.0 |
| 36-72 Months | 1,218 | 135 | 11.1 | 0 | 0.0 | | 0.0 |
| Total | 2,326 | 636 | 27.3 | 5 | 0.8 | 5 | 0.8 |
| | | | Washington County | | | | |
| 0-35 Months | 5,366 | 1,870 | 34.8 | 13 | 0.7 | 11 | 0.6 |
| 36-72 Months | 5,227 | 1,142 | 21.8 | 5 | 0.4 | 4 | 0.4 |
| Total | 10,593 | 3,012 | 28.4 | 18 | 0.6 | 15 | 0.5 |
| | | | Wicomico County | | | | |
| 0-35 Months | 3,531 | 1,668 | 47.2 | 16 | 1.0 | 14 | 0.8 |
| 36-72 Months | 3,424 | 772 | 22.5 | 6 | 0.8 | 2 | 0.3 |
| Total | 6,955 | 2,440 | 35.1 | 22 | 0.9 | 16 | 0.7 |
| | | | Worcester County | | | | |
| 0-35 Months | 1,560 | 623 | 39.9 | 5 | 0.8 | 5 | 0.8 |
| 36-72 Months | 1,443 | 339 | 23.5 | 2 | 0.6 | | 0.0 |
| Total | 3,002 | 962 | 32.0 | 7 | 0.7 | 5 | 0.5 |

**Appendix A (continued)**
**Blood Lead Testing of Children 0-72 Months by Major Age Group and Jurisdiction in 2006**

| Age Group | Population of Children | Children Tested Number | Children Tested Percent | Prevalent Cases Number | Prevalent Cases Percent | Incident Cases Number | Incident Cases Percent |
|---|---|---|---|---|---|---|---|
| | | | | County Unknown | | | |
| 0-35 Months | | 144 | | 17 | | 17 | |
| 36-72 Months | | 55 | | 4 | | 3 | |
| Total | | 199 | | 21 | | 20 | |
| | | | | Statewide | | | |
| 0-35 Months | 232,596 | 70,953 | 30.5 | 849 | 1.2 | 718 | 1.0 |
| 36-72 Months | 230,735 | 32,021 | 13.9 | 425 | 1.3 | 218 | 0.7 |
| Total | 463,331 | 102,974 | 22.2 | 1,274 | 1.2 | 936 | 0.9 |

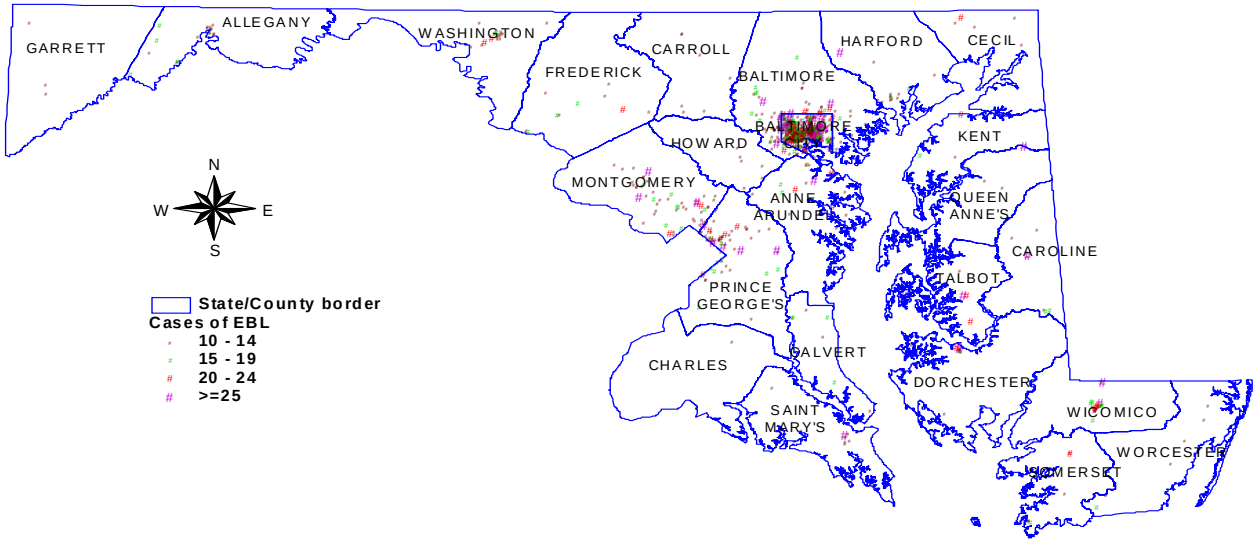
## Appendix B
## Blood Lead Testing of Children 0-72 Months: 1999-2006

