

# **CORE CITIES DATA 1998–2007**



**A SUPPLEMENT TO  
CHILDHOOD LEAD POISONING  
IN RHODE ISLAND:  
THE NUMBERS, 2008 EDITION**



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# ELIMINATING CHILDHOOD LEAD POISONING IN RHODE ISLAND BY 2010

**GOAL:** To eliminate childhood lead poisoning in Rhode Island by the end of 2010.

**MILESTONE:** To decrease the number of new cases of lead poisoning (blood lead level  $\geq 10 \mu\text{g/dL}$ ) in children under six years of age in all Rhode Island communities without displacing children, decreasing screening rates, or decreasing access to affordable housing.

In 2004, Rhode Island developed a Plan to Eliminate Childhood Lead Poisoning by 2010. This plan focuses on promoting primary prevention while maintaining secondary prevention efforts in the state. Primary prevention reduces or eliminates lead hazards in the environment before a child is exposed. Secondary prevention includes universal screening of children to identify those with elevated blood lead levels (BLL), and in turn, removing or reducing any further exposure to the child. Additional details about RI CLPPP's elimination plan and how we are measuring our progress toward elimination can be found on the web at [www.health.ri.gov/lead](http://www.health.ri.gov/lead).



# UNDERSTANDING BLOOD LEAD LEVELS

## WHAT IS A LEVEL OF CONCERN?

A level of concern is the threshold used to define an elevated blood lead level. Children with a blood lead level greater than the level of concern (i.e. children with an elevated blood lead level) should be monitored and re-tested. Primary prevention activities, such as community-wide environmental interventions and nutritional and educational campaigns, should be directed at reducing children's blood lead levels below the level of concern. Currently, CDC has defined the level of concern as  $\geq 10 \mu\text{g}/\text{dL}$ .

## SHOULD WE LOWER THE BLOOD LEAD LEVEL OF CONCERN?

In response to questions about whether to change the "level of concern," based on recent research that found that blood lead levels lower than  $10 \mu\text{g}/\text{dL}$  can have harmful effects,<sup>1,2</sup> CDC has prepared the following statement, which can be found on the web at: [www.cdc.gov/nceh/lead/policy/changeBLL.htm](http://www.cdc.gov/nceh/lead/policy/changeBLL.htm)

"Recent studies suggest that adverse health effects exist in children at blood lead levels less than  $10 \mu\text{g}/\text{dL}$ . In the past, CDC has lowered the level considered elevated in response to similar reports. However, at this time the reasons not to lower the level of concern are as follows:

Primary prevention activities, such as community-wide environmental interventions and nutritional and educational campaigns, should be directed at reducing children's blood lead levels below the level of concern.

- No effective clinical interventions are known to lower the blood lead levels for children with levels less than  $10 \mu\text{g}/\text{dL}$  or to reduce the risk for adverse developmental effects.
- Children cannot be accurately classified as having blood lead levels above or below a value less than  $10 \mu\text{g}/\text{dL}$  because of the inaccuracy inherent in laboratory testing.
- Finally, there is no evidence of a threshold below which adverse effects are not experienced. Thus, any decision to establish a new level of concern would be arbitrary and provide uncertain benefits.

These studies support making primary prevention of childhood lead poisoning a high priority for health, housing, and environmental agencies at the state, local, and federal levels."

## WHAT IS AN ACTION LEVEL?

An action level is the threshold at which interventions should be implemented based on evidence that the interventions are effective. It is impossible to define one action level for all interventions, so various action levels trigger different interventions. According to CDC guidelines, community prevention activities, such as nutritional and educational campaigns,

1 Canfield RL, Henderson CR, Cory-Slechta DA, Cox C, Jusko TA, Lanphear BP. Intellectual impairment in children with blood lead concentrations below  $10 \mu\text{g}$  per Deciliter. *New England Journal of Medicine* 2003; 348:1517-26.

