

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH



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EHS Circular Letter # 2013-27

DATE: April 19, 2013

TO: Directors of Health and Chief Sanitarians

FROM: Francesca Provenzano, MPH, CHES, RS
Health Program Supervisor

RE: Local Health Department Responsibilities as a result of the Updated Childhood Lead Screening Requirements

In July 2012, the Department of Public Health's (DPH) Lead and Healthy Homes Program reconvened the Childhood Lead Poisoning Advisory Committee to review and amend state guidelines for childhood lead screening. The CT committee was reconvened after the Centers for Disease Control and Prevention (CDC) supported the recommendations of the national Advisory Committee for Childhood Lead Poisoning (ACCLPP). The national guidelines included several recommendations that relate to lower blood lead values and actions by public health practitioners such as the following:

- (1) Eliminating the term "blood lead level of concern," which was 10 micrograms per deciliter ($\mu\text{g}/\text{dL}$),
- (2) Establishing the new "Reference Value" of 5 $\mu\text{g}/\text{dL}$ and;
- (3) Encouraging clinicians to identify and educate families about lead poisoning prevention during office visits.

The ACCLPP based the 5 $\mu\text{g}/\text{dL}$ reference value on data from the National Center for Environmental Health, National Exposure Report (i.e., NHANES survey report). The 5 $\mu\text{g}/\text{dL}$ limit represents the population of children aged 1-5 years whose blood lead levels (BLLs) are in the highest 2.5% of children tested. CDC will update the reference value every four years using the two most recent NHANES surveys.

A complete copy of the ACCLPP report and the CDC's subsequent adoption of those recommendations can be found at the following website (bottom of page):

http://www.cdc.gov/nceh/lead/ACCLPP/blood_lead_levels.htm



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Subsequent to these federal actions, the CT Childhood Lead Poisoning Advisory Committee convened and updated *the Requirements and Guidance for Childhood Lead Screening by Health Care Professionals in Connecticut* (see attachment). Revisions to the guidance documents call for action on the part of medical providers to:

- Confirm capillary results for BLLs in the range of **5µg/dL** - 19µg/dL
- Conduct venous testing for BLLs in the range of **5µg/dL** - 14µg/dL
- Provide educational information about lead poisoning prevention during routine office visits
- Simplify the questions when screening children for lead exposure risk (reduced from eight questions to four)

The revised guidance and supporting educational materials were electronically conveyed by the CT DPH to licensed pediatric medical providers on April 16, 2013. Additionally, the CT Chapter of the American Academy of Pediatrics has agreed to disseminate the information to their membership in their E-newsletter. A copy of the letter is posted on the program website at: www.ct.gov/dph/lib/dph/environmental_health/lead/pdf/provider_letter-3-2-13_commissioner_signature.pdf.

There are also implications for local health department childhood lead poisoning prevention activities as a result of these newly adopted policies. Currently, local health departments generate re-test reminder letters in the lead surveillance system, and provide the standardized educational packet to families of children with BLLs at or above 10µg/dL. The success of universal screening, combined with early diagnosis and intervention on the part of local health effectively reduced the rate of childhood lead poisoning in CT to a historic low of 0.8% by 2011. This primary and secondary prevention approach has reduced both the rate and severity of childhood lead poisoning cases. We must continue this work to eliminate a preventable environmental health disease burdening our most vulnerable populations.

Under the new guidelines, local health departments will carry out the following amended responsibilities:

- (1) Generate re-test reminder letters in the surveillance system for blood lead levels (BLL) of 5µg/dL or more;
- (2) Send families the standardized educational packets for **venous** BLLs of 5µg/dL or more; and
- (3) Send families the standardized educational packets for initial blood lead screening (capillary) test results of 10µg/dL or more.

Lead inspection triggers, and epidemiological investigation triggers will remain unchanged.

The Lead and Healthy Homes Program will be taking several actions to support your efforts. We will submit two legislative proposals at the end of this fiscal year for consideration during the next session of the CT General Assembly. To ensure timely reporting of actionable blood lead levels for children, CT General Statute (CGS) section 19a-110(a) will be revised to require laboratory reporting to both the DPH and local directors of health within 48-hours for blood lead results that are at or above 5µg/dL. Currently, results of 5µg/dL or more are reported monthly. Similarly, we will submit a legislative proposal to revise CGS 19a-110(d) to reflect the

requirement that local health departments provide educational information for venous BLLs of 5µg/dL or more, in addition to the existing requirement for BLLs of 10µg/dL or more (capillary).

We will modify the web-based lead surveillance system so the automated reminder letters can be generated with ease. All local health departments have been trained on the use of this lead surveillance system. If you or your staff need additional instruction or a quick reminder on how to use the system to generate letters or reports, we will assist you.

