## Lead
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### CASE MANAGEMENT

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**Lead Poisoning Prevention Screening Guide**

**Child enrolled in Medicaid/ MCO?**
- **NO**
- **YES**

**Child lives in a zip code Identified to be high risk?**
- **NO**
- **YES**

**Pregnant Women**
- **NO**

- Review *Lead Poisoning Verbal Risk Assessment to determine patient lead based health hazard risks*

**High Risk:** Test all at-risk patients with a **blood** test. Upon receipt of the elevated results notify parents/prenatal patient and follow case management and health education guidelines set forth by the KY Department for Public Health and the Healthy Homes and Lead Poisoning Prevention Program. ALL Medicaid children require a blood lead test at ages 12 and 24 months and any time 25-72 months of age if not previously tested (SEE NOTE).

**Low Risk:** Individual has no known risk factors for lead at this time. Administer *Lead Poisoning Verbal Risk Assessment* at next preventative visit.

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*American Academy of Pediatrics (AAP) recommends lead poisoning verbal risk assessment to be performed at ages 6, 9, 12, 18, and 24 months, and ages 3, 4, 5, and at 6 years (72 months of age and younger) with a blood lead test performed for ‘yes or don’t know’ response to any question. AAP recommends and **Medicaid requires** blood lead testing at ages 12 and 24 months.

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**NOTE:** According to the Centers for Medicare & Medicaid Services’ Early and Periodic Screening, Diagnosis and Treatment (EPSDT) guidelines, all preventive EPSDT examinations **must** include a blood lead laboratory test for children at 12 and 24 months of age and anytime under the age of 72 months if not previously tested.

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**PRENATAL: See CCSG Prenatal section for lead screening guidelines for at-risk patients**
**LEAD POISONING VERBAL RISK ASSESSMENT**

The Lead Poisoning Verbal Risk Assessment questions should be reviewed at every preventive visit for all children ages 6 months–6 years to determine the patients lead based health hazard risk(s). The American Academy of Pediatrics (AAP) recommends the verbal risk assessment to be performed at ages 6, 9, 12, 18, and 24 months, and ages 3, 4, 5, and at 6 years. A blood lead test should be performed for any “Yes or Don’t know” response to any question on the assessment. AAP recommends and Medicaid requires blood lead testing at ages 12 and 24 months.

The Lead Poisoning Verbal Risk Assessment questions are included on the Health Risk Assessments ACH 25, 90 and ACH 91.

**Pregnant Women**

Review each of these questions at the positive pregnancy test visit or initial prenatal visit to determine if patient is at-risk.

A copy of the Lead Poisoning Verbal Risk Assessment questionnaire can be found in the CCSG/Lead Section or on our website puthelidonlead.org.

See also the Prenatal section for Lead Screening Guidelines and Follow-Up.

Document in the medical record at the initial prenatal visit and anytime that the assessment was done, any positive response(s), and action taken according to the class chart guidelines located in the Prenatal section.

Document in the medical record when assessment was completed, any positive response(s) and action(s) taken:

- If the verbal risk assessment is negative at each visit, a blood lead level test should be routinely completed for all Medicaid children and children who reside in a **targeted zip code area at 12 and 24 months of age.**
- A “Yes” or “don’t know” answer to any question on the Lead Poisoning Verbal Risk Assessment will warrant a blood test for lead poisoning at that time, regardless of the child’s payer source or zip code area.
- Any child with a positive risk factor but not having an elevated blood lead level should be provided preventive education and tested at least annually, until 6 years of age, as long as any risk factor exists.

**BLOOD LEAD TESTING**

Blood lead testing should be provided for at-risk patients. At-risk patients include children seventy-two (72) months of age and younger and prenatal patients who:

1. Are enrolled in Medicaid.
2. Have a “Yes or Don’t know” response to any question on the Lead Poisoning Verbal Risk Assessment.
3. Live in a targeted zip code area.

Medicaid requires blood lead testing for eligible children seventy-two (72) months of age and younger, at ages 12 and 24 months of age and for all children between 2 and 6 years (≤72 months) of age who do not have a documented blood lead test.

A list of Targeted Zip Code areas can be found at: puthelidonlead.org.

