REPORT TO THE GOVERNOR

BY THE

LEAD POISONING PREVENTION COMMISSION

January 2001

MARYLAND LEAD POISONING PREVENTION COMMISSION

JANUARY 2001 REPORT TO THE GOVERNOR

EXECUTIVE SUMMARY

Environment Article Title 6, Subtitle 8 of the Annotated Code of Maryland established the Lead Poisoning Prevention Commission to advise the Department of the Environment, the Legislature, and the Governor regarding lead poisoning prevention in Maryland. The Commission monitors and evaluates the effectiveness of the "Reduction of Lead Risk in Housing" statute, and provides oversight of lead poisoning prevention in general for the State.

As part of the January, 2000 Lead Initiative, Governor Glendening charged the Commission with making recommendations on a number of specific issues. This report summarizes the findings and recommendations from the Commission in response to that request. Key recommendations include the following.

Reduce Barriers to blood lead testing

Fewer than 13% of children aged 0-6 years and 24% of children aged 2 have been tested for blood lead. The Commission recommends that the State facilitate the process for obtaining blood lead tests for children by several strategies aimed at families, health care providers, and access to testing sites. This is particularly important in "at risk" areas as identified by the Department of Health and Mental Hygiene (DHMH) *Maryland Lead Risk Targeting Plan*.

Increase enforcement of the laboratory blood lead reporting requirements

Current reporting from private sector laboratories is often incomplete for children's addresses and other important information. The Commission recommends that the State implement several actions to enforce complete, uniform laboratory reporting. Actions range from updating the current reporting regulations to strengthening enforcement.

Prepare lead tax credit legislation using the Massachusetts model for the 2001 legislative session

Tax credits offer a simple yet effective financial tool to motivate property owners to address the problem of lead safe housing. The Commission recommends that the Governor’s Office work with a sponsor and the various State Departments such as Maryland Department of the Environment (MDE), Department of Housing and Community Development (DHCD), the Comptroller’s Office and the Department of Budget and Management (DBM) to develop legislation for the 2001 session.

Support the Primary Prevention components of the "Windows of Opportunity" program

The "Windows of Opportunity" program developed by the Coalition to End Childhood Lead Poisoning includes primary prevention, outreach, and enforcement proposals. Efforts to support the creation of lead-safe housing, such as grant and loan funding, Healthy Homes projects, private housing rehabilitation, HEPA-vacuum loan programs, and safe demolition are critical to lead poisoning prevention.

Petition Department of Housing and Urban Development (HUD) to include compliance with Maryland's Environment Article 6-8 as a condition for participating in the Section 8 rental assistance program

Owners of Section 8 rental units do not clearly understand that they must comply with the Maryland risk reduction standards. The Commission recommends that DHCD be charged with coordinating among public housing authority's in Maryland to petition for a change to the HQS standards to require compliance with MDE's rental registration law. It is understood that PHAs will need time to completely understand the State law as well as their new responsibilities under the HUD rule change.

Expand education efforts to increase knowledge of Title 6 and the applicable Maryland insurance laws within the insurance community

Maryland insurers do not have a clear understanding of their requirements under the law. The Commission recommends additional education efforts for insurers. Such efforts should include coordination with the Maryland Insurance Administration and MDE by providing seminars in conjunction with required continuing education for insurance agents and brokers.

Expand outreach to childcare providers, schools, and health care providers to improve prevention and early intervention for children with elevated blood lead levels

Awareness of resources and treatment protocols can improve referrals for medical intervention and educational supports for children with lead poisoning.

Seek statutory changes to Environment Article, Title 6, Subtitle 8.

There are sections of the Reduction of Lead Risk in Housing law that need to be amended to further mitigate lead poisoning hazards to children, particularly those that allow the dust test without removing chipping, peeling, and flaking paint. Several other amendments are needed to facilitate program funding and assessment of penalties.

Improve property owner compliance with rental registration requirements.

Additional education and outreach efforts need to be made to assist property owners in understanding the lead law and how to comply. Concurrently, enforcement efforts must be more aggressive to reach the recalcitrant violators.

CONCLUSION

In response to specific inquiries from Governor Glendening, the Lead Poisoning Prevention Commission has reviewed several aspects of Maryland's lead poisoning prevention efforts. The Commission finds that a broad, diverse infrastructure for prevention, early intervention, and enforcement is in place. However, implementation and effectiveness of the programs vary widely.

Awareness, coordination, and resource availability are significant variables for the improved success and evaluation of these programs. To improve lead poisoning prevention in Maryland, the Commission recommends several improvements to build on existing efforts and

develop new programs. The recommendations range from policy and statutory changes to expanded outreach and services coordination. The Commission will continue to track these issues over the next year and requests that the MDE, DHMH, and DHCD provide an interagency response on their initial review of this report in three months.

The Commission recognizes that the recommendations in this report may require increased resources, both staff and funds. However, the Commission does not have the information to quantify the increases. It suggests that the three state agencies provide estimates of increased resources and make those estimates a part of the response to the Commission.

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Environment Article Title 6, Subtitle 8, of the Annotated Code of Maryland established the Lead Poisoning Prevention Commission to advise the Department of the Environment, the Legislature, and the Governor regarding lead poisoning prevention in Maryland. The Commission monitors and evaluates the effectiveness of the "Reduction of Lead Risk in Housing" statute, and provides oversight of lead poisoning prevention in general for the State. The Commission has 18 members, 16 of whom are appointed by the Governor and 2 of whom are appointed by the General Assembly. The Commission members serve four-year staggered terms, and are required to meet at least quarterly.

As part of the January, 2000 Lead Initiative, Governor Glendening charged the Commission with making recommendations on several specific issues. This report summarizes the findings and recommendations from the Commission in response to that request.

Review and assess the effectiveness of the "Reduction of Lead Risk in Housing" law including:

- **Developing specific measurable milestones for the next six years**
- **Developing recommendations for regulatory and legislative changes**

The Commission, as well as other interested parties, has collectively reviewed various documents and reports provided by the Maryland Department of the Environment (MDE). The Commission focused on three areas of the regulatory process, focusing at first on the registration of the affected properties, secondly, on the percentage of risk reductions performed with these affected properties and lastly the number of available qualified personnel to perform lead-safe work practices as required under the rule. The first two areas appeared to be very important benchmarks in order for the Commission to determine overall effectiveness of the program. The third area came of interest after several discussions with the Commission and interested parties. Several members of the Commission suspected that the lack of trained personnel may contribute to overall lack of program compliance.