We will recalculate the allocation formula for the lead prevention funding to account for these changes in practice, so that health departments and districts will receive equitable funding amounts. Attached you will find maps that outline the number of children with first time venous BLLs between 5µg/dL - 9µg/dL (using 2011 data). You will also find a map that projects the number of children with BLLs of 5µg/dL - 9µg/dL for year two. The maps provide an estimate for the increased amount childhood lead poisoning prevention work that is anticipated in your health department or district.

Several health departments in CT have already begun responding to childhood BLL cases of 5µg/dL or more. We anticipate that these changes will assist the early adopters, and that all health departments will implement these new responsibilities as soon as possible, but not later than July 1, 2013.

If you have any questions regarding the updated guidelines, their implications, or your essential role in reducing childhood lead poisoning, please contact me at 860-509-7390.

cc: Suzanne Blancaflor, M.S., M.P.H., Chief, Environmental Health Section
Ellen Blaschinski, R.S., M.B.A., Chief, Regulatory Services Branch



**Requirements and Guidance for Childhood Lead Screening
by Health Care Professionals in Connecticut
Lead Poisoning Prevention and Control Program**

Revised April 2013

www.ct.gov/dph

A. Universal Blood Lead Testing is Mandated

Test children:

- Between 9 months and 36 months of age, each year for elevated blood lead levels
 - Most providers test at 12 months and 24 months of age
- Between 25-72 months of age, if not previously been tested, regardless of risk
- < 72 months of age, with developmental delays (especially if associated with pica)

B. Diagnostic Testing and Follow-up

Timetable for Confirming Capillary (Screening) Blood Lead Results with a Venous Blood Lead Test*

If result of screening test (µg/dl) is	Perform Venous Blood test within:
5-19	3 months
20-44	1 month-1 week*
45-59	48 hours
60-69	24 hours
≥ 70	Immediately

*The higher the result on the capillary test, the more urgent the need for venous testing.

Schedule for Follow-up Venous Blood Lead Testing for Children with an Elevated Blood Lead Level^a

Blood Lead Level (µg/dl)	Early follow-up (1 st 2-4 tests after identification) test within:	Late follow-up (after BLL begins to decline) test within:
5-14	3 months ^b	6 - 9 months
15-19	1 - 3 months ^b	3 - 6 months
20-24	1 - 3 months ^b	1 - 3 months
25-44	2 weeks - 1 month	1 month
> 45	As soon as possible	Chelation and follow-up

^a Seasonal variations of BLLs exists and may be more apparent in colder climates. Greater exposure in the summer months may necessitate more frequent follow ups.

^b Some case managers or PCPs may choose to repeat blood lead tests on all new patients within a month to ensure that their BLL is not rising more quickly than anticipated.

- If a capillary blood test is elevated (equal to or greater than 5µg/dL), confirm with a diagnostic (venous) blood lead test.
- Children with an elevated diagnostic blood lead test require additional follow-up blood testing at appropriate intervals.
- Children should be tested according to schedule above until BLL is below the reference value of <5µg/dl.
- Providers can contact one of Connecticut’s Regional Lead Treatment Centers for guidance and assistance with clinical management of a lead poisoned child (see below).

Consultation and supportive services are available by contacting:
Hartford Regional Lead Treatment Center, (860-714-5184)
Yale-New Haven Regional Lead Treatment Center, (203-764-9106)

For more information contact:
State of CT Department of Public Health Lead Poisoning Prevention and Control Program
(860-509-7299)

C. Provide Anticipatory Guidance to Families

- Provide educational information about lead poisoning
- Written materials, along with verbal education, should be provided in the family's primary language (at an appropriate reading level)
- Resources available at www.ct.gov/dph/lead

D. Risk Assessment

- In addition to testing children at the recommended time intervals, at each well-child visit, health care providers shall evaluate children 6 months to 72 months of age for risk of lead exposure using the following risk assessment questions.

Risk Assessment Questions

1. Does your child live in or regularly visit a house built before 1978?
2. Does your child have a brother or sister, housemate, or playmate being followed or treated for lead poisoning?
3. Does your child frequently come in contact with an adult whose job or hobby involves exposure to lead (e.g., construction, welding, automotive repair shop, other trades, stained glass making; using lead solder, artist paints or ceramic glazes; etc.)?
4. Has your child been exposed to any imported products (spices, foods/vitamins, ethnic home remedies, or ethnic cosmetics)?
 - Some examples include: azarcon (also known as rueda, Maria Luisa, alarcon, liga); albayalde; greta; pay-loo-ah; ghasard; bala goli; kandu; kohl; litargirio; bebetina; chyawan prash.