2 Selevan SG, Rice DC, Hogan KA, Euling SY, Pfahles-Hutchens A, Bethel J. Blood Lead Concentration and Delayed Puberty in Girls. *New England Journal of Medicine* 2003; 348:1527-36.

should be implemented at blood lead levels  $\geq 10 \mu\text{g/dL}$ , and individual prevention activities, such as case management and environmental investigations, should be implemented at blood lead levels  $\geq 15 \mu\text{g/dL}$ .<sup>3</sup> For example, while the overall goal is to reduce children’s blood lead levels below  $10 \mu\text{g/dL}$ , there are reasons for not implementing individual, environmental, and medical interventions for children with blood lead levels between 10 and  $14 \mu\text{g/dL}$ . Effective environmental and medical interventions for

children with blood lead levels in this range have not yet been identified. Given limited resources, the sheer number of children in this range would preclude effective case management and would detract from the individualized follow-up required by children with higher blood lead levels.

**LEAD ACTION LEVELS IN RHODE ISLAND**

The guidelines issued by CDC were used to define various action levels in Rhode Island. The different action levels are detailed in the table below.

CATEGORY	ACTION LEVEL	ACTION
<b>ELEVATED BLOOD LEAD LEVEL</b>	One BLL between 10-14 $\mu\text{g/dL}$	<b>CAPILLARY:</b> Letter sent to Primary Care Provider recommending venous test to confirm the BLL*  <b>VENOUS:</b> Letter sent to family inviting them to call the HEALTH Information Line 800-942-7434 or visit the website for additional information <a href="http://www.health.ri.gov/lead">www.health.ri.gov/lead</a>
	One BLL between 15-19 $\mu\text{g/dL}$	<b>CAPILLARY:</b> Letter sent to Primary Care Provider recommending venous test to confirm the BLL  <b>VENOUS:</b> Family is referred to a lead center** for an in-home lead education visit and some environmental intervention (i.e. temporary lead hazard control measures, window replacement)
<b>SIGNIFICANT LEAD POISONING</b>	One Venous BLL $\geq 20 \mu\text{g/dL}$ ~ or ~ Two Venous BLLs 15-19 $\mu\text{g/dL}$ done 90-365 days apart***	Family is referred to a lead center for an in-home lead education visit and is offered an environmental inspection.

\* In addition to the actions described, a letter is sent to families living in Providence ONLY, informing them that they can contact the City of Providence for a free environmental inspection of their home.

\*\* A lead center is a non-profit agency funded by Medicaid that offers comprehensive case management services to families of children with lead poisoning.

\*\*\* Two venous blood lead levels 15-19  $\mu\text{g/dL}$  done between 90 and 365 days apart may also be referred to as "Persistent Lead Poisoning." Prior to January 1, 2006, two blood lead levels, capillary or venous,  $\geq 15 \mu\text{g/dL}$  were used to define persistent lead poisoning.

<sup>3</sup> CDC. Preventing Lead Poisoning in Young Children. Atlanta: U.S. Department of Health and Human Services, 1991.

# UNDERSTANDING THE LEAD DATA

In Rhode Island, healthcare providers are required by law to annually screen their patients between nine months and six years of age for lead poisoning. The screening process involves collecting a sample of blood from the child, either from a capillary (finger stick) or a vein (venous test), and analyzing the blood to determine the amount of lead in the sample. Blood lead levels are measured and reported as micrograms of lead per deciliter of blood ( $\mu\text{g}/\text{dL}$  or  $\text{mcg}/\text{dL}$ ).

The data presented in this report are based on all blood lead results, both capillary and venous, performed on children from birth to six years of age in the state of Rhode Island. Although the guidelines recommend that children begin screening at nine months of age, some children may be screened earlier if they are at high risk for lead poisoning. For the incidence and prevalence analyses, each child is represented once per year in which he was screened.

The data presented in this report are based on all blood lead results, both capillary and venous, performed on children from birth to six years of age in the state of Rhode Island.



## RACE AND ETHNICITY DATA

The collection of race and ethnicity data is an important part of public health. These data allow us to monitor disease trends, track health status, and assess progress in improving health among various populations. These data also help us assure non-discriminatory healthcare access and treatment, identify issues surrounding access to care and discrimination, and track the extent to which members of

minority groups are beneficiaries of and participants in federally assisted programs.