Additional areas of program effectiveness (e.g. qualified offer counseling, temporary housing for relocation, the overall reduction in childhood lead poisoning and the success of the regulation as a primary prevention tool) are addressed in other sub-sections.
Barriers to the Commission to provide accurate program information for this report included:

- MDE's data set relating to the total number of certified lead free properties or certified lead free rental dwelling units. The Department's database is not delineated by age of construction. This area of data management is critically important because the statute is driven by the property's actual date of construction. The break point for mandatory program participation is pre-1950. Various properties constructed between 1950 and

1978 has been inspected for the presence of lead-based paint and have been found to be free of lead-based paint. However, this population of properties has been dumped into one single data field. This data field is known as certified lead free properties or certified lead free dwelling units. MDE, non-profit organizations, property owners, and other interested parties have no effective way to determine the extent of pre-1950 constructed lead free dwelling units. This restricts the overall program effectiveness when families are searching for housing free of lead based paint. This search is at times elective (e.g., looking for lead free housing during a new unit search) but in many cases this search is mandatory at a critical point in a process (e.g., during the narrow window of opportunity involved with a qualified offer).

- MDE's data set relating to the total number of pre-1950 constructed rental units. The Department's database utilizes the 1990 census (this set of data is known not to be reflective to the actual size of the regulated community). This area of data input is of concern because over the last ten years the inventory of pre-1950 constructed housing has significantly changed in several areas of the State.
- MDE does not have the statutory authority to track the actual number of Rental Dwelling Unit turnovers in the calendar year. The department's authority under 6-811 (b)(7) is limited to an inquiry about the date of the latest change in occupancy of an affected property. In the event the rental dwelling unit has a change in occupancy more then once in a calendar year the Department's database is blind to this event. This reduces the Department's ability to determine the level of compliance with the mandatory Risk Reduction Treatment (triggered at unit turnover or a change of occupancy). This area of data management is critically important because the statue requires very specific actions to be under taken by the property owner during a "unit turnover" to minimize the likelihood of lead hazard exposure to new residents. This step is a significant component of the program's check and balance system. Without the turnover data linked to the recorded Risk Reduction certificates the overall "actual" program compliance may never be known.

Registration of the pre-1950 constructed residential rental dwelling units or properties is illustrated in ***Appendix A***. This chart illustrates the cumulative level of participation after the enactment of the Annotated Code of Maryland Environment Article Title 6, Subtitle 8, and the registration process (§6-811). This process is primarily an administrative function with associated fees. The detailed process for the Registration process can be found in the statute in Section 6-811.

The apparent lack of program participation can be best illustrated in Charles County – posting a 14 percent level of rental dwelling unit registration. Wicomico County holds the state's highest level at 56 percent. Larger populated areas such as Baltimore City, Baltimore, Prince George's and Montgomery Counties trend with similar levels: 50%, 43%, 31% and 35%, respectively. These larger more densely populated areas have a larger community of multifamily housing. It appears that the compliance levels in Baltimore City, Baltimore, Prince George's and Montgomery Counties are positively increased due to the higher portion of multifamily rental properties in these areas. Registration of the one "property" may result in the registration 150 rental dwelling units. Factors like this assist in the overall positive percentages. However, the

reported level of registration appears to be well below any acceptable “Level of Success” for a program that has been in place for more than 5 years.

Risk Reduction activities conducted in the pre-1950 constructed rental dwelling units are illustrated in ***Appendix A.*** This chart illustrates the level of participation after more than five years associated with the Risk Reduction process. Risk Reduction typically requires a positive action to be undertaken by the Property Owner. These actions may include (i) Lead Hazard Reduction Treatments or (ii) Testing for Lead-contaminated dust. Either action is completed during the process of making the rental dwelling unit "Rent Ready" or in conjunction with a unit turnover.

At this time based on the number of reported affected properties and the recorded number of Risk Reductions it appears the numerous property owners will not met the February 24, 2001 deadline. Although the available data sets are very limited and require extensive interpretation, it appears that the levels of compliance range from less then one percent to 64 percent. Another serious problem with the available data sets from the Department is the lack of knowledge regarding the number of actual times a rental dwelling unit has had a change in occupancy. This is important because Risk Reductions are mandated at each and every change in occupancy. However, due to both statutory language and database design, property owners are only required to submit the “last change in occupancy.” The available data only reflects a Risk Reduction, but not the number of changes in occupancy. This disparity of information results in an unknown level of compliance.

The number and rate of Risk Reductions completed by year or in the cumulative appears to be low in several counties at a time when property owners are rapidly approaching the February 24, 2001 deadline. Non-compliance calls into question the Property Owner’s ability to afford them the provision of Part V - Qualified Offers and have the Protection from Liability (6-836). An owner of affected properties shall ensure that at least 50 percent of the owner's affected properties have satisfied the Risk Reduction standard specified in Environmental Article 6-815, without regard to the number of affected properties in which there has been a change in occupancy.

RECOMMENDATIONS:

Continue funding, based on written reports of Program performance, to the Maryland Department of the Environment in order for the department to update its Rental Housing database. This is required to enable both the regulating and the regulated communities to have quick and ready access to data in order to determine real time status of the affected properties and the associated residential dwelling units.

Require MDE to present to the Commission the findings of the “Needs Assessment” that was prepared prior to starting the development of the new database. These efforts are necessary to ensure that the design of the database meets the needs both the various regulating agencies and the regulated community.

Notify in writing all Property Owners of their current regulatory status -- relating to Risk Reductions.

Statutory changes to Environmental Article Title 6, Subtitle 8 are required, based on experience and historical departmental interpretation. These changes are required to reflect current knowledge and application of "best practices." These changes include:

- Amend the defined terms (i) "Affected Property" and (ii) "Rental Dwelling Unit".
- Define "Accessible to a child".
- Amend the Definition section to reflect a "deminimus" level of defective or deteriorated paint.
- Amend Section 6-816 – Lead Contaminated Dust Testing to include the need for tested areas to have be free of deteriorated paint (subject to the deminimus level).
- Amend the Commission's size and staffing (e.g., establish permanent seats for housing representatives, include other government agencies that provide services to families impacted by lead exposure, etc.).
- Provide for a statutory exception, regardless of age of construction, for designated Elderly Communities.
- Provide Limited Tort Liability protection, without any further obligation, to all Rental Property Owners that have properties that are post-1978 constructed or have a valid Certificate indicating that the property is free of lead-based paint.
- Evaluate the need for funding that is mandated for Lead Poisoning Prevention.
- Evaluate the structure and means for administrative penalties and fines.

In order to reach the goal of 100% compliance by 2003 we must improve the level of Registration of Affected Properties and their associated Rental Dwelling Units. In order to accomplish this goal the State of Maryland shall:

- Provide for a one-year period of statewide education. This program shall be performed in conjunction with established apartment associations (e.g. Maryland Multi-Housing Association, Apartment and Office Buildings Association, Institute of Real Estate Management and the Property Owners Association). Funding for the effort can be accomplished through the existing funds available for out reach and education.
- Provide for an Amnesty Program through legislative action. This Program shall be linked to the statewide education program being conducted through professional trade association.
- Provide for an aggressive program of enforcement following the Amnesty Program. This process is necessary to ensure that non-compliant property owners are made aware of the law and participate.
- Continue to monitor the levels of trained workers, supervisor and inspectors. This is necessary to determine if the market place is adequately staffed to provide property owners a continuous resource.