See AR: Training Guidelines and Program Descriptions: Lead Sections

Blood Specimen Collection Guidelines can be found at: puthelidonlead.org.
**COMPLETION OF LABORATORY SUBMISSION FORMS**

Please fill out lab requisition forms accurately and completely, including your agency as the provider. Please assure the entity analyzing the LHD blood lead results are reporting all blood lead levels >2.3µg/dl to the cabinet.

A. SCREENING

This should be checked for the:

- initial capillary sample; first venous sample
- venous samples should always be taken on pregnant women
- re-screenings of children with levels equal to or greater than 5µg/dL
- and any screening test being repeated due to clot, insufficient quantity, or any other reason the sample could not be analyzed.

B. CONFIRMATORY

This should be checked for:

- the second capillary sample when the first capillary sample was equal to or greater than 15 micrograms per deciliter (considered a confirmed elevated blood lead level/lead poisoning).
- venous samples submitted as confirmatory samples after a first capillary sample was equal to or greater than 15 micrograms per deciliter and
- confirmatory tests being repeated due to clot, insufficient quantity, or any other reason the sample could not be analyzed.

C. MEDICAL FOLLOW-UP

This should be checked for:

- follow-up tests of ALL children who have been identified with an elevated blood lead level and
- medical follow-up tests being repeated due to clot, insufficient quantity, or any other reason the sample could not be analyzed.

**NOTE**: Venipunctures are considered a confirmed specimen. If the results are greater than or equal to 15 micrograms per deciliter (µg/dL), this is to be considered a confirmed elevated blood lead level. Follow the recommended actions for levels greater than or equal to 15µg/dL as indicated in the “Guidelines for Blood Lead Levels and Follow-Up.”
**NOTE:** See Administrative Reference for payment procedures. **GUIDELINES FOR BLOOD LEAD LEVELS (BLL) AND FOLLOW-UP**

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<thead>
<tr>
<th>BLOOD LEAD LEVEL</th>
<th>ASSESSMENT</th>
<th>INTERVENTIONS</th>
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</table>
| Less than 5 µg/dL 0-4.9µg/dL | Not considered lead poisoning *(No amount of lead in the body is normal. Even low blood lead levels can cause adverse neurological effects such as loss of IQ points and learning disabilities. It is very important that education on ways to prevent lead poisoning begin at this level)* | • Continue to review risk assessment questions at each preventive health visit up to ≤72 months of age  
• Complete routine blood lead testing for at-risk patients (Medicaid, Targeted Zip Code areas, and “+” or “don’t know” verbal lead risk assessment responses)  
• Assure blood lead testing at 12 and 24 months on all Medicaid recipients/ at-risk patients  
• Provide lead poisoning preventive education pamphlets and review with parent/guardian  
• Refer for WIC services  
• Contact State HHLPPP NCI if you have questions | • Retest at next periodicity visit if risk factor continues or changes  
• Medicaid recipients or children who reside in a targeted screening area:  
1. Routine blood lead level obtained at 12 and 24 months of age.  
2. Blood lead level obtained on all children 25 months–≤72 months of age who have never been screened. |
| 5–14.9 µg/dL | Elevated Blood Lead Level (EBLL): CDC Reference Value based on the 97.5th percentile of the population BLL in children aged 1-5 years of age (12 months –≤72 months of age). | • Provide lead poisoning preventive education pamphlets and review with parent/guardian,  
• Refer for WIC services  
**Home Visits:**  
• *If after a review of preventive education, the 2nd BLL remains at this level, a home visit to include the visual investigation must be made within 30 days of 2nd EBLL result to identify potential lead based health hazards.*  
• Fax completed case management and investigative visual home visit report forms to HHLPPP NCI 2nd EBLL result. Contact State HHLPPP NCI if you have questions | • Repeat blood lead level in 12 weeks of the initial, if BLL is still in this range repeat every 12 weeks until blood lead level is < 5 µg/dL.  
• Establish a tracking system that assures retesting. Provide Case management follow-up interventions.  
• For medical case closure see case closure section  
• Environmental: Lead hazards have been addressed. |
### GUIDELINES FOR BLOOD LEAD LEVELS AND FOLLOW-UP