Despite the mandate to collect this information, race and ethnicity data are often incomplete. Approximately 40-50% of blood lead records collected from laboratories and hospitals report race and ethnicity; therefore, lead poisoning information presented in this report is not broken down by race and ethnicity.

In 2004, RI CLPPP conducted a survey to better understand the barriers to collecting race and ethnicity information. The survey findings, which can be found in more detail on the web at

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<sup>4</sup> The numbers presented here are estimates, given that calculations in this document are based on screening data rather than population data for all children under the age of six.

www.health.ri.gov/lead indicate that while clients did not object to reporting their race and ethnicity, most laboratory professionals were uncomfortable asking people about their race and ethnicity, and some were not aware that they were required to collect race and ethnicity information. Laboratory professionals were not interested in receiving training, however. In an effort to educate the public about the importance of reporting race and ethnicity information, RI CLPPP plans to send informational posters to all licensed laboratories in the state annually.

#### **CONFIRMED TESTS IN 2005-2007**

Prior to July 1, 2004, if a child under the age of six had a capillary blood lead level  $\geq 20 \mu\text{g}/\text{dL}$ , the Rhode Island Department of Health would

recommend that the child have a confirmatory venous test within three months. On July 1, 2004, the Rhode Island Department of Health revised the Lead Screening and Referral Guidelines and began recommending a confirmatory venous test for any child under the age of six who had a capillary blood lead level  $\geq 10 \mu\text{g}/\text{dL}$  (instead of  $\geq 20 \mu\text{g}/\text{dL}$ ). The Rhode Island Department of Health is also recommending that only venous tests be used for confirmatory purposes. Since these changes went into effect in July 2004, the first full year for which RI CLPPP has confirmed capillary test data is 2005. As a result, 2005-2007 data in this document are based on venous and confirmed capillary tests only. The data presented for previous years are based on all venous and capillary tests.



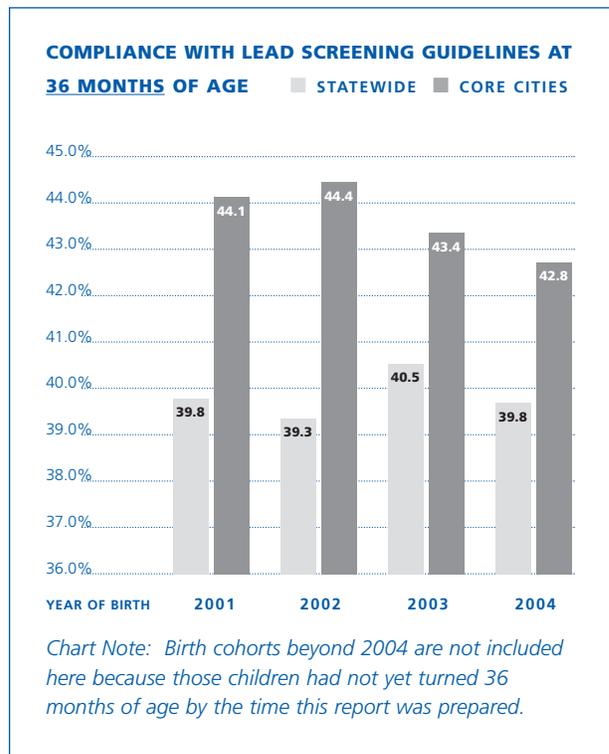
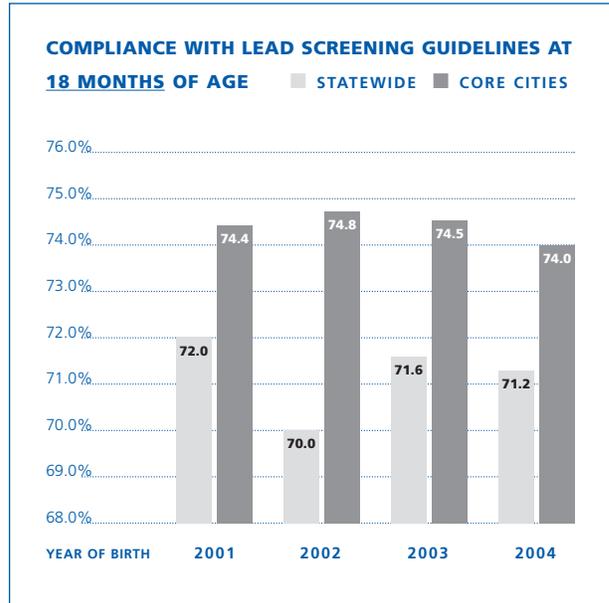
# COMPLIANCE WITH SCREENING GUIDELINES