Coordinate a program to train low-wage workers to work as lead abatement workers and develop funding for this purpose.

Given the Governor's Lead Initiative, new HUD lead regulations, and expanded State and Baltimore City enforcement, the Commission anticipates that there will be an increase in lead hazard reduction activities. This will increase the need for trained workers. While Maryland is fortunate in having a worker and contractor certification and accreditation program in effect for several years, prior demand has been low. Currently, the Eastern Shore and Western Maryland report insufficient availability of trained workers, contractors, and inspectors. Simultaneously, there is a need for job training programs to assist certain individuals with job development skills.

During the 2000 session, the General Assembly passed HB 1267 to create a job training pilot program for clients receiving services through the Drug and Alcohol Administration. The program provides one year of training or employment to individuals 18-34 years of age that have completed an in-patient drug or alcohol treatment program. The program is limited to 10 individuals in the first year, with a total of 40 more in years 2 and 3 of the pilot. Eighty percent of the participants will be selected from Baltimore City and Prince George's County and twenty percent of the participants are to be selected from Allegany, Dorchester, Somerset, Wicomico and Worcester Counties. Individuals elected for participation in the program shall be eligible to receive training to become a certified lead abatement technician or full time employee with a State government contractor in housing inspection and lead abatement services. The pilot project is not expected to get underway until January 1, 2001.

Similar model programs in Petersburg, Virginia and Pittsburgh, Pennsylvania have been successful in the development and implementation of such worker training programs. The Coalition to End Childhood Lead Poisoning currently operates a community based hazard reduction program that combines job development with lead abatement work. The program works with Americorp volunteers to provide them expertise in lead hazard reduction and prevention education while earning money for college. The services provided are specialized cleaning, painting, and light construction and are provided free of charge to qualifying families and property owners.

RECOMMENDATION:

Review existing State and national models when developing Maryland 's job training pilot project. In particular, it is recommended that the Drug and Alcohol administration, Department of Health and Mental Hygiene (DHMH), analyze the budget of these model programs in order to ensure that Maryland's program has adequate funds to operate a successful project.

Explore the possibility of assisting pre-natal patients with living arrangements in a lead-safe environment.

The Commission acknowledges the extreme importance of providing women of childbearing years with information on the importance of living in a lead safe environment. Assisting this population with information and providing access to resources that can provide them a lead safe environment are important for the safety of the unborn children.

The Commission believes that the task of actually having the State provide the lead safe housing for the prenatal client group is too large a task at this time. The Commission does, however, in other recommendations addressed in this report, support State programs and initiatives such as a Lead Tax Credit and increases in funding for lead abatement grant and loan programs that will directly increase the supply of lead safe housing.

The Commission agrees that the State should explore ways to provide appropriate education and information on lead resources to prenatal clients during their pregnancy. As a model approach, the Commission reviewed the Coalition to End Childhood Lead Poisoning's statewide education project entitled *Pediatricians as Partners in the Primary Prevention of Lead Poisoning.* With support from DHMH, the Coalition provides extensive training and education to pediatricians on federal and state testing requirements on linkage of treatment/prevention to community resources. While the Coalition's coordinator for this project does seek opportunities to get information to obstetricians and gynecologists, current community resources are limited.

RECOMMENDATION:

Expand education to include physician outreach to prenatal patients. The Commission recommends that DHMH expand its statewide education effort to include physicians who care for prenatal patients with particular emphasis to those of limited income. The Commission also supports the efforts of the Coalition to expand its hazard reduction program services to this group. The Coalition Lead Hazard Reduction Program, which is addressed in other sections of this report, provides minor cleanup and repair services at no cost to the property owners as a way to address lead hazards in the home. Additional funding would need to be provided to expand this effort.

Explore the possibility of reporting the names of children that have tested positive for lead to their respective school districts for the purpose of developing and tracking suitable educational programs.

The current School Health Inventory Form, ("Form") completed by both parent/guardian and physician, for Maryland public schools has been updated to include questions related to the child's blood lead exposure history. Both the parent's and the health care provider's sections of the Form include a section regarding concern about lead exposure, with the possible responses of "Yes" or "No" and a space for remarks. The Form does not specifically request information on blood lead levels nor does it specifically inquire about blood lead testing. After the school has received the completed Form, the school nurse reviews it to determine whether there are any health concerns. As needed, referrals are made to the pupil services team, which discusses the needs of the child in conjunction with input from the physician and the family. Under this system, both physicians and parents/guardians are already reporting information directly to the school regarding the child's lead exposure. While not all children with a history of elevated blood lead will require special individualized educational plans, such a plan would be handled through the current system.

It is not anticipated that the educational needs of lead poisoned children would differ substantially from those with developmental or learning disabilities or other neurological impairments. Dr. Gerard A. Gioia, Pediatric Neuropsychologist and Director of the Division of Pediatric Psychology/ Neuropsychology of the Mt. Washington Hospital was consulted on this issue. He stated that he believes that, in general, schools' special programs are not meeting the educational needs of children with neurologic impairments, but that these needs are not unique to children who have had a history of elevated blood leads.

Dr. Cecilia T. Davoli of the Kennedy-Krieger Institute was also consulted on the issue of educational needs of children with elevated blood lead levels. Dr. Davoli believes that more education is needed for both parents and educators about childhood lead poisoning, its prevention, and its potential consequences. Often parents and educators work best as partners in the care of children when they have the information that they need to fully understand a child's behaviors, needs, and challenges. Simply telling the school that a child had lead poisoning five years ago will not meet that need.

The need for tracking and developing suitable educational programs for children in early education and preschool settings is another issue of great importance. In order to be appropriately responsive to possible increased educational needs, childcare staff should also review the Health Inventory Forms and respond with appropriate early educational assessment and referrals, as needed. Currently the Health Inventory Form used by the Department of Human Resources, Child Care Administration does not include specific questions about lead exposure, however documentation of an "appropriate lead screen" is required for entrance to daycare since 1997. This documentation is not specific as to whether a blood test was performed or the results of the screen.

Once a child reaches the age where he/she enters the school system, a process for tracking children with special educational needs is already in place. For children with a history of elevated blood lead levels, the issue is whether the school recognizes the significance of the lead-related information on the health inventory and is proactive in addressing the needs of these children.