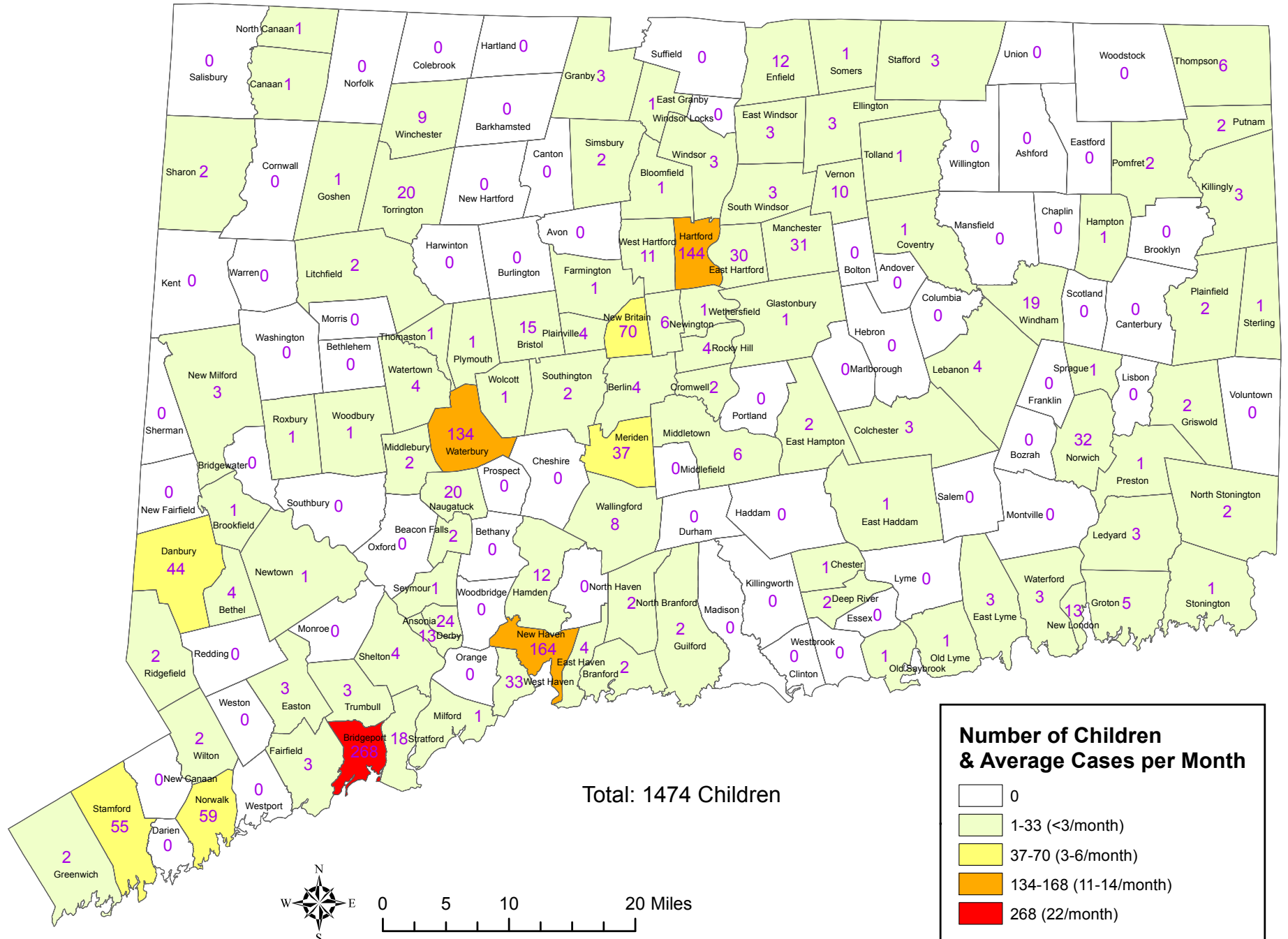
Ask any additional questions that may be specific to situations that exist in a particular community (e.g. operating or abandoned industrial sources; waste disposal sites; drinking water; has your child ever lived outside the U.S.; does your family use pottery for cooking, eating or drinking; etc.).

If the answer to any of the above questions is YES or UNKNOWN, then the child is considered to be at risk and should be tested.

NOTE: Blood lead testing shall also be considered for any child regardless of age, with:

- Unexplained seizures, neurologic symptoms, hyperactivity, behavior disorders, growth failure, abdominal pain, or other symptoms consistent with lead poisoning or associated with lead exposure;
- Recent history of ingesting, or an atypical behavior pattern of inserting, any foreign object (even if the foreign object is unleaded) into a body orifice.

Connecticut Children Tested with an Initial Venous Test 5-9 $\mu\text{g}/\text{dL}$ in 2011 (Projection for the Second Year excluding children with previous 5-9 $\mu\text{g}/\text{dL}$)



Connecticut Children Tested with a Venous Test 5-9 $\mu\text{g}/\text{dL}$ in 2011 (Test in 2011 is not a Decline from Previous 10 $\mu\text{g}/\text{dL}$ and above)