* SEE PRENATAL LEAD SCREENING GUIDELINES IN PRENATAL SECTION FOR PRENATAL PATIENTS

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</table>
| 15–29.9µg/dL     | Confirmed Elevated Blood Lead Level as defined by KRS 211.900. >15µg/dL | • Provide lead poisoning preventive education pamphlets and review with parent/guardian. **Once Lead Poisoning is Confirmed:**  
  • Refer for WIC Services and Medical Nutrition Therapy, lead prevention diet counseling should be provided within 2 weeks to prevent lead absorption.  
  • Refer to a primary care provider (PCP) for medical evaluation. Provide PCP with letter/information on lead specialist consult.  
  • A home visit to include the visual investigation must be made within one week of EBLL result to identify potential lead based health hazards  
  • Refer to a *Certified Risk Assessor to perform an environmentalead hazard risk assessment within 2 weeks of LHD receiving confirmed EBLL results.  
  • Fax completed case management and investigative visual home visit report forms to HHLPPP NCI after confirming result.  
  • Contact HHLPPP NCI if you have any questions | 1. Submit confirmation (see assessment criteria) specimen within one week  
2. Repeat blood lead levels at 1–2 month intervals until:  
  a. Blood lead level is less than 5µg/dL for 6 months  
  b. or as s ordered by the physician  
3. Establish a tracking system that assures retesting.  
4. Provide Case management follow-up interventions.  
5. For medical case closure see case closure section  
6. Environmental: Lead hazards have been addressed. |
| 30-44.9µg/dL     | Confirmed Elevated Blood Lead Level BLL’s >15µg/dL | Same as above |

Venous Specimens are uncontaminated, preferred by CDC and considered confirmed.  
First capillary specimen at this level will need to be confirmed.  
2nd Capillary is acceptable; however, special care is needed when obtaining a capillary confirmation for lead poisoning.
### GUIDELINES FOR BLOOD LEAD LEVELS AND FOLLOW-UP

#### SEE PRENATAL LEAD SCREENING GUIDELINES IN PRENATAL SECTION FOR PRENATAL PATIENTS

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<th>BLOOD LEAD LEVEL</th>
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<th>INTERVENTIONS</th>
<th>FOLLOW-UP</th>
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</thead>
</table>
| 45–69.9 µg/dL    | Confirmed Elevated Blood Lead Level \textit{BLL}> 15 \µg/dL | Same as listed above except refer to PCP for medical evaluation within 48 hours. | • Submit venous confirmation specimen within 48 hours  
• During and post chelation therapy, retest monthly until:  
  • Blood lead level is less than 5µg/dL for 6 months (capillary specimens are acceptable)  
  • or as s ordered by the physician  
  • Establish a tracking system that assures retesting  
  • Provide Case management follow-up interventions  
  • For medical case closure see case closure section  
  • Environmental: Lead hazards have been addressed |
| 70µg/dL and above | Confirmed Elevated Blood Lead Level \textit{BLL}> 15 \µg/dL  
  \textbf{MEDICAL EMERGENCY} | Same as listed above except refer to PCP for medical evaluation within 24 hours. | • Submit venous specimen within 24 hours  
• During and post chelation therapy, retest monthly until:  
  • Blood lead level is less than 5µg/dL for 6 months (capillary specimens are acceptable)  
  • or as s ordered by the physician  
  • Establish a tracking system that assures retesting  
  • Provide Case management follow-up interventions  
  • For medical case closure see case closure section  
  • Environmental: Lead hazards have been addressed |

* Contact KY HHLPPP for Lead Specialist contact information
LEAD POISONING PREVENTION AND MANAGEMENT

**Case Management:**

Environmental lead exposure continues to cause harm, particularly to young children and pregnant women. This section offers guidance on the provision of lead screening and follow-up services for children 6 months – ≤72 months of age. Lead screening and follow-up guidelines for pregnant women are included in the Prenatal Section.

According to the Centers for Disease Control and Prevention (CDC), case management of children and pregnant women with elevated blood lead levels (EBLL’s) involves the coordination, provision and oversight of services required to reduce lead levels to below a level of concern. A hallmark of effective case management is ongoing communication with caregivers and other service providers, and a cooperative approach to solving any problems that may arise during efforts to decrease a patient’s elevated blood lead level by reducing lead based health hazard exposure, and eliminate those hazards in the patient’s environment.