All healthcare providers in Rhode Island are required by law to annually screen their patients between nine months and six years of age for lead poisoning. Compliance with these guidelines is assessed by measuring the proportion of children born in a given year with at least one blood lead test by 18 months of age, and at least two blood lead tests, no less than 12 months apart, by 36 months of age.

Approximately 70% of all Rhode Island children born between 2001 and 2004 were screened for lead poisoning at least once by 18 months of age. When looking only at children living in the core cities, the percent of children screened at least once by 18 months of age increases to approximately 74%.

The same pattern is evident among children 36 months of age. Statewide, approximately 40% of children are screened twice, a minimum of 12 months apart, by 36 months of age. When looking only at children living in the core cities, the percent of children screened in compliance with the screening guidelines at 36 months of age increases to approximately 44%.

The increased screening rates in the core cities indicate that we are screening the high-risk populations in Rhode Island. Although this is a success, we still need to focus on increasing screening compliance among children 36 months of age.



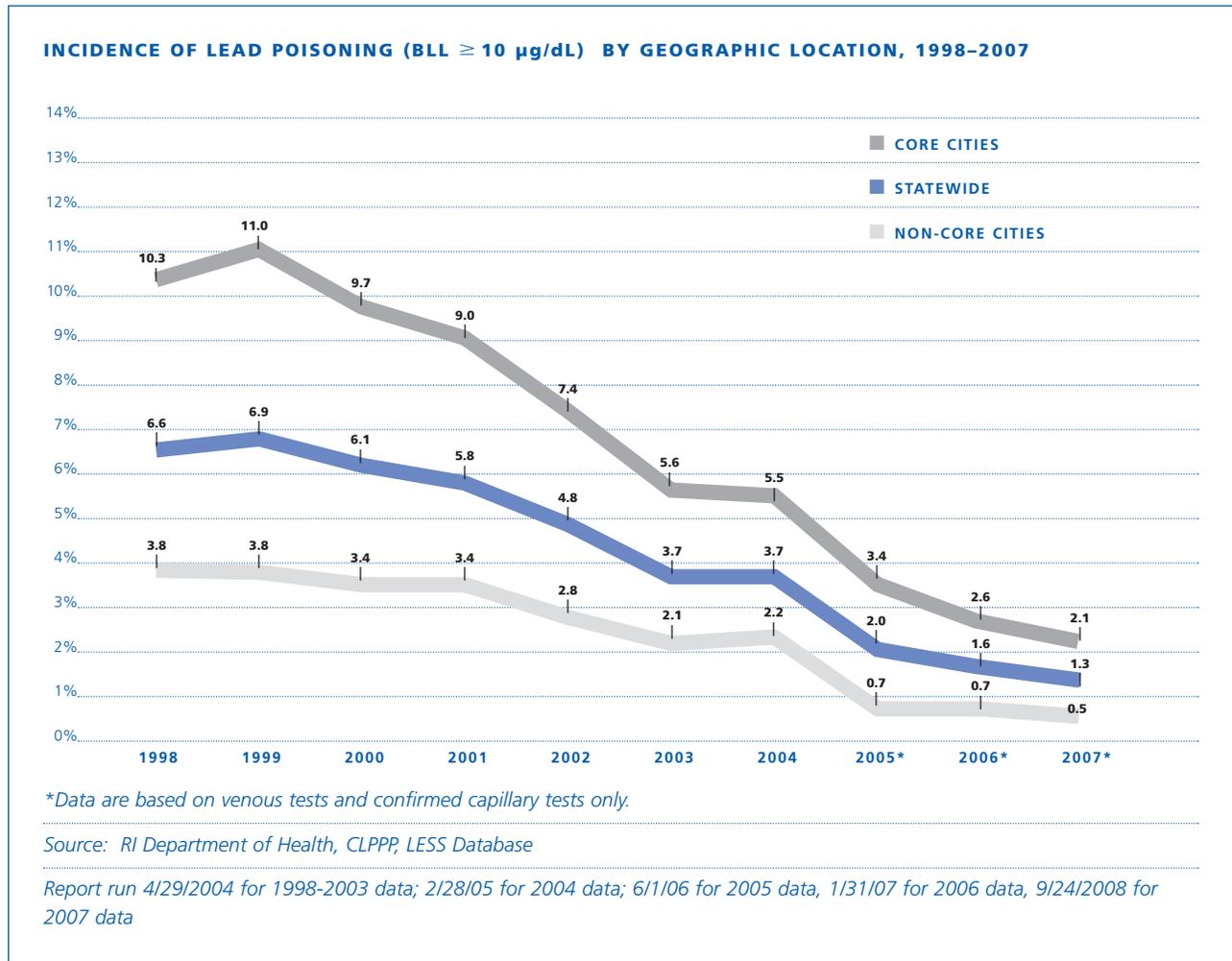
# INCIDENCE OF LEAD POISONING OVER TIME

The Rhode Island Department of Health tracks and reports the number of newly lead poisoned children each year. This is known as the incidence of lead poisoning. Incident cases include children with a blood lead level  $\geq 10 \mu\text{g}/\text{dL}$  for the first time who are less than six years of age.

Although all Rhode Island cities and towns have experienced a dramatic decline in incidence

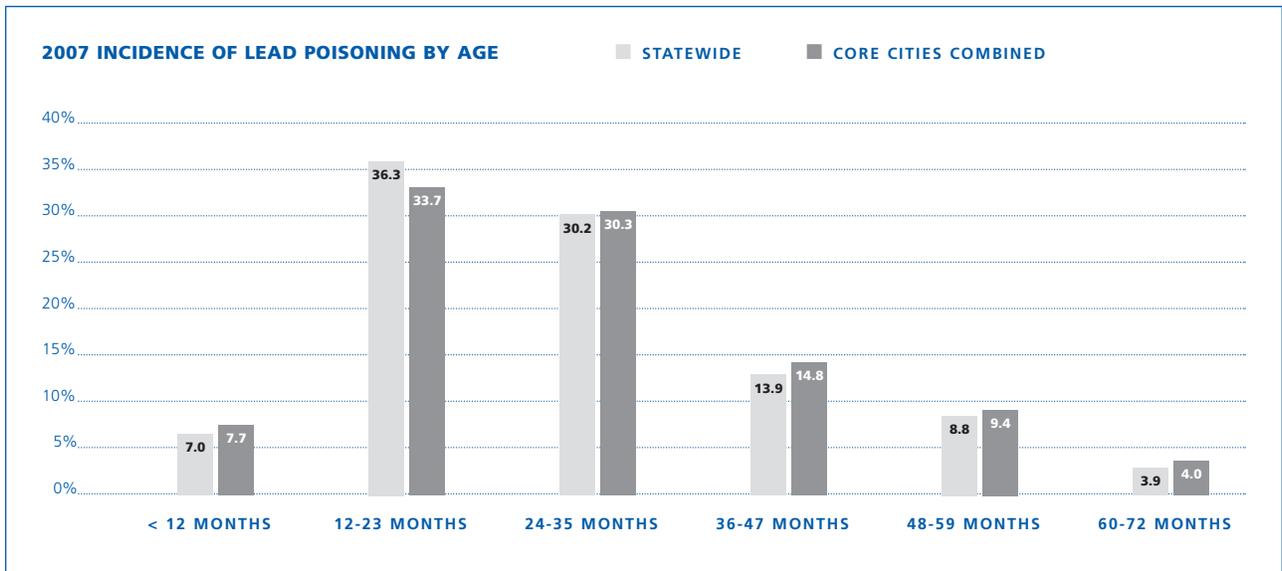
over the last ten years, cases of lead poisoning continue to be concentrated in the core cities. In 2007, 297 (77%) of the 388 newly lead poisoned children were living in the core cities.

