INDIANA LEAD AND HEALTHY HOMES PROGRAM

Report to the Legislature for Calendar Year 2009

Submitted

March 10, 2010

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This report addressing state lead poisoning activities is required by IC 16-41-39.4-5, as follows:

IC 16-41-39.4-5
Annual report

Sec. 5. (a) The state department shall, in cooperation with other state agencies, collect data under this chapter and, before March 15 of each year, report the results to the general assembly for the previous calendar year. A copy of the report shall be transmitted in an electronic format under IC 5-14-6 to the executive director of the legislative services agency for distribution to the members of the general assembly.

(b) The report transmitted under subsection (a) must include for each county the following information concerning children who are less than seven (7) years of age:

(1) The number of children who received a blood lead test.

(2) The number of children who had a blood test result of at least ten (10) micrograms of lead per deciliter of blood.

(3) The number of children identified under subdivision (2) who received a blood test to confirm that they had lead poisoning.

(4) The number of children identified under subdivision (3) who had lead poisoning.

(5) The number of children identified under subdivision (4) who had a blood test result of less than ten (10) micrograms of lead per deciliter of blood.

(6) The average number of days taken to confirm a blood lead test.

(7) The number of risk assessments performed for children identified under subdivision (4) and the average number of days taken to perform the risk assessment.

(8) The number of housing units in which risk assessments performed under subdivision (7) documented lead hazards as defined by 40 CFR 745.

(9) The number of housing units identified under subdivision (8) that were covered by orders issued under IC 13-14-10-2 or by another governmental authority to eliminate lead hazards.

(10) The number of housing units identified under subdivision (9) for which lead hazards have been eliminated within thirty (30) days, three (3) months, and six (6) months

Indiana Lead and Healthy Homes Program
2009 Annual Report

The mission of the Indiana Lead and Healthy Homes Program (ILHHP) is to eliminate lead poisoning as a public health problem in Indiana by 2011. To accomplish this mission the program focuses on primary and secondary prevention goals set forth in the lead elimination plan. Primary prevention of lead poisoning includes the identification and remediation of environmental lead hazards. Secondary prevention consists of screening and testing of children for lead, followed by case management activities that have been the traditional strength of the program. Historically, ILHPPP has placed its emphasis on the primary prevention of lead poisoning in an effort to head off the disease before it strikes. In partnership with local county health departments, ILHPPP pursues the most appropriate approach to both prevention and treatment of childhood lead poisoning in communities throughout Indiana.

Lead poisoning is a silent menace which often does not manifest itself until the damage is done. The disease can permanently and irreversibly damage the developing brain and other organs of young children. Serious effects can include lowered intelligence, behavior disorder, and slowed physical development. Once poisoned, a young child's chances for academic, social and occupational success are significantly diminished.

Indiana tests children who are less than seven years old, and who present *any* of five at-risk factors. The five questions used to screen for at-risk children are:

- Is the child living in or regularly visiting, or has the child lived in or regularly visited, a house or child care center built before 1978?
- Does the child have a sibling or playmate who currently has or has had lead poisoning in the past?
- Does the child frequently come in contact with an adult who works in an industry or has a hobby that uses lead?
- Is the child (a) a recent immigrant – or – (b) a member of a minority – or – (c) enrolled in Hoosier Healthwise?
- Does anyone in the family use folk remedies or ethnic cosmetics?

Children who have a confirmed elevated blood lead level (CEBLL) at ten (10) micrograms per deciliter of blood or above are qualified as lead poisoned. Confirmation of the blood lead level depends upon the initial testing method. A blood test may be completed by the capillary method in which the child's finger is pricked and the blood is collected in a capillary tube or daubed onto filter paper. The blood can also be taken by the venipuncture method in which the sample is drawn directly from the vein into a syringe. Since the venous draw is more reliable, an elevated blood level by that method needs no further confirmation. However, if the initial test is by the less reliable capillary method a follow-up test is required to confirm that the child has lead poisoning. This is significant because the capillary method is used more often as it is less invasive to the child. Performing the confirmatory test that the capillary method requires can be problematic as it can be difficult for the child to return for the required testing. Thus, two key numbers on the county chart below show that of 606 children who had a screening test indicating blood lead poisoning, 206 of those requiring confirmation never returned for the confirmatory test. Follow-up on these children remains an important concern.