**Case management** is much more than a simple referral to other service providers. There are 8 components, which should be under the purview of a registered nurse:

- Client identification and outreach
- Individual assessment and diagnosis
- Service planning and resource identification
- The linking of clients to needed services
- Service implementation and coordination
- The monitoring of service delivery
- Advocacy
- Evaluation

Case management should occur for every child with a 2nd blood lead level of 5ug/dL or greater and for every pregnant woman with a venous level of 5ug/dL or greater. Children and pregnant women with elevated blood lead levels become “health department patients” when their cases are brought to the attention of staff, even if they are or have been receiving direct clinical services elsewhere. They will remain a health department patient until case closure.

The report forms are used to coordinate communication between the LHD lead case managers and the state HHLP PPP NCI in an effort to assure that all children with an EBLL receive appropriate and timely care. The KHHLPPP NCI monitors incoming lab data and compares with incoming LHD EBLL case management reports. Date appropriate interventions when completed. *A zip code must be included to enter the data into the system.*

The KHHLPPP case management report form must be filled out for all children with a 2nd blood lead level of 5 -14.9µg/dL or confirmed BLL of 15µg/dL or greater and for every pregnant woman with a venous BLL of 5µg/dL or greater. The original report is to be placed in the patient’s chart and a copy of this form should be faxed or mailed to the KHHLPPP NCI. Updates on BLL’s and interventions should be made on the back of the form and faxed to KHHLPPP.
HOME VISITS & ENVIRONMENTAL MANAGEMENT FOR PATIENTS WITH ELEVATED BLOOD LEAD LEVELS (EBLL)

Environmental Management through onsite visual investigative home visits is one component of an ongoing process related to the elimination of lead poisoning as a public health problem. Onsite Visual Investigative Home Visits help to:

- Identify areas in the home that could potentially be a source for lead exposure;
- Provide suggestions and educational materials to the family in an effort to make the home lead-safe;
- Reduce the patient’s current BLL to less than 5µg/dL by reducing or eliminating the amount of lead exposure;
- Assure that patient’s with an EBLL receive timely and appropriate care.

According to KRS 211.905, an inspection of the property where an EBLL child seventy-two (72) months of age or younger routinely spends more than six (6) hours per week must be completed to determine the existence of lead-based health hazards.

Priority should be given to the child’s primary place of residence. The environmental investigations may include the visual investigative home visit as well as the comprehensive lead hazard risk assessment to determine the existence of lead based hazards. Persons certified in KY by the Environmental Lead Program must complete the environmental lead risk assessment.

Collaboration of the environmentalist and the lead case manager assures appropriate and timely environmental investigative visual home visits for patients who are identified with EBLL’s. Interventions during investigations include:

- Informing the patient/parent/guardian/care giver of child’s blood lead level; review level of understanding; monitoring of blood lead levels,
- Reviewing what lead poisoning is and common sources of lead, provide preventive educational materials;
- Reviewing lead preventive health education,
- Reviewing lead poisoning prevention diet,
- Reviewing patient’s physical status, including behavior problems/changes, nutritional status and specific habits such as placing fingers in mouth or eating dirt or paint chips;
- Establishing who is providing patients primary and acute health care;
- Visualize the patient’s home environment and child’s play areas to identify potential sources of lead and discuss preventive strategies to reduce the patient’s lead hazard exposure;
- Assure the well-being of the child by referring to appropriate agencies; services may include social services for emergency or temporary housing agencies and community partners to help correct potential lead health hazards.

Investigative visual home visits are to be conducted for all children referred into or already receiving services in a health department clinic with a second blood lead level remaining at 5–14.9µg/dL or a confirmed blood lead level of 15µg/dL micrograms per deciliter or above and for pregnant women with a BLL of 10ug/dL or greater.
Upon receipt of EBLL results, the lead case manager is responsible for collaboration and referrals to the environmentalist or risk assessor for appropriate environmental investigations. For children identified as having BLL’s of:

- 2nd BLL of 5µg/dL or greater, a investigative visual home visit is to be completed at the child’s or pregnant women’s primary residence to identify potential sources of lead based health hazard exposure.
- **Confirmed** EBLL’s of 15µg/dL or greater: in addition to the investigative visual home visit, a referral should be made to the environmentalist to assure a lead hazard risk assessment is completed by a KY certified risk assessor.