Rhode Island must maintain primary prevention efforts in order to protect additional children from becoming lead poisoned and to eliminate childhood lead poisoning by 2010.



# INCIDENCE OF LEAD POISONING BY AGE

The distribution of newly lead poisoned children by age in the core cities in 2007 is similar to the statewide distribution. In the core cities and statewide, most first-time poisonings occur among one and two-year-old children. Of the 297 newly lead poisoned children in the core cities in 2007, 23 were identified as lead poisoned before the age of one, 100 were identified at age one, 90 were identified at age two, 44 were identified at age three, 28 were identified at age four, and 12 were identified at age five.

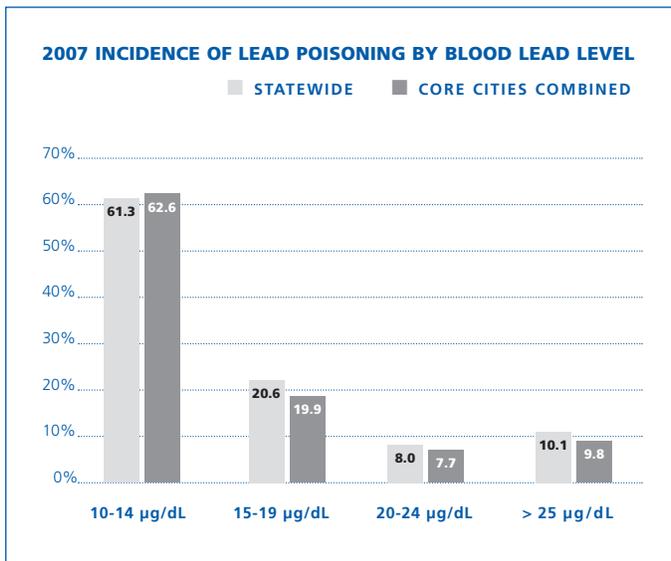


# INCIDENCE OF LEAD POISONING BY BLOOD LEAD LEVEL

The distribution of newly lead poisoned children by blood lead level in the core cities in 2007 follows the same trend as the statewide distribution. In the core cities, as well as statewide, lead poisoning is being detected among the majority of children when their blood lead levels are in the 10-14 µg/dL range. In the

The concentration of children with elevated blood lead levels in the core cities suggests that these areas have a greater need for special education and health care services