Deteriorated lead-based paint in the child's home environment is the primary source of lead poisoning. Young children, who are most vulnerable to the effects of lead poisoning, often pick up lead dust from the floor and ingest it through hand-to-mouth activity. In recent years other sources of lead poisoning have come to prominence. Consumer products such as children's toys or inexpensive jewelry are often imported from countries where there are few restrictions on the use of lead; this has resulted in some notorious cases of lead poisoning and even death. All of these factors must be examined in addition to the presence of lead-based paint.

The Childhood Lead Poisoning Elimination Plan submitted to the CDC in 2004 encompassed two long term goals: primary and secondary prevention of childhood lead poisoning. The following sections detail agency progress towards reaching those goals.

GOAL 1: PRIMARY PREVENTION

Primary prevention efforts are directed toward increasing the number of housing units and child-occupied facilities where lead hazards are identified and remediated. This goal also includes activities to reduce hazards from non-structural, non-paint sources of lead poisoning.

The age of the home is one of the leading indicators for the possibility of lead poisoning. Indiana ranks eleventh nationally in the percentage of older homes, with 717,111 or 28% of its total housing units built prior to 1950. Progress toward the primary prevention goal has been made in the following areas:

A. Indiana statute 410 IAC 29 was revised to mandate local health departments to initiate a court case if the property owner does not complete remediation activities in 180 days.
B. Eighty-three percent (83%) of Indiana target areas have obtained funds for lead hazard control activities through the Department of Housing and Urban Development (HUD). Elkhart County and the City of Gary each received three million dollars for lead hazard remediation (also from HUD).
C. The Indiana State Department of Health received an increase of $42,000 in funding from the U.S. Environmental Protection Agency in support of the Lead-based Paint Program. An additional $19,000 of program income was generated as a result of this program.
D. The Apartment Association of Indiana has sponsored Lead Safe Work Practices training numerous times. During the coming year, the Indiana Lead and Healthy Homes Program will focus on reaching out to property managers operating smaller properties or duplexes.
E. The Indiana Lead and Healthy Homes Program implemented the Indiana Lead Environmental Assessment Database (I-LEAD) to collect information on environmental investigations. 1,080 environmental investigations had been entered into I-LEAD in 2009. The I-LEAD database was expanded to collect data concerning healthy homes issues as well as lead data.
F. The State of Indiana invested approximately $455,000 to provide updated x-ray fluorescence monitors to the 26 Community Action Programs conducting weatherization services throughout the state. All Indiana Community Action Programs are required to maintain at least one licensed lead professional on staff at all times.

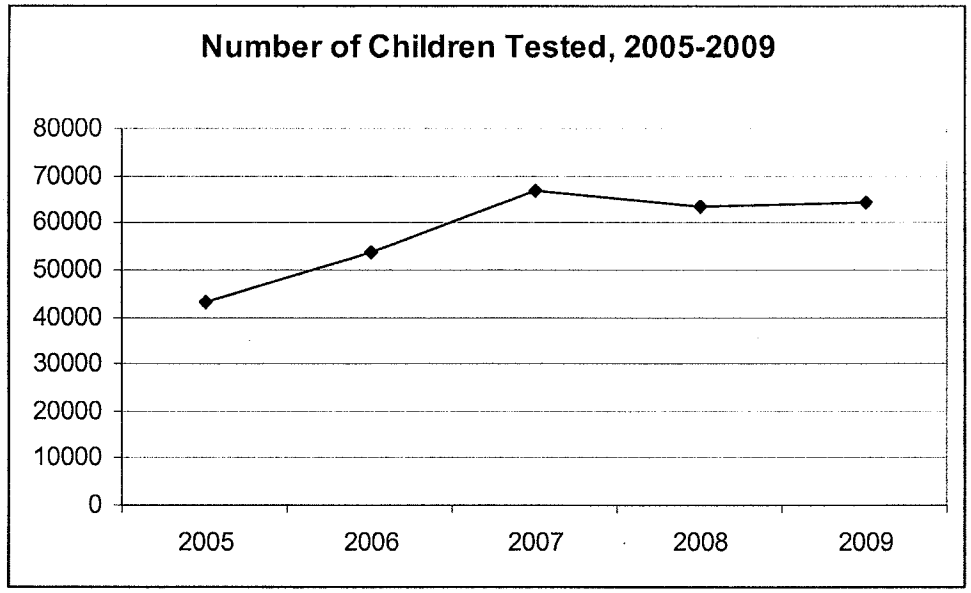
G. The total number of licensed risk assessors, lead inspectors and clearance examiners has increased by 15 percent.
H. The overall number of environmental inspections and investigations increased by 22 percent (n=2595).
I. In two of eight targeted jurisdictions, county health departments are conducting outreach programs for mothers in high risk areas based upon data derived from vital statistics. The Indiana Lead and Healthy Homes Program is working with the remaining six programs to incorporate similar activities.