**Investigation of the Primary Address:**
The investigative visual home visit should be initiated by the LHD lead case manager or home visiting nurse following time frames listed below (See Table 1). Investigations should be conducted within the appropriate timeframes according to CDC’s recommendations. (See Table 1) However, KHHLPPP recommends timeframe of two (2) weeks for BLL’s 5-14.9ug/dL to visualize potential sources of lead and to review preventive education with the parent/guardian/care giver and to prevent further elevation of the BLL.

**Table 1: Home Visit and Visual Investigation**

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<thead>
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<th>Time Frame for Assessment</th>
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<td>2nd BLL 5-14.9µg/dL</td>
<td>4 weeks of 2nd BLL in this range</td>
</tr>
<tr>
<td>15-19.9 µg/dL</td>
<td>2 weeks; refer for comprehensive lead risk assessment</td>
</tr>
<tr>
<td>20-44.9 µg/dL</td>
<td>1 weeks; refer for comprehensive lead risk assessment</td>
</tr>
<tr>
<td>45-69.9 µg/dL</td>
<td>48 hours; refer for comprehensive lead risk assessment</td>
</tr>
<tr>
<td>&gt;70 µg/dL</td>
<td>24 hours; refer for comprehensive lead risk assessment</td>
</tr>
</tbody>
</table>

At the time of the investigative visual home visit, preventive education should be reviewed with the parents/guardians/care giver. **Preventive education** includes discussing the child’s potential source of lead-based health hazards and how to prevent further exposure to those sources, an increase in the child’s hand washing with soap and water (especially prior to eating/snacking and sleep times), and house cleaning techniques such as damp dusting, wet mopping, and daily vacuuming of the home. Temporary measures to reduce further exposure are not required within a specific timeframe, however it is recommended to immediately keep the child away from the potential lead hazard sources. If the child’s BLL should increase to a confirmed elevated blood lead level, considered lead poisoning (BLL >15ug/dL), it is required per KRS 211.905 to correct any identified lead hazards within sixty (60) days. Temporary measures may include but are not limited to:

- Blocking child from potential hazardous area with a barrier, (i.e. door, child gate);
- Using furniture to block child’s access to the hazard (i.e. furniture in front of a chipping window sill);
- Use of duct or masking tape and plastic or cardboard to cover an area of chipping/peeling surface until permanent work can be conducted;
- Daily damp dust, wet mop and vacuum with a hepa vac especially in the child’s play area;
- Wipe child’s toys clean, keep toys in clean dry tote, and placing tote in clean play area and limiting the child’s play to this area; (especially if child is crawling and/or in hand-to-mouth exploration stage);
- Keep child’s hands washed with soap and water, (germ gel does not remove lead), wash hands before snacks and meals and before any nap or bedtime (especially if child is crawling and/or in hand-to-mouth exploration stage);
• Leaving shoes outside, or placing shoes in a tote or on a shelf and out of the child’s reach to keep lead dust/paint chips from being tracked in from outside.
• Exploring the possibility to relocate child(ren) and pregnant women from the home while renovation/remediation work is in progress.

A thorough visual investigation of the child’s home helps to identify possible sources of lead. The investigation should visualize both the interior and exterior environment of the child with attention given to child accessible painted surfaces, dust and soil. Other potential sources of lead should be considered during the assessment i.e., water, family occupation, hobbies, etc.

If the BLL remains elevated and is not decreasing in 8-12 weeks, an environmental investigation may need to be conducted at another property where the child routinely spends more than six (6) hours a week.

Please fill out the investigative visual home visit form thoroughly.

Follow-Up Home Visits
Follow-up home visits assure preventive measures for lead poisoning prevention are continuing. Follow-up home visits are also indicated when:

a. Child fails to return for blood lead monitoring
b. Blood lead levels remain elevated
c. Blood lead levels are increasing
d. At any other time the case manager feels a home visit would be beneficial