| Calendar Year | | Population | Blood Lead Tests | | BLL ≥10 µg/dL | | Lead Poisoning | |
|---|---|---|---|---|---|---|---|---|
| | | | Number | Percent | Number | Percent | Number | Percent |
| 1999 | | | | | | | | |
| | City | 55,401 | 17,414 | 31.4 | 2,902 | 16.7 | 446 | 2.6 |
| | Counties | 363,511 | 43,524 | 12.0 | 925 | 2.1 | 102 | 0.2 |
| | Unknown | | 591 | | 77 | | 7 | |
| | Total | 418,912 | 61,529 | 14.7 | 3,904 | 6.4 | 555 | 0.9 |
| 2000 | | | | | | | | |
| | City | 50,380 | 18,033 | 36.8 | 2,198 | 12.2 | 266 | 1.5 |
| | Counties | 377,559 | 51,210 | 13.6 | 847 | 1.7 | 85 | 0.2 |
| | Unknown | | 5,273 | | 357 | | 2 | |
| | Total | 427,939 | 74,516 | 17.4 | 3,402 | 4.6 | 353 | 0.5 |
| 2001 | | | | | | | | |
| | City | 53,149 | 21,231 | 40.0 | 2,027 | 9.5 | 230 | 1.1 |
| | Counties | 387,289 | 55,470 | 14.3 | 814 | 1.5 | 58 | 0.1 |
| | Unknown | | 41 | | 0 | | 0 | |
| | Total | 431,438 | 76,742 | 17.8 | 2,841 | 3.7 | 288 | 0.4 |
| 2002 | | | | | | | | |
| | City | 52,744 | 16,595 | 31.5 | 1,558 | 9.4 | 183 | 1.1 |
| | Counties | 384,073 | 62,822 | 16.4 | 737 | 1.2 | 77 | 0.1 |
| | Unknown | | 90 | | 2 | | 0 | |
| | Total | 436,817 | 79,507 | 18.2 | 2,297 | 2.9 | 260 | 0.3 |
| 2003 | | | | | | | | |
| | City | 51,892 | 18,242 | 35.2 | 1,166 | 6.4 | 160 | 0.9 |
| | Counties | 386,076 | 58,470 | 15.1 | 552 | 0.9 | 77 | 0.1 |
| | Unknown | | 9 | | 1 | | 0 | |
| | Total | 437,968 | 76,721 | 17.5 | 1,719 | 2.2 | 237 | 0.3 |
| 2004 | | | | | | | | |
| | City | 52,796 | 18,970 | 35.9 | 1183 | 6.2 | 147 | 0.8 |
| | Counties | 395,310 | 83,002 | 21.0 | 573 | 0.7 | 83 | 0.1 |
| | Unknown | | 3,577 | | 55 | | | |
| | Total | 448,106 | 105,549 | 23.6 | 1,811 | 1.7 | 230 | 0.2 |
| 2005 | | | | | Prevalent cases | | Incident cases | |
| | City | 53,626 | 17,943 | 33.5 | 854 | 4.8 | 534 | 3.0 |
| | Counties | 401,888 | 80,848 | 20.1 | 463 | 0.6 | 382 | 0.5 |
| | Unknown | | 357 | | 14 | | 0 | |
| | Total | 455,514 | 99,148 | 21.8 | 1,331 | 1.3 | 916 | 0.9 |
| 2006 | | | | | | | | |
| | City | 54,547 | 18,363 | 33.7 | 843 | 4.6 | 573 | 3.1 |
| | Counties | 408,784 | 84,611 | 20.7 | 431 | 0.5 | 363 | 0.4 |
| | Unknown | | 199 | | 21 | | 20 | |
| | Total | 463,331 | 102,974 | 22.2 | 1,274 | 1.2 | 936 | 0.9 |

