



# OLR RESEARCH REPORT

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## LEAD TESTING

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You asked for a summary of the law's requirements for testing children for lead poisoning.

### SUMMARY

The law generally requires primary care providers to annually test children between nine and 35 months old for lead. They must also screen children (1) between 36 and 72 months old who have never been screened and (2) children under 72 months if the provider determines it is clinically indicated. In addition, providers must conduct annual lead risk assessments for children ages 36 to 71 months ([CGS § 19a-111g](#)). Individual and group health insurance policies must cover the lead screening and risk assessment mandates ([CGS §§ 38a-490d & -535](#)).

Lead testing can also be required in other contexts, such as part of school health assessments for new enrollees or for children enrolled in Head Start.

The law requires health care institutions and clinical laboratories to report on tests showing elevated blood lead levels to local health directors, among others. Directors must provide parents with information after tests show that their children have elevated blood lead levels. When a director receives a report that two blood tests taken at least three months apart confirm a child's blood lead level is over a certain threshold, the director must take various actions, including investigating the lead source and ordering remediation.

The Department of Public Health (DPH) is the lead state agency for lead poisoning prevention. Among various other requirements, DPH must provide funding, within available appropriations, to local health departments to help finance their lead poisoning prevention and remediation services. An act passed this session ([PA 12-202](#)) establishes eligibility criteria for local health departments seeking such funding from DPH. Among other things, the act conditions a local department's funding eligibility on DPH approving its lead program, which must include case management, education, and environmental health components.

DPH's website contains detailed information on the department's lead poisoning prevention and control program:  
[http://www.ct.gov/dph/cwp/view.asp?a=3140&q=387550&dphNav\\_GID=1828](http://www.ct.gov/dph/cwp/view.asp?a=3140&q=387550&dphNav_GID=1828).

The law also provides various requirements related to lead abatement. For example, owners of dwellings with toxic lead levels occupied by children under age six must abate, remediate, or manage the dangerous materials and follow DPH regulations for doing so ([CGS § 19a-111c](#)). Local health directors can also order various actions related to lead abatement, such as orders to correct chipped or loose lead-based paint on exposed interior surfaces in rented properties. If you would like detailed information on these or other lead abatement requirements, please let us know.

## **LEAD TESTING REQUIREMENTS**

### ***Lead Screening and Risk Assessments***

**Screening.** By law, primary care providers who provide pediatric care, other than hospital emergency departments, must screen annually for lead every child between nine and 35 months old. The screenings must follow the Childhood Lead Poisoning Prevention Screening Advisory Committee's recommendations. These recommendations call for blood lead screening tests at age 12 months and 24 months with follow-up venous blood tests if the initial screening shows an elevated blood lead level.

These providers must also screen (1) all children between 36 and 72 months old who have never been screened and (2) any child under 72 months if the provider determines it is clinically indicated under the advisory committee's recommendations (which call for screening children who exhibit developmental delays and consideration of blood lead testing

for any child who has unexplained seizures, neurologic symptoms, hyperactivity, behavior disorders, growth failure, abdominal pain, or other symptoms consistent with elevated lead levels or a recent history of ingesting foreign objects).

**Risk Assessments.** The law also requires these primary care providers to conduct annual lead risk assessments for children ages 36 to 71 months. Providers can assess younger children if they determine it is needed. Assessments must be conducted according to the Lead Screening Advisory Committee's recommendations. These recommendations call for questioning parents or guardians about the child's housing (age and location) and family history of elevated blood lead levels.

**Exemptions.** The law exempts children whose parents object to blood tests on religious grounds from these screening requirements ([CGS § 19a-111g](#)).

### ***Reporting Elevated Blood Lead Levels***

By law, health care institutions and clinical laboratories must notify DPH, appropriate local health officials, and the health care provider who ordered the test, within 48 hours of receiving or completing a report on a person with a lead level of 10 or more micrograms of lead per deciliter of blood (10 µg/dL) or other abnormal bodily lead level. Within 72 hours of learning the results, the provider must make reasonable efforts to notify the parents or guardians of a child under age three of the results. Institutions or laboratories that conduct such lead testing must also, at least monthly, submit to the DPH commissioner a comprehensive report that includes specified information.

When a local health director receives a report that a child has been tested with a blood lead level of at least 10 µg/dL or other abnormal body lead level, the director must inform the parents or guardians (1) of the child's potential eligibility for the state's Birth to Three program, which provides services to families with children with disabilities or delays from birth to 36 months and (2) about lead poisoning dangers, ways to reduce risks, and lead abatement laws.

Whenever a local health director receives a report that two blood tests taken at least three months apart confirm a child's venous blood lead level is between 15 to 20 µg/dL, the director must conduct an on-site investigation to identify the source of lead causing the elevation and

order whoever is responsible for the condition to remediate it. This threshold is lowered to 10 µg/dL if 1% or more of Connecticut children under age six have been reported with blood levels of at least 10 µg/dL ([CGS § 19a-110](#)).

The law also requires the DPH commissioner to establish an early lead diagnosis program that includes routine exams of children under age six. Under this program, exams showing blood levels of 10 or more µg/dL must be reported to the child's parents or legal guardians, the local health director, and DPH ([CGS § 19a-111b](#)).

Local health directors must also conduct an epidemiological investigation for lead levels of 20 or more µg/dL. After the investigation identifies the lead source, the local health director must take action to prevent further lead poisoning. Among other things, the director can order abatement and must try to find temporary housing for residents when the lead hazard cannot be removed from their dwelling within a reasonable time ([CGS § 19a-111](#)).

### ***School Health Assessments***

By law, school boards must require each child to have a health assessment prior to public school enrollment. Among other things, the assessment must include tests for lead levels in the blood where the school board determines the tests are necessary, after consultation with the school medical advisor and the local health department (or in the case of a regional board of education, each local health department).

Appropriate school health personnel must review the results of student health assessments and screenings. When, in the health personnel's judgment, a pupil is in need of further testing or treatment, the superintendent must give written notice to the pupil's parent or guardian and make reasonable efforts to assure that further testing or treatment is provided ([CGS § 10-206](#)) (2012 Supp.)

### ***Head Start***

Each director of a Head Start program must require children attending the program to be tested for blood lead levels after determining that such tests are necessary, after consultation with the school medical advisor and the local health department (or in the case of a regional board of education, each local health department) ([CGS § 10-206b](#)).

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