



REPLY TO
ATTENTION OF

SGPS-PSP (40-5)

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3250



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MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Childhood Lead Poisoning Prevention

1. PURPOSE. To establish policy for the Army Medical Department Childhood Lead Poisoning Prevention (CLPP) Program.

2. REFERENCES:

a. House Report 102-95 for the Defense Appropriations Act of 1992.

b. Public Law 102-550 - "The Residential Lead-based Paint Hazard Reduction Act of 1992".

c. DoD Memorandum, dated 23 November 1992, subject: Risk Assessment, Associated Health Risk in Children, and Control of Hazards in DoD Housing and Related Structures.

d. Preventing Lead Poisoning In Young Children, Centers for Disease Control, October 1991.

3. BACKGROUND.

a. Reference 2a directed DoD to:

(1) Take a more active role to ensure military dependent children are not affected by lead-based paint (LBP).

(2) Offer screening to all dependent children (six years old or younger) for lead uptake, including payment for screening through CHAMPUS.

b. Reference 2b states that DoD must comply with all Federal, State, interstate, and local requirements for certification, licensing, recordkeeping, including payment of reasonable service charges, with respect to LBP, LBP activities, and LBP hazards.

c. Reference 2c establishes policy for assessment of the health risk from LBP, and control of LBP hazards in DoD housing and related structures (child care

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centers, family child care homes, schools, other facilities frequented by children under six years old and/or younger, and playground equipment). The policy states that the responsibility for addressing lead poisoning on a DoD installation is shared between installation and medical authorities.

d. Centers for Disease Control (CDC) has declared lead poisoning the number one environmental health hazard facing children today. Environmental exposure to even low levels of lead potentially increases a child's risk of developing permanent learning disabilities, reduced concentration and attentiveness, and behavior problems. These problems may persist and adversely affect the child's chances for success in school and life.

e. Children get lead poisoning by ingesting lead. The most significant sources of environmental lead are deteriorating LBP in housing, and house dust and soil contaminated by lead. Other sources of lead, such as lead in consumer products, parental occupations, family hobbies, lead in gasoline, lead in drinking water, and lead in ambient air may significantly contribute to lead poisoning.

f. Lead based paint was universally available and used in the United States until 1978 and has been commonly found in Department of Defense (DoD) housing units. If a child is living in a dwelling with high levels of lead in dust on surfaces, there is a chance that the child may become lead poisoned. There have been children at some Department of Army (DA) Installations who have been found to have elevated blood lead levels.

4. DISCUSSION.

a. Community-level prevention of lead poisoning in children is the goal of the DA CLPP Lead Based Paint Management (LBPM) Program.

b. Initial implementation of the program will be directed towards case management of children who have already been lead exposed. This will involve systematically identifying and remediating environmental sources of lead for these children to include LBP. With time, this program will shift emphasis from case management to case prevention.

c. The shift from case management to community-level prevention will require a fundamental shift in perspective from the individual child to the population of children at risk and to the environment. The purpose of community-level

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Intervention is to identify and respond to sources, not cases, of lead exposure. Community-level intervention must be accomplished in an expeditious, but prudent and affordable manner.

5. AMEDD CLPP PROGRAM INSTALLATION SUPPORT.

a. The medical treatment facility (MTF) commander can expect the AMEDD to be a key component in the command directed installation CLPP/LBPM program. The installation commander will be directed to establish a working group/committee on lead issues (Lead Team), which should be established from an existing installation safety and health committee, chaired by a coordinator (Lead Program Coordinator) who is authorized direct access to the installation commander. The composition of the Lead Team will be DA directed through command channels, as the spectrum of lead hazards cross many traditional organizational boundaries and can only be effectively handled by a coordinated team effort.

b. As part of the installation Lead Team, the AMEDD will participate in defining areas of responsibility within the program, developing a coordinated strategy to implement treatment activities and lead poisoning prevention by identification, exposure reduction, and lead remediation activities, and coordinating installation support for all cases of childhood lead poisoning. The installation team will also be tasked with developing and implementing a comprehensive education program regarding environmental lead exposures and lead poisoning directed at key professional groups, parents, the military community, and other appropriate target groups.

6. MEDICAL RESPONSIBILITIES IN CLPP:

a. Each MTF will need to develop a formalized plan. As lead screening and surveillance requires multidisciplinary participation, a team approach is a prerequisite for program success. Comprise the team, as a minimum, of a preventive medicine/public health physician, pediatrician, obstetrician, family practitioner, industrial hygienist, environmental science officer, laboratory officer, CHAMPUS coordinator, and community health nurse. Include:

(1) Childhood blood lead screening program:

(a) A lead exposure risk questionnaire (Encl 1) is administered at each well child visit beginning at age six months and all preschool examinations. This

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questionnaire may be modified locally as needed to reflect lead risks at the installation. Information about at risk on-post housing may be obtained from the installation, rather than the parents. This questionnaire should also be considered for administration to women as part of antenatal care where lead exposure is a potential risk.