GOAL 2: SECONDARY PREVENTION

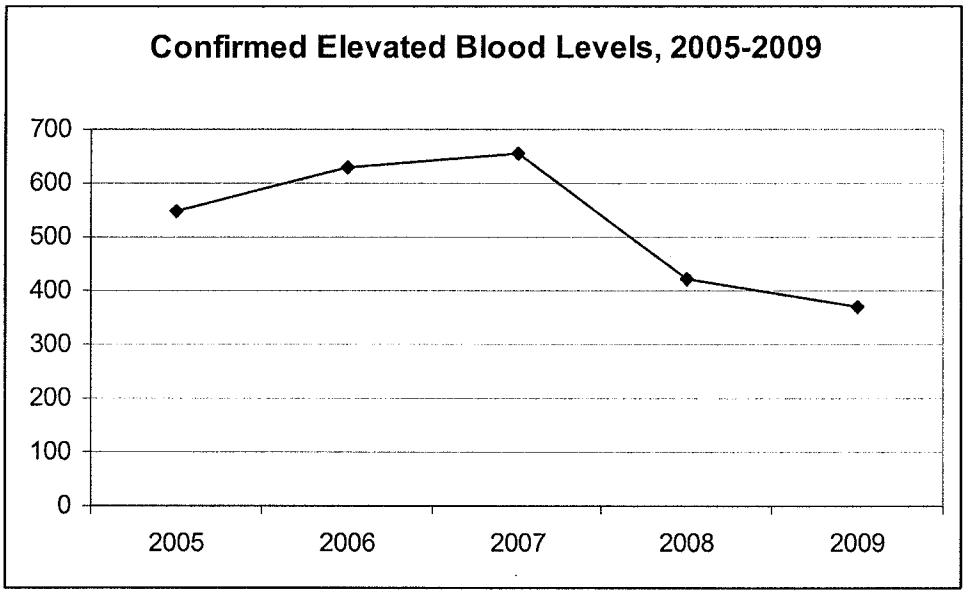
Secondary prevention efforts of ILHHP aim to increase the identification of lead poisoned children followed by treatment of the disease and case management in cases in where the child already exhibits an elevated blood lead level.

The CDC predicts that 13,800 children may be lead poisoned at any given time in Indiana. Progress on Goal 2 has been made in the following areas:

A.) The number of children tested is displayed for each county in the charts included in this report. During the past five years, the number of children tested for blood lead levels increased steadily through 2007 and reached a high of 66,722 children tested in 2007. The number of tested children increased from 63,320 in last year's 2008 legislative report to 64,359 children for calendar year 2009. Sex distribution was nearly evenly divided: 52% were male (n=35,531) and 48% were female (N=33,397). Half of the children tested were White (50%, n=34,487); 17% were Black (n=11,854); 2% were Asian/Pacific Islander (n=1191); 0.10% were Native American (n=72); 0.39% were identified as multiracial (n=266); 4% were identified as 'other' race (n=2446); over one quarter were identified as 'unknown' race (n=18,366).