RECOMMENDATIONS:

Provide training and education. The Commission recommends that the Department of Health and Mental Hygiene, in collaboration with the Maryland State Department of Education, and the Department of Human Resources (DHR), Child Care Administration (CCA), provide training and education to school nurses and day care/preschool providers. This training will serve to increase awareness regarding the blood lead information in the Health Inventory Form. The training and education should aim to equip schools and licensed day care providers with the information necessary to make appropriate referrals and develop educational services for children with educational, learning, or health sequelae to lead poisoning. This training can be provided through the current system of school nurse training provided by the Maryland State Department of Education and the Department of Health and Mental Hygiene. Training for childcare providers can become part of the ongoing CCA training provided through DHR.

Develop specific guidelines. The Commission recommends that Department of Health and Mental Hygiene, in collaboration with the Maryland State Department of Education, and the Department of Human Resources (DHR), Child Care Administration (CCA), and the Maryland Department of the Environment develop guidelines for how schools and licensed day care facilities should approach children with a history of elevated blood lead levels. The Maryland State Department of Education, the Department of Health and Mental Hygiene, and the Maryland Department of the Environment have expressed interest in developing a school health guideline for school nurses that targets children with elevated lead levels, possibly in conjunction with the Mt. Washington Hospital. This guideline would contain guidance for assessing the need for care coordination and follow-up.

Conduct a review of protocols. The Commission recommends that the Department of Health and Mental Hygiene, in collaboration with the Maryland State Department of Education conduct a review of other state departments of education to obtain information regarding the role of schools in addressing issues related to children with elevated blood lead.

Explore the possibility of providing tax incentives (much like was done during the energy crisis in the 1970's) or grants combined with low-interest loans for property owners who replace windows or other lead hazard areas in the home.

In addressing the problem of lead safe housing, the State needs to consider a wide array of strategies to motivate the private sector to action. Income tax credits can be a strong incentive to encourage and reward owners who take it upon themselves to make their housing lead safe. Massachusetts has had success with their tax credit program, which has been in existence since January 1994. In 1995, over 1800 individuals qualified to claim a lead paint credit in

Massachusetts at a cost of $2.8 million. Sixty one percent of those qualified to take the credit had incomes of under $50,000.

The Lead Tax Credit program in Massachusetts is private sector driven. Owners must make arrangements to have the property tested by certified professional, arrange to have the work (either full compliance or interim controls) carried out by a certified company and arrange for follow-up testing. This documentation is attached with the appropriate claim forms from the Massachusetts Department of Revenue with the individual's income tax return. The amount of the credit is up to $2000 for full compliance or $500 for interim controls. The cost to administer the credit is minimal.

Legislation to create a similar credit program in Maryland was introduced in 1997 and in 2000. The legislation, which has been introduced by Delegate Samuel Rosenberg, proposed the program to be administered by the Department of Housing and Community Development. In 1997, the legislation called for program authorization of up to $5 million; in 2000, the legislation called for budget authorization of up to $10 million. It is our understanding that budget constraint was a primary factor in the decision not to move forward with the legislation.

Tax credits offer a simple yet effective financial tool to motivate property owners to address the problem of lead safe housing. As demonstrated in Massachusetts, it can also be setup with a minimum of intervention on the part of the State. (Note: Tax credits claimed for lead in Massachusetts totaled $5.2 million in 1994.)

RECOMMENDATION:

Prepare lead tax credit legislation using the Massachusetts model for the 2001 legislative session. The Commission recommends that the Governor's Office work with the sponsor and the various State Departments such as MDE, DHCD, the Controller's Office and the Department of Budget and Management to develop legislation to create a tax credit program in Maryland that is agreeable to all parties. If necessary, the authorizing legislation could be proposed at a modest level of funding for the initial year. The goal should be to have legislation introduced at the 2001 session that is firmly supported by all interested parties.

Explore the possibility of limiting the use of Section 8 funds to housing that meets the requirements of the Maryland "Reduction of Lead Risk in Housing" law.

The Commission looked to DHCD for guidance and direction on this issue. DHCD is the State's housing finance agency and the housing authority that administers the Section 8 program in certain Eastern Shore counties. DHCD is also part of a Statewide Section 8 users group, which meets regularly to discuss technical aspects of the Section 8 program. All public housing authorities (PHAs) in Maryland are part of this workgroup. The Section 8 users group is part of the Maryland Association of Housing and Redevelopment Agencies (MAHRA).

Section 8 is a HUD funded rental assistance program for low-income tenants. In order for units to be rented under the Section 8 program, they must meet minimal property standards know as Housing Quality Standards (HQS). HUD sets these standards by regulations. Local

housing authorities may petition HUD for changes to the standards on a case by case basis. HUD approval is required to impose any additional requirements such as compliance with State rental registration requirements.

While the Commission is sensitive to imposing additional requirements that may discourage landlords from participating in the Section 8 program, it was felt that Section 8 landlords should not be above compliance with State law. The Commission also feels it is timely given the new HUD requirements that will impose new requirements on Section 8 landlords relative to the manner in which they carry out paint stabilization. The PHAs will also be required to do a visual assessment as defined in the HUD regulations and, if paint stabilization work is required, to secure clearance testing. It is timely to approach HUD about seeking a change to the Section 8 HQS requirements.

RECOMMENDATION:

Petition HUD to include compliance with Maryland's Environment Article 6-8 as a condition for participating in the Section 8 rental assistance program. The Commission recommends that DHCD be charged with coordinating among PHA's in Maryland to petition for a change to the HQS standards to require compliance with MDE's rental registration law. It is understood that PHAs will need time to completely understand the State law as well as their new responsibilities under the HUD rule change. DHCD has already been in touch with MAHRA and the Section 8 users group to discuss this recommendation and to assist them with training.

Review the "Windows of Opportunity" proposal by the Coalition to End Childhood Lead Poisoning (CECLP) and make appropriate recommendations.

The Commission is in strong support of the "Windows of Opportunity" proposal created by the CECLP. The Commission is particularly supportive of the proposal's Primary Prevention segment recommendations. The Commission offers the following comments and recommendations related to specific segments of the proposal.

Windows of Opportunity -- Primary Prevention

Targeted Demolition of Lead Contaminated Homes in Baltimore City
RECOMMENDATION:

Give highest priority to creating lead-safe housing. Assure lead safe work practices during demolition. Since lead-safe housing is one of the most critical tools for ensuring primary prevention, the Commission recommends that the State give highest priority to put resources into creating lead-safe housing. The Commission agrees that lead safe work practices should be followed when demolition occurs. This is important as unsafe practices increase exposure risks to children and communities. The Baltimore City Housing Department is addressing lead-safe work practices as part of its demolition plan.

DCHD Grant /Loan Program Increased Funding
RECOMMENDATION:

Increase statewide funding to $1 million, and assure future funding of State's abatement commitment in Baltimore City. DCHD has an allocation of $642,000 in FY 2001 for lead hazard reduction in various parts of the State. With the increased attention on lead poisoning and the new HUD requirements, which will require all federally funded rehabilitation to address lead hazards, it is prudent for the State to increase the Statewide pool of lead hazard reduction funds. The Commission recommends that funding Statewide be increased to one million dollars and that future years of funding be assured. The Commission would like to ensure that the State live up to its commitment to Baltimore City regarding lead hazard reduction funding while also continuing to make these resources available Statewide. The State's current commitment to Baltimore City's $10.5 million over a three-year. The initial funding of $3.5 million has been approved for FY 2001.