(b) Universal blood lead determination is made as part of the 12-month (or equivalent) well baby exam. Blood lead analysis will be performed by a CDC certified lab by the graphite furnace method (the anion exchange stripping (ASX) or erythrocyte protoporphyrin (EP) methodologies are not acceptable). This may be done in house, in state labs, or at military referral labs as the MTF commander directs. Blood lead levels may also be offered to women during prenatal care. Currently, the only Army CDC certified laboratory is at Eisenhower Army Medical Center; other Army labs may not be used without clearance from the laboratory consultant until they have completed the certification process for the graphite furnace method.

(c) A physician must be designated as the medical point of contact for the clinical portion of the program.

(d) Responsibility for tracking of blood lead samples and results must be formally assigned.

(e) Case management procedures must be established and investigations conducted according to the CDC recommendations. At a minimum, all children with elevated laboratory blood lead levels will receive recommended follow-up, evaluation and treatment as required. Any child requiring chelation therapy will be referred to the supporting MEDCEN or equivalent university level civilian institution which has pediatric intensive care capability.

(f) DoD requires reporting of lead screening by age, blood level and housing location (on or off post). You may use Encl 2 to record and report this information until DoD approves an official form. Please include this information in the monthly Command Health Report when screening programs have been initiated. Additional reporting to CDC or state and local health departments will be done as required,

(g) A case management committee should be convened to address cases when the blood lead level exceeds 15 ug/dL. The committee should include representation from ambulatory care, pediatrics, laboratory, preventive medicine,

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occupational health, quality assurance and risk management.

(2) Clinically indicated screening.

(a) All children who are at high risk of lead exposure, determined by questionnaire or examination, will have a blood lead level performed. All children referred because of presence of lead in their environment (e.g., lead-based paint, water, other) will be screened to determine risk of lead exposure and will have blood lead determinations and examinations as appropriate. Strong consideration should be given to using the venous blood lead test to reduce the chance of contamination during capillary specimen collection for children at known risk.

(b) If elevated blood lead levels are found on capillary blood, confirmatory venous blood specimens should be drawn. The single, all-purpose definition of childhood lead poisoning has been replaced with a multi-tiered approach and case management should be instituted as indicated based on the CDC guidelines.

(c) Families with children determined to have elevated blood lead levels will receive counseling and materials to educate them on the hazards of childhood lead exposure and to advise them of the actions necessary to reduce future lead exposures.

b. Lead hazard abatement support will require that:

(1) The MTF commander or representative must actively participate on the installation lead team to provide medical input to the installation strategy that addresses childhood lead poisoning prevention and lead-based paint management.

(2) Occupational Health and Preventive Medicine support will be provided to the installation. This may include medical surveillance to service members or installation workers, industrial hygiene, and hazardous waste management consultation. Support for environmental case management includes a number of actions in the workup of a child with lead poisoning. Actions include:

(a) Educating parents about the courses, effects, and prevention of lead poisoning.

(b) Investigating the child's home and other likely locations where exposure may have occurred to identify possible sources of lead (both the interior

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and exterior environment with special attention to painted surfaces, dust, soil, hobbies, ceramic ware, toys, and water) and pathways leading to exposure.

(c) Dealing with the emotional aspects of the problem.

(d) Providing recommendations to reduce lead exposure.

c. Outreach and Education:

(1) Information obtained from screening and surveillance efforts must be analyzed and interpreted by the lead team/committee in order to make integrated decisions when cases of elevated blood lead occur or high risk hazard reduction actions must be taken. Guidance for investigating elevated blood level cases is being developed. Enclosure 3 contains a discussion concerning reduction of the risks of exposure to lead hazards.

(2) Informing health care providers, parents, day care center personnel, early childhood educators, housing managers, and facilities engineering/public works personnel about lead poisoning prevention program activities.

(3) The outreach effort is most meaningful when it comes from the installation commander. Outreach and education must take place during every phase of the community activity, beginning before health and environmental screening and ending when risk reduction is complete. Among the most important targets for outreach and educational programs are health care providers, parents, day care providers, and early childhood educators. The outreach programs can be carried out through pamphlets (EPA's pamphlet on lead with toll-free number will be distributed within DoD) and other written materials, local news media, public meetings, and school programs.