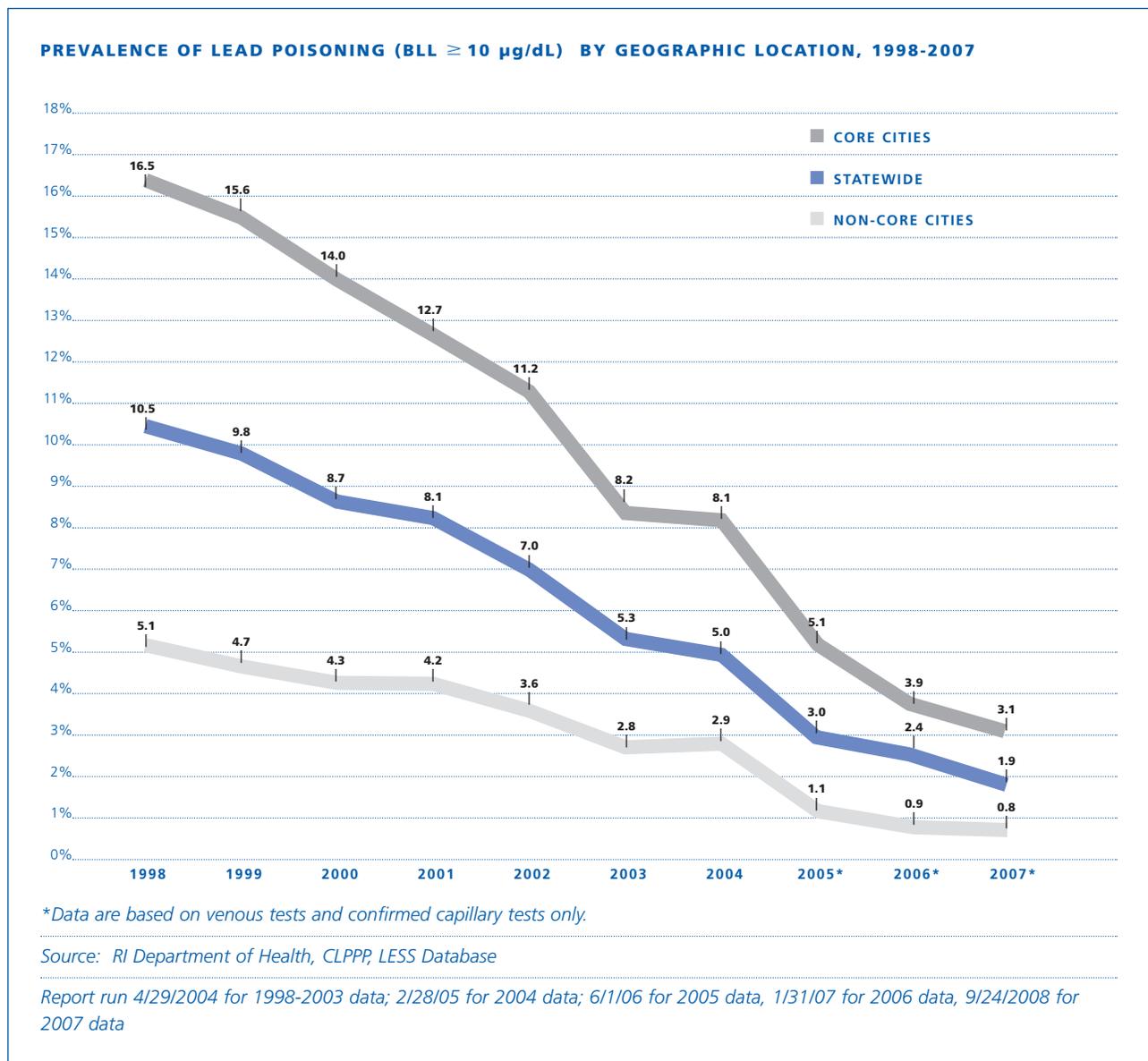
core cities, 186 (63%) of the 297 children lead poisoned in 2007 had a blood lead level between 10 and 14 µg/dL. This indicates that screening practices are successfully identifying children with elevated blood lead levels before they become highly elevated.