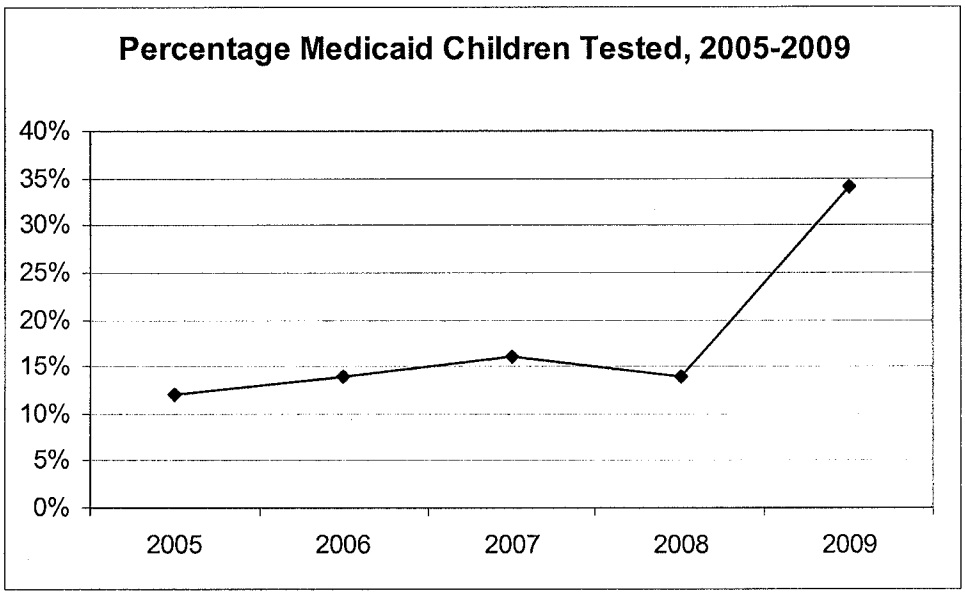


B.) The number of confirmed lead-poisoned children identified in calendar year 2009 was 375. It is important to remember that the effects of an elevated blood lead level are generally irreversible; therefore, the cumulative number of poisoned children is important in gauging the scope of the problem. Over the last five years 2,624 have been diagnosed as lead poisoned (blood level confirmed as at least 10 μg/dL) in Indiana. Of those children with a confirmed EBLL, over half were male (54%, n=201; female – 46%, n=174). In the testing distribution, nearly half were White (49%, n=182) but other races are represented in higher proportions. Black children had a confirmed EBLL rate of 23% (n=85). While the proportion of Asian/Pacific Islander children tested was 2%, the EBLL rate for Asian/Pacific Islander children was three times as high at 6%. For multiracial children, one child (0.27%) had a confirmed EBLL. Children identified as 'other' race represented 3% (n=10) of confirmed EBLLs while 18% (n=74) were identified as 'unknown' race. No Native American children exhibited a confirmed EBLL.



C.) The Indiana Lead and Healthy Homes Program has worked with local health departments and other agencies to ensure that all children with elevated blood lead levels receive environmental inspection of their surroundings to determine the cause of the lead poisoning. In 2009, the completion rate for environmental risk assessments was over 93% (n=277) for the 296 open cases. Of those, 46% (n=127) of the properties were determined to contain lead hazards. Average number of days to perform the assessments was measured as well. Of the 24 counties for which data were obtained, the number of days to perform risk assessments ranged from a low of 2 days (Gibson and Tippecanoe Counties; 5 assessments performed for each county) to a high of 102 days (Jefferson County; 2 assessments performed). Completing environmental risk assessments for 100% of identified case remains a goal for the program; ILHHP personnel are diligently working with county assessors to ensure that risk assessments are performed and the data is entered in a timely manner in the I-LEAD database.

D.) Nearly half of all children in Indiana are enrolled in Medicaid. Of the nearly 65,000 children tested, 59% (n=38,411) were Medicaid participants. Over half (54%, n=201) of those children with a confirmed EBLL were enrolled in Medicaid. Since poverty is a leading risk factor for lead poisoning, ILHHP continues to work with the Office of Medicaid Policy and Planning (OMPP) to increase testing rates among children under the requirements of the Medicaid EPSDT program (Hoosier Healthwise). The lifetime testing rate has risen steadily since 2005 to reach 44% of all eligible children by 2009. However, since it is mandated that all eligible children be tested, this remains an area in which ILHHP can increase its performance standard. In 2009, 34% of Medicaid eligible children were tested. This represents a sizeable increase from the proportion reported in 2008 (14%).



The Indiana Lead and Healthy Homes Program also worked with the Office of Medicaid Policy and Planning (OMPP) and EDS to increase awareness among Medicaid providers. At the thirteen (13) Medicaid provider workshops held throughout Indiana in 2009, lead was added as a topic. Raising awareness among Medicaid providers resulted in a screening increase but there has been no similar, measurable increase in parental awareness.

For children under the age of seven, Table 1 (see Appendix) illustrates each county's race/sex distribution by payment type (non-Medicaid payment, Medicaid, unknown payment type).