Healthy Homes Campaign
RECOMMENDATION:

Pursue Federal funds for Healthy Homes projects. HUD has a major campaign and funding available for the Healthy Homes initiative. The State should aggressively pursue funding under this program. DHMH and MDE should be designated as the lead agency to apply for funding.

Private Housing Rehabilitation
RECOMMENDATION:

Support DHCD's private housing rehabilitation programs. DHCD has numerous programs, which support the rehabilitation of privately owned homes. It is an important component of the State's revitalization strategy. DHCD also works closely with a variety of nonprofit partners across the State to carry out affordable housing programs including rehabilitation. The Commission supports those programs and encourages foundations to get involved as well.

HEPA-Vacuums
RECOMMENDATION:

Obtain funding for HEPA-vacuums for loan by local health or housing statewide. The Commission recommends HEPA vacuums be easily available through local agencies or non-profits for tenants or owners to borrow. Since lead poisoning can affect any child from any socioeconomic background, local Health Departments should have HEPA vacuums available to all members of their communities. Housing programs and nonprofit agencies throughout the State should also be encouraged by DHCD to participate in loaning out the equipment and providing practical information to residents in their community on how to address lead hazards. This could be a component of a Healthy Homes Initiative in the State, or funded through targeted community lead outreach funds currently provided to local health departments by MDE under Lead Rental Registry registration and renewal fees.

Windows of Opportunity --- Outreach and Education

Expand Outreach and Support for Risk Reduction Treatment under Environmental Article 68
RECOMMENDATION:

Provide compliance-assistance training. The Commission recommends that outreach to rental property owners and tenants be expanded as a means of increasing both compliance and market demand for safer housing. The Commission supports the State's Interdepartmental Strategic Plan compiled by MDE, DHMH, and DHCD to integrate lead awareness and information about the Maryland lead laws into routine interactions with their respective target populations. The Commission also recommends developing compliance assistance programs or workshops, which could be held at local community colleges throughout the State, to help property owners understand the rules and process of compliance. The Commission notes that MDE and DHMH have agreed to focus outreach efforts on property-owner associations throughout the State.

Expand Outreach and Education regarding other Sources of Lead
RECOMMENDATION:

Include information about other lead exposure sources in outreach. Children may be exposed and poisoned by lead from sources other than house dust and paint. Primary prevention should, therefore, include other sources of potential lead exposure. Mini-blinds, old painted toys, imported cans, pottery, and recalls from the Consumer Product Safety Commission are examples of non-traditional sources of lead. It is also recommended that the Commission support outreach efforts to organizations that work with clients from multi-cultural backgrounds. Individuals who are Hispanic, Vietnamese, Indian, and Migratory workers should receive information on lead poisoning and prevention. Collaboration with organizations including the Hispanic Apostilate, the American Indian Cultural Center, and the Vietnamese Center should be considered.

Development of a Lead Programs Service Directory for Professionals
RECOMMENDATION:

Develop and distribute a lead services directory. The Commission supports the development of a Lead Programs Service Directory, which will include local, State, and nonprofit programs that provide services related to Lead Poisoning and Prevention. This is an important tool to keep professional parties abreast of services throughout the State. The Commission is aware that MDE has begun this process and supports coordination with MDE to complete and update the project. It is possible that this directory could be made available through the Internet.

Windows of Opportunity -- Enforcement, Baltimore City Health and Housing Department Phase I Plan
RECOMMENDATION:

Assure continued funding for newly expanded enforcement efforts. Propose legislation to revise land installment contracts. The Commission supports Baltimore City's proposal to increase interagency coordination. The Commission also supports the State's Intergovernmental Strategic Plan, which outlines suggestions regarding collaboration. The Commission supports

Baltimore City's proposal to increase enforcement efforts. The Commission understands that this process has already begun in Baltimore City and supports its continuation. The State must ensure that the additional funding promised to the City for years 2 and 3 of the effort is included in FY2002 and FY2003 budgets.

The Commission defers to the City regarding changes to the City law regarding enforcement and lead poisoning prevention. The Commission recommends that the State take aggressive action in getting information to property owners as well as tenants about the new state requirement (2000 HB 1062) that a copy of the inspection certificate be provided at time of new rental. The Commission also recommends that legislation to revise land installment contracts be considered in FY2001.

Windows of Opportunity --- Relocation and Housing Assistance
RECOMMENDATION:

Expand support to relocation programs. The Commission recommends that DHCD expand its work with non-profits regarding the development of housing relocation resources. DHCD has programs such as the Group Home Financing Program or the Transitional Housing Grant Program that can be used by non-profits to acquire and renovate homes that can be used for transitional housing. DHCD is also working closely with Baltimore City to develop a Relocation Plan for the City's lead Initiative. Lessons learned form the City's experience will be important information for DHCD to share with the other jurisdictions throughout the State.

The Commission also recommends the review of programs like the Kennedy Krieger Institute's Community Lead Poisoning Prevention Program, a capitated model that existed between 1994 and 1997. This program provided medical, environmental, and case management services to families of children with lead poisoning. The program included a flexible spending component which allowed families funding assistance for items like security deposits, application fees, moving expenses, and utilities, since these are often obstacles preventing a family from moving to a lead-safe home.

Explore the effectiveness of the current lead poisoning treatment levels.

The Commission determined that the key issue to be addressed is whether the interventions for children at each category of blood lead level are working to reduce the blood lead level and to prevent the blood lead level from rising. The underlying issue is the ability of the current health care and case management systems to meet the needs of each family (i.e., are these systems producing reduction of blood lead levels and lead exposure for both individual children and the child population as a whole).

To address the effectiveness of current blood lead intervention/action levels, the Commission reviewed current blood lead levels and corresponding interventions/actions (See Attachment 3). At each level, specific interventions are required. The interventions are performed by the designated responsible agency. Two particular areas are of concern to the

Commission: 1) children with blood lead levels between 10 and 14 µg/dL and 2) children with blood lead levels above 45 µg/dL.

The CDC "level of concern" is designated as a blood lead level of 10 µg/dL. It is important to note that no blood lead level can be considered acceptable. At a blood lead level of 10 µg/dL, the need for follow-up testing, education, and awareness of exposure is established. No specific system intervention is performed. Generally, the Commission is concerned that (1) for a child above the age of six years, there is no mechanism in place for case management, and (2) the system currently in place may not be effective for children with blood lead levels between 10 and 14 µg/dL.