**ATTACHMENT 1**

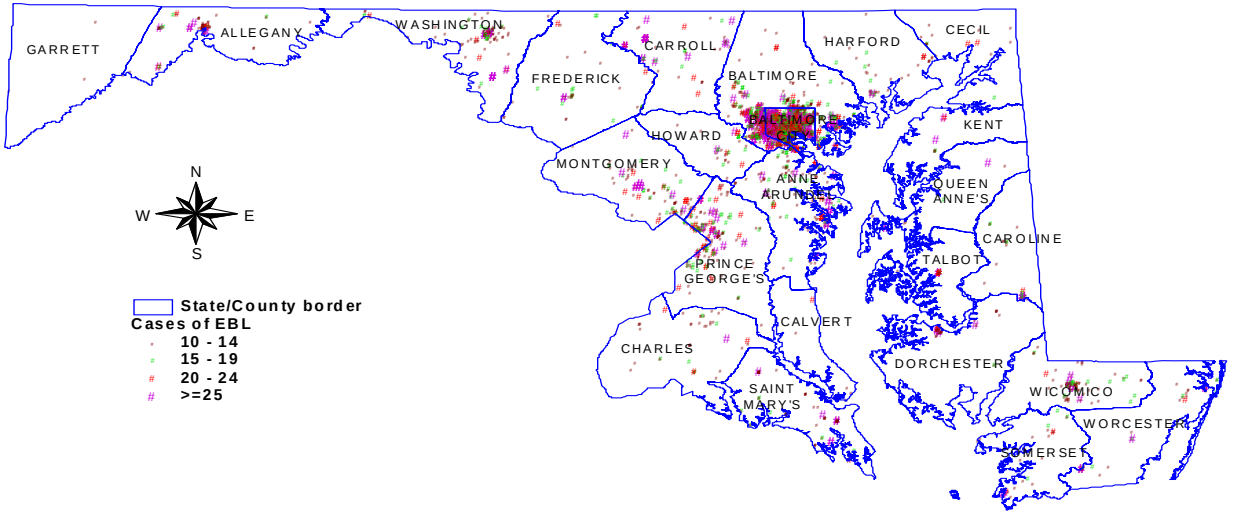
## Map Two-a

Distribution of Children 0-72 Months Tested for Lead in 2006 with Blood Lead Level >=10 µg/dL



## Map Two-b

Distribution of Children 0-72 Months Tested for Lead in 1996 with Blood Lead Level >=10 µg/dL



**ATTACHMENT 3**

Article - Environment

§6–807.

(a)There is a Lead Poisoning Prevention Commission in the Department.

(b)(1)The Commission consists of 19 members.

(2)Of the 19 members:

(i)One shall be a member of the Senate of Maryland, appointed by the President of the Senate;

(ii)One shall be a member of the Maryland House of Delegates, appointed by the Speaker of the House; and

(iii)17 shall be appointed by the Governor as follows:

1.The Secretary or the Secretary's designee;

2.The Secretary of Health and Mental Hygiene or the Secretary's designee;

3. The Secretary of Housing and Community Development or the Secretary's designee;

4. The Maryland Insurance Commissioner or the Commissioner's designee;

5. The Director of the Early Childhood Development Division, State Department of Education, or the Director's designee;

6. A representative of local government;

7. A representative from an insurer that offers premises liability coverage in the State;

8. A representative of a financial institution that makes loans secured by rental property;

9. A representative of owners of rental property located in Baltimore City built before 1950;

10. A representative of owners of rental property located outside Baltimore City built before 1950;

11. A representative of owners of rental property built after 1949;

12. A representative of a child health or youth advocacy group;

13. A health care provider;

14. A child advocate;

15. A parent of a lead poisoned child;

16. A lead hazard identification professional; and

17. A representative of child care providers.

(3) In appointing members to the Commission, the Governor shall give due consideration to appointing members representing geographically diverse jurisdictions across the State.

(c) (1) (i) The term of a member appointed by the Governor is 4 years.

(ii) A member appointed by the President and Speaker serves at the pleasure of the appointing officer.