In conclusion, progress has been made on many fronts to eliminate lead poisoning as a public health problem. However, many challenges emain in implementing policies and procedures to assure effective case management and treatment of poisoned children, as well as the prevention of the disease through the detection and remediation of environmental lead hazards. The Indiana Lead and Healthy Homes Program continues to push for transition to primary prevention from secondary prevention.

The following chart is offered under Indiana Code 16-41-39.5 to detail the results of extensive work by the Indiana Lead and Healthy Homes Program, local health departments, and the many program partners in each county in Indiana.

Blood Lead Testing, Elevated Blood Lead Levels and Environmental Investigations Report (2009)

COUNTY NAME	Number of children who received at least one blood test (Note 1) 1	Number of children with blood lead level ≥ 10 µg /dL (Note 2) 2	Number of children with initial level ≥ 10 µg /dL venous (Note 3) 3(a)	Number of children with initial level ≥ 10 µg /dL Capillary (Note 3) 3(b)	Number of children with initial capillary blood lead level ≥ 10µg/dL not returning for a confirmation test. (Note 3) 3(c)	*Number of children with confirmed blood lead level ≥ 10µg/dL (Note 3) 4	Number of children with false positives after Confirmation (Note 4) 5	Average number of days to confirm an initial elevated capillary blood lead test result (Note 3) 6	Number of risk assessments performed for confirmed elevated blood lead levels 7(a) (Notes 5)	Average number of days to perform a risk assessment (Notes 5 and 6) 7(b) (Notes 5)	The number of housing units with documented lead hazards from the risk assessments performed 8 (Notes 6)	The number of housing units identified with lead hazards and covered by orders issued under IC 13-14-10-2 or by another governmental authority to eliminate lead hazards. 9 (Notes 6)	The number of housing units with lead hazards eliminated within thirty (30) days 10 (Notes 6)	The number of housing units with lead hazards eliminated within three (3) months 10 (Notes 6)	The number of housing units with lead hazards eliminated within six (6) months 10 (Notes 6)
Adams	187	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Allen	3631	84	51	33	22	59	≤5	30	43	27	16	-	-	-	-
Bartholomew	735	5	≤5	≤5	≤5	≤5	≤5		2	-	2	-	-	-	-
Benton	84	≤5	≤5	≤5	≤5	≤5	≤5		1	-	-	-	-	-	-
Blackford	124	≤5	≤5	≤5	≤5	≤5	≤5		1	-	-	-	-	-	-
Boone	398	≤5	≤5	≤5	≤5	≤5	≤5		2	7	1	-	-	-	-
Brown	96	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Carroll	123	≤5	≤5	≤5	≤5	≤5	≤5		1	-	1	-	-	-	-
Cass	501	6	≤5	5	≤5	≤5	≤5		3	17	2	-	-	-	-
Clark	1251	≤5	≤5	≤5	≤5	≤5	≤5		1	-	-	-	-	-	-
Clay	207	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Clinton	282	≤5	≤5	≤5	≤5	≤5	≤5	68	2	-	1	-	-	-	-
Crawford	110	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Daviess	174	≤5	≤5	≤5	≤5	≤5	≤5		1	-	-	-	-	-	-
Dearborn	221	≤5	≤5	≤5	≤5	≤5	≤5		2	-	2	-	-	-	-

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Decatur	195	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
DeKalb	340	≤5	≤5	≤5	≤5	≤5	≤5		1	-	-	-	-	-	-
Delaware	1170	28	≤5	24	18	9	≤5		7	-	-	-	-	-	-
Dubois	227	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Elkhart	3697	40	≤5	36	25	17	≤5	45	8	-	7	-	-	-	-
Fayette	327	≤5	≤5	≤5	≤5	≤5	≤5		3	-	1	-	-	-	-
Floyd	562	8	≤5	7	≤5	≤5	≤5	43	3	-	-	-	-	-	-
Fountain	103	≤5	≤5	≤5	≤5	≤5	≤5		4	6	4	-		-	-
Franklin	144	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Fulton	129	≤5	≤5	≤5	≤5	≤5	≤5	27	1	-	-	-	-	-	-
Gibson	214	9	5	≤5	≤5	5	≤5	10	5	2	3	-	-	-	-
Grant	398	5	≤5	5	≤5	≤5	≤5	46	3	10	2	-	-	-	-
Greene	317	≤5	≤5	≤5	≤5	≤5	≤5		1	-	1	-	-	-	-
Hamilton	1290	6	≤5	6	5	≤5	≤5		-	-	-	-	-	-	-
Hancock	291	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-