(4) Education of the in-house and contractor engineering or facilities engineering/public works work force is an important consideration. If untrained, their maintenance work may increase, not reduce, the hazards associated with LBP.

(5) DoD is working with EPA to develop a supervisor's lead training course for personnel responsible for an installation's CLPP/LBPM Program.

7. Further guidance will be provided as it becomes available in conjunction with the DA Undersecretary for Installations, Logistics and Environment. At the

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present, no new funding is available for this program in FY 93. Unfunded requirements should be identified to your MACOM through command channels. Funding requirements have been submitted in the Army Budget process for FY94 and beyond. In accordance with CDC guidelines, childhood lead screening may be phased in as resources are available. At minimum, screening and testing of high risk children must be instituted this fiscal year. Each MTF will periodically reevaluate records and reports of lead screening and modify their programs to meet the specific needs of their communities.

8. Points of contact: Laboratory, COL Clark Southworth DSN 289-0153, Industrial Hygiene, Andrea Russiello, DSN 584-5482, Occupational Medicine, LTC Holly Doyne DSN 289-0125, Pediatrics, LTC Gerald Poley, DSN 291-1107.

FOR THE SURGEON GENERAL:



THOMAS R. TEMPEL
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ALEXANDRIA, VA 22333-0001

Screening Questionnaire for Childhood Lead Exposure

OVERVIEW

Lead is a common and dangerous environmental poison which is particularly harmful to children and fetuses. Lead poisoning is potentially the most common and devastating environmental disease of young children. Lead Poisoning is preventable. The Department of Defense is one of many Government Agencies working to address this problem.

Parents and Health Care Providers are asked to complete and review this Questionnaire at each well child visit between 6 months and 6 years of life. If all answers are negative then your child is probably at low risk for lead poisoning.

If an answer on this questionnaire is positive then a blood lead determination may need to be performed. Your child's follow-up care will be provided in accordance with Centers for Disease Control (CDC) guidelines; published in "Preventing Lead Poisoning in Young Children -October 1991".

The CDC recommends that all children have a blood lead determination at 12 months of age and again at 24 months if resources permit unless your area has been found to be low risk.

Children of any age with unexplained illnesses for which lead poisoning is part of the differential diagnosis should have a lead determination. Examples of conditions include unexplained seizures and neurological conditions, abdominal pain, growth failure, developmental delay, hyperactivity and behavioral disorders, hearing loss and anemia.

Please turn to the back of this form and answer the questions. Please ask your Health Care Provider about any responses for which you may be unsure or uncertain. There are no incorrect answers. Your responses are used to assess the potential for lead exposure to your child.

LEAD SCREENING QUESTIONNAIRE

NAME OF CHILD _____ BIRTH DATE _____
 SPONSOR _____ DATE / / _____
 SPONSOR'S SOC. SEC NUMBER _____ FMP _____

ADDRESS#1 _____ PHONE _____
 ADDRESS#2 _____ DATE / / _____
 ADDRESS#3 _____ PHONE _____
 _____ DATE / / _____
 _____ PHONE _____

Please circle Y (yes) or N (no) and initial and date your response. Please sign at the left with your initials.

Signature _____ DATE _____
 Signature _____ INITIALS _____
 Signature _____ INITIALS _____

1. Do this child live in or regularly visit a home, day-care center or preschool built before 1960 which has peeling or chipping paint or which is currently undergoing renovation or remodelling? Y/N Y/N Y/N Y/N
2. Is there a sibling, housemate, or close playmate who has been treated for lead poisoning or a confirmed blood lead ≥ 15 ug/dl? Y/N Y/N Y/N Y/N
3. Live with an adult whose job or hobby involves exposure to lead? Y/N Y/N Y/N Y/N
4. Do you live near an active lead smelter, battery recycling plant or any industry you know that releases lead? Y/N Y/N Y/N Y/N
5. Do you use home or folk remedies? Such as Alarcon, Alkohl, Azarcon, Bali Goli, Coral Ghasard, Greta, Liga, Pay-loo-ah or Rueda. Or use folk cosmetics Kohl or Surma? Y/N Y/N Y/N Y/N
 or use home made ceramic pottery, lead crystal or lead soldered cans to store food or drink? Y/N Y/N Y/N Y/N
6. Do you live in an area where leaded gasoline use is prevalent? Y/N Y/N Y/N Y/N
7. Live in or regularly visit a house, day-care or pre-school that has been identified by DoD or HUD as high risk for lead? Y/N Y/N Y/N Y/N