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<th>Assessment</th>
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<td>Family’s verbal understanding of lead poisoning and prevention</td>
<td>Reinforce previous health education</td>
</tr>
<tr>
<td>Assess barriers to patients ability to keep appointments, refer as appropriate</td>
<td>Stress importance of monitoring blood lead levels every 1–2 months or as ordered by the physician for confirmed lead poisoning cases and every 3 months for 5–14.9 µg/dL</td>
</tr>
<tr>
<td>Patient’s physical status.</td>
<td>Provide health education and referral, if indicated.</td>
</tr>
<tr>
<td>Patients blood lead level status.</td>
<td>Collect blood and/or schedule a clinic appointment, if indicated. (Coded “Screening” or “Confirmatory” sample. “Medical Follow-up” if child has been confirmed.)</td>
</tr>
<tr>
<td>Home environment: determine whether temporary measures are continuing.</td>
<td>Reinforce previous recommendations. Provide education, as indicated.</td>
</tr>
<tr>
<td>Determine whether permanent measures have occurred/are planned.</td>
<td>Stress importance of workers using safety precautions and appropriate clean-up procedures during abatement. Encourage pregnant women and children to be kept away from work areas. While extensive work is being done, it is preferable to move the family out of the home.</td>
</tr>
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</table>

• Case closure
Case closure is determined according to the initial blood lead level and can be closed as follows:
• **BLL 5–14.9 µg/dL** – Case closure is when BLL is less than 5µg/dL, repeat BLL as indicated.

• **BLL 15µg/dL and greater** – Case closure occurs when BLL is less than 5µg/dL for at least 6 months; environmental hazards have been addressed; and there are no new environmental hazards. When a child is closed to follow-up, the date and reason for case closure, and any actions/interventions or comments should be recorded on the case management report in area provided.
For prenatal lead exposure, case closure ends for the pregnant woman at delivery of the infant. If the prenatal patient’s BLL is >25µg/dL, follow-up will be with the patients PCP. The newborn will need to be tested at delivery. A cord blood sample is to be used for testing at the time of delivery. Protocols for case management will be initiated for newborns with BLL’s ≥5µg/dL.

**A case may also be designated as administrative closure if all directives, as enumerated in the “Follow-up/Internal Tracking/Referral” section, have been completed.** The case manager must follow all procedures for closure in a ‘lost to follow up’ case closure.

Cases where all directives have been completed and there has been no contact or follow-up appointment completed by the patient, will need to be referred to Department for Community Based Services (DCBS). Please see Administrative Reference (AR) Volume I, Abuse, Neglect and Violence section/ Department for Community Based Services.

If a case has been closed and at a later date is reopened, please send a new Report Form with initial BLL and updated information. Please do not continue on old file and write reopened.

**Forms available @ [http://chfs.ky.gov/dph/Local+Health+Department.htm](http://chfs.ky.gov/dph/Local+Health+Department.htm)—CCSG/Lead Section.** Forms should be filed at the county local health department in the patient’s chart and a copy is to be faxed or mailed to the state HHLPPP NCI

Mail to: Healthy Homes and Lead Poisoning Prevention Program
Division for Maternal and Child Health
275 East Main Street, HS2GWA
Frankfort, Kentucky 40621

Or Fax to: (502) 564-5766

**Resources:**

- “Lead Poisoning: Are Your Children at Risk?”
- “Lead Poisoning and Your Children” [www.epa.gov/lead](http://www.epa.gov/lead)
- “Protect Your Children from Lead in Your Home”
- “Fight Lead Poisoning with a Healthy Diet”
- “Lead Paint Safety”
- “Preventing Lead Exposure in Young Children” [www.cdc.gov/niosh](http://www.cdc.gov/niosh)
- “Prevent Lead Poisoning, Eat Healthy” [www.putthelidonlead.org](http://www.putthelidonlead.org)

**Manuals:**

2. *Managing Elevated Blood Lead Levels Among Young Children: Recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention.* (CDC, 2002)

**Targeted Zip Codes**

Targeted zip code areas are those areas where patients are more likely to have exposure to lead paint hazards. Children and prenatal patients living targeted zip code areas are considered high risk due to the number of pre-1950 housing in a particular zip code area and percentage of the population living at or below the poverty level. Housing structures built prior to 1950 are more likely to contain structural deficiencies that may lead to deterioration of lead paint and increase exposure to lead paint chip and dust hazards. Children living in or below the the poverty level are more at-risk due to poverty stricken families are more likely to live in sub-standard housing that include deteriorating pre-1950 housing. The Targeted Screening Plan by zip code can be accessed on the website: [putthelidonlead.org](http://putthelidonlead.org). Staff screening children for lead should determine if the zip code of the child’s residence is at high-risk for lead hazards.