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Harrison	358	5	≤5	5	≤5	≤5	≤5		-	-	-	-	-	-	-
Hendricks	314	≤5	≤5	≤5	≤5	≤5	≤5		1	-	-	-	-	-	-
Henry	519	6	≤5	≤5	≤5	≤5	≤5		4	15	-	-	-	-	-
Howard	1017	≤5	≤5	≤5	≤5	≤5	≤5	91	-	-	-	-	-	-	
Huntington	331	≤5	≤5	≤5	≤5	≤5	≤5		1	-	-	-	-	-	-
Jackson	349	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	
Jasper	206	≤5	≤5	≤5	≤5	≤5	≤5		2	-	-	-	-	-	-
Jay	202	≤5	≤5	≤5	≤5	≤5	≤5		1	-	-	-	-	-	
Jefferson	318	≤5	≤5	≤5	≤5	≤5	≤5		2	102	1	-	-	-	-
Jennings	378	≤5	≤5	≤5	≤5	≤5	≤5		2	44	2	-	-	-	-
Johnson	558	5	5	≤5	≤5	5	≤5		4	12	-	-	-	-	-
Knox	224	≤5	≤5	≤5	≤5	≤5	≤5		4	-	2	-	-	-	-
Kosciusko	365	≤5	≤5	≤5	≤5	≤5	≤5		1	-	-	-	-	-	-
La Grange	106	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Lake	4653	39	19	20	5	30	≤5	44	20	11	8	-	-	-	-

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LaPorte	898	5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Lawrence	598	≤5	≤5	≤5	≤5	≤5	≤5	53	2	8	2	-	-	-	-
Madison	1245	15	5	10	≤5	6	≤5	14	5	4	4	-	-	-	-
Marion	12048	79	55	24	18	66	≤5	24	64	4	41	-	-	-	-
Marshall	394	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Martin	115	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Miami	248	7	7	≤5	≤5	7	≤5		6	-	-	-	-	-	-
Monroe	1677	≤5	≤5	≤5	≤5	≤5	≤5		2	-	-	-	-	-	-
Montgomery	277	5	≤5	≤5	≤5	≤5	≤5	50	3	-	1	-	-	-	-
Morgan	484	5	≤5	≤5	≤5	≤5	≤5	31	3	-	-	-	-	-	-
Newton	79	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Noble	263	≤5	≤5	≤5	≤5	≤5	≤5		2	-	-	-	-	-	-
Ohio	17	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Orange	230	≤5	≤5	≤5	≤5	≤5	≤5		2	9	2	-	-	-	-
Owen	340	≤5	≤5	≤5	≤5	≤5	≤5	1	1	-	-	-	-	-	-

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Parke	52	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Perry	145	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Pike	41	≤5	≤5	≤5	≤5	≤5	≤5		1	-	-	-	-	-	-
Porter	666	5	≤5	≤5	≤5	≤5	≤5		1	15	1	-	-	-	-
Posey	206	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Pulaski	56	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Putnam	383	7	≤5	7	≤5	≤5	≤5		-	-	-	-	-	-	-
Randolph	182	≤5	≤5	≤5	≤5	≤5	≤5		2	-	1	-	-	-	-
Ripley	329	6	≤5	≤5	≤5	5	≤5		3	25	2	-	-	-	-
Rush	102	≤5	≤5	≤5	≤5	≤5	≤5		2	40	1	-	-	-	-
Scott	224	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Shelby	140	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Spencer	230	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
St. Joseph	4365	58	25	33	17	38	≤5	29	7	6	5	-	-	-	-
Starke	164	≤5	≤5	≤5	≤5	≤5	≤5		-	0	-	-	-	-	-