For children who must undergo chelation therapy for blood lead levels above 45 µg/dL, there are specific concerns relating to the over all benefit of therapy in the absence of coordinated activities related to housing and case management. As per CDC guidelines, chelation therapy is indicated when a child has a blood lead level of 45 mg/dL or higher. Administering the treatment must occur in a systematic and accurate way, and is not always easy to administer. Specifically, assumptions are made that treatment, because it is oral, can be given to a child on an outpatient basis. This can be a false and potentially dangerous assumption. Children who are chelated in an environment that is not lead safe may suffer an adverse effect from the medication. The blood lead level may become elevated if the child is exposed to lead hazards while on the medication. It is also known that the medicine is difficult to give due to the odor, the properties of the drug, and the timing within which it needs to be administered. For these reasons, hospitalization is generally recommended for children undergoing chelation.

The Commission determined that in order to measure the effectiveness of interventions based on these action levels, measurable outcome indicators must be identified. The Maryland Department of the Environment currently maintains certain information that could potentially allow one to examine progress of individual families during long-term case management (e.g., number of children/families lost to follow-up, number of cases closed administratively, the incidence of increased blood lead levels during case management). To determine the level of success of current intervention strategies, agencies will need to look at the current data sets/sources in new ways and develop a new set of markers to measure success.

The Commission selected the following as important outcome measures of effectiveness of lead interventions:

- The number of cases referred and/or received for case management per year.
- The percentage of these cases where appropriate source control (including removal of child from lead environment, risk reduction, and abatement) is achieved.
- The percentage of identified cases with a documented reduction in blood lead level.
- The percentage of children with levels 10-14 µg/dL whose levels rise.
- Number of children who have levels that remain ≥20µg/dL and that decrease from ≥20µg/dL to 15-19 µg/dL, 10-14 µg/dL, and ≤9 µg/dL.
- The number of children who are lost to follow-up/administratively closed.
- The number of children (cases) with home remediations.

- Number of children levels ≥10 µg/dL who remain in a home without remediation.
- The number of children who are lead exposed in owner occupied vs. rental property.
- The length of time between obtaining the blood lead result and;
- Confirmation of the blood lead level.
- The first nursing home visit.
- The inspection and environmental testing.
- Relocation.
- Property treatment for children with blood lead levels >15 µg/dL and for blood lead levels between 10-14 µg/dL.
- The length of time a child's blood lead remains elevated.

Analysis of the information on the length of time between different elements of the intervention process and the length of time a child's blood lead level remains elevated is an issue related to the efficiency of the system. Currently there are requirements on minimum time frames for performing each step of the intervention. These time frames have been set according to CDC recommendations. Thorough analysis of the data on the above indicators will allow us to determine if these minimum timeframes are adhered to. In addition, it will allow us to evaluate if the time frames are effective in meeting program expectations for improvement in lead levels for individual children. This will provide information that can aid in determining if interventions should be performed at lower levels. If blood lead levels remain elevated for long periods of time, interventions should clearly be performed earlier (e.g., at lower blood lead levels) and in a more timely manner. It is important to note that the currently available data on these indicators does not account for children who have undergone chelation. Of note is that it is difficult to determine the effectiveness of chelation since the results, as determined by the blood lead levels, are highly dependent upon whether there is ongoing exposure during the therapy.

Using the statewide childhood lead registry database, it would be illuminating to address the above selected indicators a statewide basis in order to evaluate Maryland's progress in preventing childhood lead exposure and reducing blood levels in already exposed children. Unfortunately, the Commission was unable to examine above indicators because of limitations with the current database and data collection systems. First, the 1998 and pre-1998 data in the Maryland Department of the Environment's and Baltimore City's Stellar databases are unable to be compared because the processes for data entry were not the same thus rendering comparisons in appropriate. Secondly, the Maryland Department of the Environment and Baltimore City Health Department began entering case management data for children with blood lead levels below 20 µg/dL during 1998, making comparison between 1998 and earlier years inappropriate. The Maryland Department of the Environment suggested that the 1999 data be utilized as a baseline for comparison with data collected in future years. Finally, due to the limitations in the current data system, the ability to track these indicators for individual cases over time is limited.

The ability to assess effectiveness of current lead poisoning treatment levels is not only impacted by the data capabilities of the Childhood Lead Registry (CLR) database maintained by the Maryland Department of the Environment, but also limited by the quality and completeness of the data the database. Currently, all blood lead levels for children from birth to age 18 are maintained in the childhood lead registry at the Maryland Department of the Environment

(MDE). Blood lead testing results are obtained through mandatory laboratory reporting to MDE. Laboratories report high lead levels (children at 20 µg/dL and above) to MDE on a daily basis. Laboratories report all other child blood lead levels on at least a monthly basis. The data are received by e-mail, modem, diskette, hard copy, and by fax. Approximately eighty-five thousand records are received per calendar year. The laboratory report is to contain, at a minimum, the specimen date, child's name, date of birth, specimen result, specimen type (capillary or venous), child's address, and provider's name and address. This information enhances the State's ability to track children with elevated blood leads.

Unfortunately, more than 30% of the reports submitted by private laboratories contain incomplete demographic information, which hinders our ability to adequately conduct surveillance and reduce efficiency of the case management process. The state laboratory has an excellent history of providing timely and thorough information to MDE but handles and reports only approximately 7% of the testing. The importance of obtaining complete information on children with elevated blood lead levels cannot be overstated. Without this information, we will not be able to evaluate the State's effort in reducing childhood lead exposure. In addition, at this time, there are no data to indicate whether the primary care provider (PCP) interventions for children with levels 10-14 µg/dl are having an effect in lowering blood lead levels or preventing a further increase in blood lead levels. It is also unknown what education strategies and materials families are actually receiving from their PCPs regarding blood lead levels, especially for those children with blood lead levels between 10-14 µg/dl.

A related issue is whether information on housing can be utilized to prevent increases in blood lead levels for those children with blood lead levels between 10-14 µg/dL. Data on property registration and certification and 1990 census data for pre-1950 and pre-1978 houses are currently available. However, specific housing information (age, registration status) for children with a blood lead level of 10-15 µg/dL is not currently reviewed at the state level. Access to this type of information by Local Health Departments will provide useful information to home visitors, outreach staff, and case managers. This information can be used to determine the specific case management interventions aimed at preventing a rising level. This information would also be useful in determining interventions for children residing in owner-occupied homes, as well as rental property. Finally, review of housing information can aid in relocation efforts, family education, and promotion of obtaining lead-safer housing when moving.

RECOMMENDATIONS:

Conduct a review: The Commission recommends that the Maryland Department of the Environment and the Department of Health and Mental Hygiene conduct a review of the action/intervention levels from other states and their available data on the indicators above to determine if in states with different action levels if these indicators suggest greater success.

Develop or enhance materials: If insufficient materials are available, the Commission recommends that the Maryland Department of the Environment and the Department of Health

and Mental Hygiene develop and enhance materials for primary care providers to effectively treat children with blood lead levels 10-14 µg/dL.