(2) The terms of members are staggered as required by the terms provided for the members of the Commission on October 1, 1994.

(3) At the end of a term, a member continues to serve until a successor is appointed and qualifies.

(4) A member who is appointed after a term has begun serves only for the remainder of the term and until a successor is appointed and qualifies.

**ATTACHMENT 4**

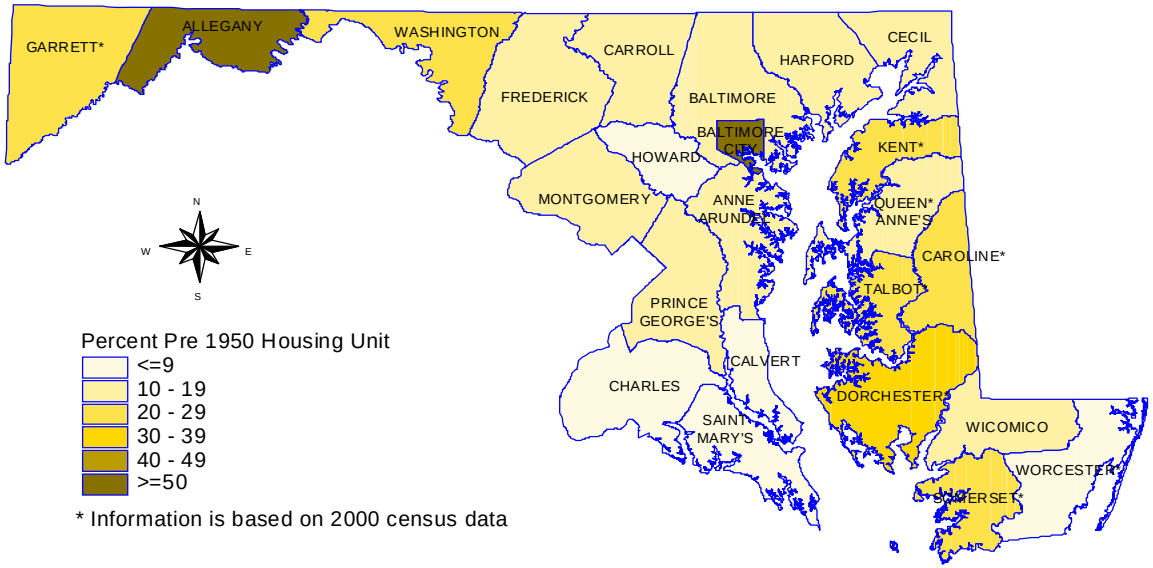
**Map 1**

# MARYLAND DEPARTMENT OF THE ENVIRONMENT

## Lead Poisoning Prevention Program: Childhood Lead Registry

Percent Pre-1950 Housing Units

Source: US Census Bureau, 2005 American Community Survey




* Information is based on 2000 census data

**ATTACHMENT 5**

## AWARENESS

State and local agency based outreach to different audiences important to lead poisoning prevention are summarized below. Specific activities range from hotlines and participation in local health fairs to information meetings with rental property owner associations and judicial training.

| | Youth & Children | Parents | Tenants | Landlords | Owner-Occupants Renovators | Realty Mgmt. | Insurers & MCO's | Hlth. Care Providers | Judges, Courts | At Risk Communities | Faith Communities | Property Mgr., Maint. Worker, Contractor |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| State MDE | | Websites, contracts | X | X | Websites, contracts | X | | Websites, contracts | X | | | X |
| State Housing | X | | X | X | X | X | | | | | | |
| State and Local Health | X | X | | | | | X | X | | | | X |
| Other Local Agencies | | X | X | X | X | X | | X | | X | X | |
| Baltimore City | | X | X | X | X | X | | X | | X | X | |
| CECLP | | X | X | X | X | X | X | X | X | X | X | X |
| MSDE | X | | | | | | | | | | | |

# County Health Departments' National Lead Poisoning Prevention
# Awareness Week Activities
## October 21-27, 2007

**Allegany County, Maryland**

• Partner with Lead Coalition to conduct a training at Head Start on Monday the 22nd
• Distribute the CDC information to the newspaper (waiting on date of publication)
• Providing each pediatrician's office in the county a 3 ring binder containing all the toys, jewelry and other items that have been recalled in 2007 as it relates to lead. This will also be placed in the Health Department's waiting area.