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COUNTY NAME	Number of children who received at least one blood Test (Note 1) 1	Number of children with blood lead level ≥ 10 µg /dL (Note 2) 2	Number of children with initial level ≥ 10 µg /dL venous (Note 3) 3(a)	Number of children with initial level ≥ 10 µg /dL Capillary (Note 3) 3(b)	Number of children with initial capillary blood lead Level ≥ 10µg/dL not returning for a confirmation test. (Note 3) 3(c)	*Number of children with confirmed blood Lead level ≥ 10µg/dL 4*	Number of children with false positives after Confirmation (Note 4) 5	Average number of days to confirm an initial Elevated capillary blood lead test result (Note 3) 6	Number of risk assessments performed for Confirmed elevated blood lead levels 7(a) (Notes 5)	Average number of days to perform a risk assessment 7(b) (Notes 5)	The number of housing units with documented lead hazards from the risk assessments performed 8 (Notes 6)	The number of housing units identified with lead Hazards and covered by orders issued under IC 13- 14-10-2 or by another governmental authority to eliminate lead hazards .9 (Notes 6)	The number of housing units with lead hazards eliminated within thirty (30) days 10 (a) (Notes 6)	The number of housing units with lead hazards eliminated within three (3) months 10 (b) (Notes 6)	The number of housing units with lead hazards eliminated within six (6) months 10 (c) (Notes 6)
Steuben	370	≤5	≤5	≤5	≤5	≤5	≤5	71	-	-	-	-	-	-	-
Sullivan	122	≤5	≤5	≤5	≤5	≤5	≤5		2	4	2	-	-	-	-
Switzerland	54	≤5	≤5	≤5	≤5	≤5	≤5		1	24	-	-	-	-	-
Tippecanoe	2183	8	≤5	7	6	≤5	≤5	82	5	2	1	-	-	-	-
Tipton	49	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Union	91	≤5	≤5	≤5	≤5	≤5	≤5		2	7	1	-	-	-	-
Vanderburgh	2315	29	9	20	≤5	12	7	24	10	-	-	-	-	-	-
Vermillion	68	≤5	≤5	≤5	≤5	≤5	≤5		1	-	-	-	-	-	-
Vigo	1360	10	≤5	7	5	≤5	≤5		4	-	3	-	-	-	-
Wabash	311	≤5	≤5	≤5	≤5	≤5	≤5		1	-	-	-	-	-	-
Warren	35	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Warrick	254	≤5	≤5	≤5	≤5	≤5	≤5		1	-	-	-	-	-	-
Washington	197	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Wayne	1052	22	8	14	≤5	12	≤5		5	60	3	-	-	-	-
Wells	186	≤5	≤5	≤5	≤5	≤5	≤5	26	1	-	1	-	-	-	-
White	126	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Whitley	127	≤5	≤5	≤5	≤5	≤5	≤5		-	-	-	-	-	-	-
Unknown	2110	18	10	8	6	9	≤5		-	-	-	-	-	-	-
Total	**64359**	**606**	**264**	**342**	**206**	**375**	**27**		**277**			-	-	-	-

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*To protect the privacy of the child, if the number is less than or equal to 5 (including 0), it is represented as "≤5"

Notes on data:

1. For calendar year 2008, 63,320 children 0 to 7 years old were reported to ISDH as receiving at least one blood lead test.
2. All children 0 to 7 years with a capillary and venous blood draw ≥ug/dL and these are initial elevated blood lead levels.
3. Data on "average days to confirm an elevated blood lead level" reflect only the interval between an initial elevated capillary test and a confirming capillary or venous test. Column 3a is for venous elevated blood lead levels, 3b is for capillary elevated blood lead levels, and 3c is for number of children not receiving a confirmatory test.
4. * New number of children with elevated blood lead levels: The number of children who have never been identified by the reporting jurisdiction to have a previously confirmed elevated blood lead level (in a specified age range and geographic area) with a confirmed elevated blood lead level in a given time.

(Confirmed) Elevated blood lead level: A blood lead level that meets any of the following criteria is considered a confirmed elevated blood lead level: one venous blood specimen with lead concentration greater than or equal to 10 μg/dL; or the second of two capillary, two unknown, or two alternating (capillary and unknown) sample type blood specimens, drawn within 12 weeks (84 days) of each other, both with lead concentration greater than or equal to 10 μg/dL; False positive tests are those tests confirmed at ≤ 10ug/dL.

5. Risk assessments are counted if they were completed for a child identified as poisoned in the reporting year. Average number of days to perform a risk assessment represent the average time period between the risk assessment referred and completed
6. The items 8, 9, and 10, include reporting of the number of houses found to have lead hazards, the number of remediation or abatement orders issued, and the number of houses with lead hazards corrected.