Provide interventions for children with blood lead levels between 10-14 µg/dL: The Commission recommends that the Maryland Department of the Environment and the Department of Health and Mental Hygiene evaluate the feasibility of providing a more intense intervention for children with levels 10-14 µg/dL. This will ensure that families and providers have enough information to prevent levels from rising. For example, local health departments could provide educational materials to families when they are informed that a child has a blood lead level ≥ 10 µg/dl. This essentially results in more intense intervention at lower levels with the intent to prevent levels from rising.

Increase enforcement of the laboratory reporting requirements: The Commission recommends the following actions to enforce complete, uniform laboratory reporting:

- Continue efforts to amend MDE regulations to require a uniform process for submitting lab specimens (including complete demographic information). Specifically, submit the results to MDE electronically in a manner compatible with the childhood lead registry database.
- Enforce requirement to provide minimum required information on all blood lead tests.
- Institute penalties for private laboratories that do not meet the reporting requirements of MDE. Such penalties could include fines or loss of certification for blood lead testing.
- If the above enforcement/penalty actions are not effective, require all lead testing be performed by the State laboratory.

Improve Childhood Lead Registry Database: A relational database for the Childhood Lead Registry Database must be developed so that the State will be able to track all individual children over time, and follow blood lead levels (e.g., to ensure that blood lead levels are decreasing). Also, data must be collected and analyzed to assess whether primary care provider interventions are actually being performed for children with blood lead levels between 10-14 µg/dL. In addition, this data will allow improved population level data that can be used for surveillance. The Commission recommends that MDE and the Baltimore City Health Department Lead Program work to improve data collection for the indicators listed above.

Chelation Therapy: The Commission strongly recommends that it be required that during chelation therapy, the child undergoing treatment remains in a lead safe environment, which usually necessitates hospitalization. In addition, the protocol for prevention, intervention, and case management should be changed to recommend a consultation by a lead specialist as the standard of care for children with blood lead levels above 9 µg/dL.

Enhance the Housing Database: There needs to be an improvement in the link between housing data and the Childhood Lead Registry data at the local level. Second, the lead safe housing registry must be expanded. Third, the State should develop a registry of units that meet risk reduction standards. Fourth, the State should promote the use of housing information in locating new homes for families relocating.

Explore the mechanisms for enhancing blood lead testing and treatment for high-risk populations.

In addressing the above issues related to health and welfare, the Commission determined that to effectively address the issue of lead poisoning in children, the percentage of children who are tested for blood lead levels needs to increase. For example, in 1998, only 13.9% of children ages 0 to 6 were blood lead tested in 1998 (MDE 1998 Annual Report, Childhood Blood Lead Surveillance in Maryland). Clearly, there are many children in Maryland at significant risk for lead poisoning who are not being tested. While this issue is not part of the original charge to the Commission, given the critical importance of blood lead testing as a means to protect the health of children, the Commission chose to explore the following issues related to blood lead testing.

The Commission explored strategies for enhancing blood lead testing and treatment for at-risk populations. For the purpose of these recommendations, at-risk populations are considered to be any area of the state that is designated as "at-risk" under the Department of Health and Mental Hygiene targeting plan. These areas are targeted for mandated blood lead testing of all children at 12 and 24 months under HB 1221 of the 2000 legislative session. Specifically, this includes all locations areas called "high," "moderate," and "low" risk. The following strategies were discussed and are recommended.

RECOMMENDATIONS:

Provide Education, Outreach, and Training: The Commission recommends that the Departments of Health and Mental Hygiene, Environment and Housing and Community Development collaborate to provide State, local, and community coordination for education, awareness, outreach, and training. Efforts should be directed toward communities, such as tenants, property owners, realtors, childcare providers and families. One goal is to mobilize local community groups to promote testing their communities.

Special outreach, education, and training efforts should be made toward all health care providers, particularly those serving families in areas designated as "at-risk." Collaboration with the American Academy of Pediatrics, The Coalition to End Childhood Lead Poisoning, medical staff offices of local hospitals, local medical societies, and the Board of Physician Quality Assurance is strongly recommended. Some of these collaborations currently exist, and it is the judgement of the Commission that these efforts should be augmented. Healthcare providers must understand the importance of risk assessment as well as the testing requirements. It is critical that the message of "when in doubt, test" is spread through the healthcare provider community. It is also important that providers understand the scientific/epidemiological evidence that supports the testing and risk assessment requirements. Testing should also be supported through training of provider office staff on proper blood collection techniques. Finally, data on blood lead levels need to be shared with health care providers statewide in order to demonstrate that high blood lead levels exist in children residing outside the Baltimore City.

Reduce Barriers to Blood Lead Testing: The State should facilitate the process for obtaining blood lead tests for children by (i) exploring the efficacy, capital costs, reimbursement strategies, and reporting procedures for use of mobile phlebotomy services/blood collection services in "at-

risk" neighborhoods and medical offices; (ii) supporting state agencies to provide free blood lead testing at the local health departments (LHD) in "at-risk" areas; (iii) offering support for jurisdictions to provide testing to families who have no insurance coverage for lead testing; and (iv) exploring the possibility of providing jurisdictions funding to address the issue of transportation to phlebotomy sites. The State Laboratory will be receiving $300,000 under the Governor's Initiative to support processing of blood samples and to provide training to LHD staff and community providers on proper specimen collection techniques. The Commission recommends that the State explore mechanisms to efficiently utilize these services.

Provide Incentives: A program of incentives should be established, such as special reimbursement for healthcare providers who perform blood lead tests for their patients.

Enforce Testing Requirements: There should be stricter enforcement of the Early and Periodic Screening, Diagnosis, Treatment (EPSDT) program screening requirements and the new testing requirements under HB 1221.

Modify the Health Form: The Commission recommends that the Health Inventory Form be modified to include questions regarding the use to folk remedies, some of which contain high level of lead, in order to identify specific ethnic groups which may be at high risk of elevated blood lead levels.

Review the Availability of Insurance.

There are, in general, three types of coverage associated with lead contamination that impact the availability of insurance:

- Coverage for Hazards, which are mandated by Environment Article, Title 6 for Qualified Offers. This includes medical expenses and additional living expenses for children, ages of six and under, and pregnant women.
- Traditional Liability Coverage – this is a special program for lead exposures and available only in the surplus line's market, covers injuries caused by lead. The injured party must prove that the injury occurred at the insured's location and that the insured knew that it existed and failed to take adequate steps to eliminate the exposure. The typical limit is $1,000,000. Coverage is difficult to obtain. Neither the insured nor the claimant can request assistance or protection from Maryland Insurance laws.
- Professional Liability and Worker's Compensation Coverages for contractors who perform lead reduction work and inspectors.