**Anne Arundel County, Maryland**

• Lead Posters and brochures in all 10 County Libraries
• Flyer 600 homes in at-risk areas of the county-Glen Burnie
• October Article- Lead and it's Effects on Children- E-Zine Newsletter to Parents from The Parenting Center at Anne Arundel Community College
• Lead Week Announcement at 3 Area Churches
• Lead Week Announcement on Fire Station Marquee- Severn and Walgreen's Marquee, (pending final approval)
• Display and information table at Babies R-Us Store in Glen Burnie on Friday, Oct. 26, 2007 from 11 am- 6pm
• Posters and brochures at WIC Clinics- North County and Truman Parkway

**Caroline County, Maryland**

Gail Spivey (410) 479-8018
• Place News article in the Caroline Review published for Month of October
• Distribute newsletter to parents of children turning 1 & 2 this month reminding of importance of timely lead testing this month
• Create educational display at local library
• Provide lead information update to Judy Center and FSC
• Update the www.myfamilyneeds.info resource center website with recalled toys/products
• Health dept web site link to recalls
• Promote a Lead Poisoning Prevention Resource Fair, Nov. 26, Caroline County Library, Denton, Md. from 5:30-7:30

**Cecil County, Maryland**

• A bulletin board educating the public about lead poisoning will be posted in the central lobby of Cecil County Health Department. It will educate and encourage all children to receive a lead test at 12 and 24 months of age. It will also educate the public about recalls of items found to contain lead.
• Eight bulletin boards distributed throughout the county will educate families about having a blood lead test at 12 and 24 months of age. It will also offer information about recalls of items that contain lead. Four bulletin boards are located in pediatrician's offices, two are located in Family Practice offices, one in the local Judy Center, and one at the Head Start in Cecilton, the only at-risk zip code in Cecil County.
• Ten posters will be distributed throughout the county with lead education and encouraging families to get children a blood lead test at 12 and 24 months of age.

• Lead Poisoning Week will be discussed by our Health Officer at the October Board of Health meeting.

**Charles County, Maryland**

• Conduct Outreach to Parents and Children by setting up a display, distributing brochures, and answering questions at the South Potomac Church, Harvest Fest, Lancaster Neighborhood Center, Toy's R Us, and other locations throughout the community.
• Mail brochures and posters to local community centers
• Set up a display with information and brochures in the County Government Building, Permit Section to reach out and educate local contractors
• Send posters to doctors and provide information to staff of the Charles County Department of Health, and to Obstetricians and Pediatricians throughout Charles County.

**Garrett County, Maryland**

• During the whole month of October there will be a display on the 2nd Floor of the Garrett
County Health Department explaining the importance of testing and prevention. The binder with the pictures of the recalled products will be on a table in front of the display along with brochures.
• An article will be placed in the Republican in honor of Lead Poisoning Prevention week.
• A letter will be mailed to contractors, realtors, and home improvement stores explaining the importance of lead prevention in homes.
• A visit to the local hardware stores to set up a display explaining the importance of lead prevention in homes when remodeling.
• The FluMist project at Broad Ford Elementary School from 2-6:00 p.m. will include a display and the binder with the pictures of all the recalled products.
• The FluMist project at Kitzmiller Elementary School from 2-6:00 p.m. will include a display and the binder with the pictures of all the recalled products.
• Outreach to local providers

**Kent County, Maryland**

Melinda Sharp (410) 778-1350 ext. 7016
• Distribute posters to local grocery stores and pediatricians offices
• Conduct Lead Education day at Kent Family Center and WIC office
• A lead information advertisement will appear in the Tidewater Trader paper
• Distribute lead poisoning prevention stickers and handouts to local daycare centers

**Montgomery County, Maryland**

• Montgomery County is planning to have a luncheon and bring together staff from the Refugee Program, the Childhood Lead Poisoning Prevention Program, School Health Services, ESOL and Head Start.

**Prince Georges County, Maryland**

Ali Golshiri (301) 883-7662
• The LPPP will distribute MDE or MDE approved Lead awareness and prevention information flyers (in Spanish & English) to the Community Centers in AT-Risk areas of the county.
• The LPPP staff will be present at several major retail facilities (selling toys) to educate public about the lead poisoning prevention and distribute handouts and flyers.

• In partnership with the Prince George's County Child Resource Center (CRC), an informational flyer about the lead poisoning prevention and the recent toy recalls will be forwarded through E-mail to all family daycare providers, and day care centers throughout the County.

**Somerset County**

• Distribute posters/flyers as provided by MDE throughout the community.
• Create a display on Lead Poisoning and Prevention for the Health Department lobby during lead prevention week.
• Educate parents in attendance at WIC clinic during the week.
• Educate parents in the Health Department's home visiting programs during the month of
October about Lead Poisoning and testing of children for lead.
• Display a message on the Health Department marquee during the week.

**Queen Anne's County, Maryland**

Danya McCoy (410) 758-0720 ext. 371
• News paper press release in the Bay Times, Star Democrat, and Record Observer the week of October 21st
• Power point press release on QAC TV7 the week of October 21st
• A table set up through out the week of October 21st at Centreville Library, Kent Island Library, and Family Support in Grasonville

**Wicomico County**

• Distribute 50 each of the "Risk Assessment Questions for New Renters" and "FACT sheet" to 7 Faith Based organization (churches) to be distributed during their church services
• Educational Display Board on display at the Wicomico County Library in Salisbury.
• Distribute Information at regional WIC office.
• Update Bulletin board at the Fritz Building, WIC clinic, and Adkins Building.
• WIC clinic Outreach.
• Distribute 100 Prenatal Packets with Lead Information fliers to the Three Lower Counties
Community Clinic in Salisbury. Including the "Be Lead Smart Before Your Baby Is Born" pamphlet.
• Attend the Employee Health Fair at Wicomico County Health Department and educate participants.

**Worcester County Health Department**

• Place binders with recalled toys in the lobby of the health department (4), pediatrician's offices (2), and the Center for Clean Start.
• Conduct in-service for Department of Social Services workers
• Place Educational display in the Health Department lobby
• Participate in the Berlin Fall Festival, Community Fairs, and events at Pocomoke Church
• Place educational information in the local Healthy Start Newsletter
• Update the WCHD website with information on Lead and a link to the Maryland Department of the Environment.

**ATTACHMENT 6**

**Number of People Reached By Outreach / Educational Events Conducted by Local Health Departments**
**FY 2007**

| **Activity** | **Outreach Numbers** |
|---|---|
| **Outreach to:** | |
| Rental Property Owners-Presentation | 493 |
| Other Programs in Health Department (W.I.C., Healthy Start, etc.) | 12,927 |
| Outreach in "At Risk Areas" | 40,887 |
| Health/County Fairs/Schools | 209,214 |
| Attendance at grand rounds or physician office visits | 401 |
| **Via Media:** | |
| **Focus on Rental Property Owners** | **71,800** |
| Focus on Public Lead Education | 424,200 |
| **Total** | **759,922** |

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• Distribute 50 each of the "Risk Assessment Questions for New Renters" and "FACT sheet" to 7 Faith Based organization (churches) to be distributed during their church services
• Educational Display Board on display at the Wicomico County Library in Salisbury.
• Distribute Information at regional WIC office.
• Update Bulletin board at the Fritz Building, WIC clinic, and Adkins Building.
• WIC clinic Outreach.
• Distribute 100 Prenatal Packets with Lead Information fliers to the Three Lower Counties
Community Clinic in Salisbury. Including the "Be Lead Smart Before Your Baby Is Born" pamphlet.
• Attend the Employee Health Fair at Wicomico County Health Department and educate participants.

**Worcester County Health Department**

• Place binders with recalled toys in the lobby of the health department (4), pediatrician's offices (2), and the Center for Clean Start.
• Conduct in-service for Department of Social Services workers
• Place Educational display in the Health Department lobby
• Participate in the Berlin Fall Festival, Community Fairs, and events at Pocomoke Church
• Place educational information in the local Healthy Start Newsletter
• Update the WCHD website with information on Lead and a link to the Maryland Department of the Environment.