Lead Coverage Mandated by Environment Article, Title 6, Subtitle 8:
Those insurers who issue policies in Maryland that contain an exclusion for lead are required to offer limited coverage for lead if the insured complies with a lead dust test or performs lead reduction work as required by statute, Environment Article, Title 6, Subtitle 8. When the law went into effect in 1996, approximately 80 insurance companies filed to provide this limited coverage. The cost of this coverage averages $25.00 per unit.

Liability Coverage for Lead Exposures:
A typical general liability policy excludes coverage for lead. Some insurers, outside of the standard market, have opted to provide special programs that provide liability coverage for lead. These companies are part of the "surplus lines" market. The companies provide coverages for those types of risks that cannot find coverage in the standard market. The standard market is made up of those insurance companies licensed and regulated by the state of Maryland.

Professional Liability and Worker's Compensation Coverages:
It is currently difficult to obtain professional liability coverage for either lead inspectors or contractors in the standard insurance market. This coverage is available in the surplus lines market; however, the cost of the coverage is prohibitive. It is also difficult to obtain worker's compensation coverage.

General View of Lead by the Insurance Industry:
In attempting to attain a level of understanding of the insurance industry on issues surrounding lead poisoning we must deal with some general misconceptions. Most underwriters, both domestic and foreign, liken hazards from lead with asbestos. Because both are environmental in nature the insurance community today is inclined to avoid providing coverage for property owners, on any level, for claims involving lead or lead-based paint. Two primary issues arose in conversations with underwriters, latent exposure and adverse selection.

Latent exposure is a term used to define the length of time between exposure to hazard and manifestation of injury. Without exception, underwriters contacted by the Commission, believe that lead is a latent exposure hazard, as is asbestos. The crisis in the foreign reinsurance market brought on by payment of asbestos claims is not generally understood. The issue of how much was paid was not the root of the crisis. The root cause pertained to the necessity of paying those claims from premiums that were generated as much as thirty years earlier. The difference cannot come from current premiums. The sums necessarily had to come from the profits of the members who participated in the market when the policies covering the claims were written. In many instances personal funds were called into play. Underwriters believe that any premium they charge today for lead coverage will not be sufficient to pay those claims they believe they will be faced with thirty years from now.

Adverse selection pertains to the quality of a potential risk from an underwriting point of view. Underwriters are aware of the level of litigation and the amount of awards given in lead cases. If underwriters are inclined to offer coverage it will only be on a risk-sharing basis, not risk transfer. Owners of low income housing who are not willing to comply with local and federal laws are certainly not likely to be willing to share in any potential claim payment. Instead of rating a potential risk against the best possible risk (compliant, concerned, proactive) coverage for lead is viewed as being rated against the worst possible risk (non-compliant, etc.)

The Commission has conducted insurance market surveys to determine the availability of liability insurance for the rental housing industry that covers the perils associated with lead. Coverage for qualified offers made under Environment Article, Title 6 is available. Additional premium is charged to owners of older, scattered single site housing. The commercial market generally does not charge additional premium for the multi-family industry, but does exclude

coverage for all claims caused by lead over the amount of the qualified offer. Coverage for claims arising out of the lead hazard can be obtained once the prospective insured can demonstrate evidence of total abatement. These policies are generally purchased by property owners fearing defending a claim arising out of an exposure to lead at a location other than the dwelling unit.

Insurance coverage for contractors engaged in lead hazard reduction activity as well as home repair / improvement is another area examined by the Commission. With the enactment of Federal regulations many contractors who did not carry Pollution Liability coverage are now facing exposure to claim generated by the intended increase in public awareness if the issue. Additionally, high premiums for this coverage for those contractors that do carry the insurance affect the effectiveness of programs to clean or reduce lead hazards. Contractors will pass that portion of their overhead costs on to their customers or programs that are subsidizing the renovations. By eliminating that overhead cost, more hazard reduction program funds will be available for hazard reduction activity at more locations. Insurance coverage that covers inspectors and contractors is available and can be purchased with grant funds.

RECOMMENDATION:

Expand education efforts to increase knowledge within the insurance community, Environment Article, Title 6 and the applicable Maryland insurance laws. Such efforts should include coordination with the Maryland Insurance Administration and MDE by providing seminars in conjunction with required continuing education for insurance agents and brokers.

All Federal, State and local grant and loan programs should determine the level of cost overhead charged by approved contractors for insurance to determine if appropriate, (less than 1.5% of value of job), and explore alternatives if warranted.

Explore Sources of Funding for Risk Reduction Work and other Abatement Work.

The Commission has reviewed the Interdepartmental Strategic Plan for current sources of funding lead hazard reduction activity. We find the efforts of MDHCD commendable. It appears to the Commission that the largest obstacle facing their continued success is public awareness of the availability of the funds. HUD grants funds are available through Title X, CDBG, HOPE, etc. The obvious goal of the Governor's Initiative is to prevent childhood lead poisoning. All available funds should be directed to achieving that goal. The Commission finds a dichotomy in requiring private lender eligibility requirements from owners of the most dangerous residences. Many homes in the DHMH target areas of the state have low market value and may actually be worth less than the cost to repair and make lead-safe. The Commission believes that majority of grant funds should be directed at these properties to demolish and rebuild while reserving loan funds for housing stock that has not yet reached a level of disrepair as to make a loan impossible to secure by property value. By shifting the emphasis to 1950-1979 housing stock the loan program can assist in removing the possibility of the issue of lead poisoning persisting well into the future. As this group of housing stock is typically renovated on a fifteen to twenty year basis the likelihood of securing joint programs with private lenders is increased.

RECOMMENDATION:

Aggressively pursue Federal Funding for Lead Hazard Reduction. The Commission recommends all efforts to secure Federal funds through all HUD sources are pursued immediately. The Commission also strongly recommends that efforts be directed to owners of 1950-1979 housing stock to encourage hazard reduction activity in conjunction with home repair and improvement activity.

CONCLUSION

In response to specific inquiries from Governor Glendening, the Lead Poisoning Prevention Commission has reviewed several aspects of Maryland's lead poisoning prevention efforts. The Commission finds that a broad, diverse infrastructure for prevention, early intervention, and enforcement is in place. However, implementation and effectiveness of the programs vary widely.

Awareness, coordination, and resource availability are significant variables for the improved success and evaluation of these programs. To improve lead poisoning prevention in Maryland, the Commission recommends several improvements to build on existing efforts and develop new programs. The recommendations range from policy and statutory changes to expanded outreach and services coordination. The Commission will continue to track these issues over the next year and requests that the MDE, DHMH, and DHCD provide an interagency response on their initial review of this report in three months.

The Commission recognizes that the recommendations in this report may require increased resources, both staff and funds. However, the Commission does not have the information to quantify the increases. It suggests that the three state agencies provide estimates of increased resources and make those estimates a part of the response to the Commission.