# PREVALENCE OF LEAD POISONING OVER TIME

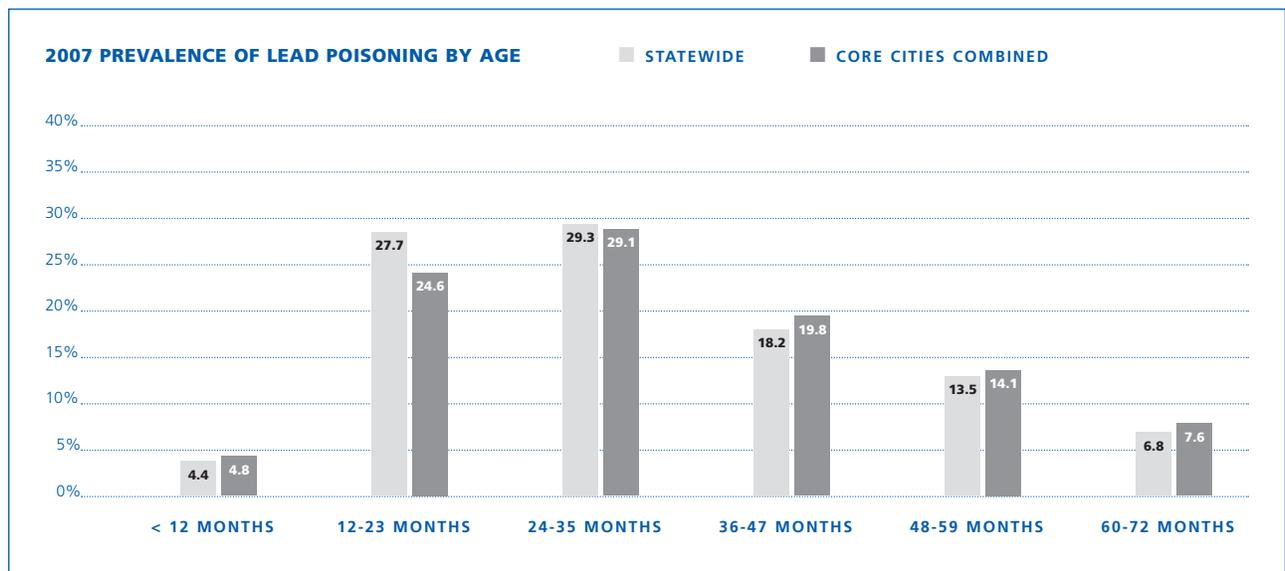
Over the past ten years, the prevalence of lead poisoning has declined throughout the state. The majority of the cases, however, are concentrated in the core cities. In 2007, 475 (77%) of the 614 children with lead poisoning lived in the core cities.

In order to decrease the number of prevalent cases of lead poisoning in the future, we must continue to work on promoting policies to increase lead-safe affordable housing.



# PREVALENCE OF LEAD POISONING BY AGE

The distribution of lead poisoned children by age in the core cities is similar to the statewide distribution. The majority of lead poisoned children in the core cities in 2007 were between the ages of one and two. Of the 475 children lead poisoned in the core cities, 117 were one year of age and 138 were two years of age. Twenty-three lead poisoned children were under one year of age, 94 were three years of age, 67 were four years of age, and 36 were five years of age.



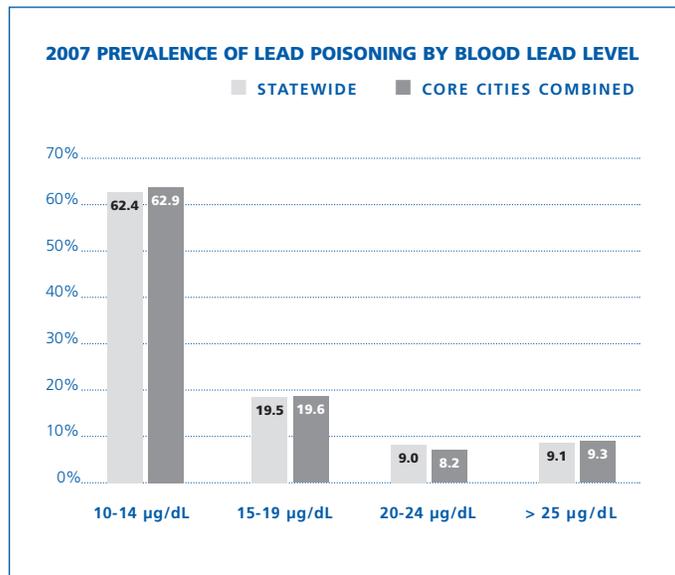
# PREVALENCE OF LEAD POISONING BY BLOOD LEAD LEVEL

The distribution of lead poisoned children by blood lead level in the core cities in 2007 is similar to the statewide distribution.

Approximately two thirds of lead poisoned children in the core cities had a blood lead level between 10-14 µg/dL. Of the 475 lead poisoned children in the core cities in 2007,

Rhode Island must continue to focus on primary prevention and lead-safe housing to protect more children from becoming lead poisoned in the future.

299 (63%) had blood lead levels between 10-14 µg/dL, and 93 had blood lead levels between 15-19 µg/dL. Of the 83 children who had blood lead levels greater than 20 µg/dL, 39 had blood lead levels between 20-24 µg/dL, and 44 children had blood lead levels greater than 25 µg/dL.





# TABLES

**TABLE 1A. COMPLIANCE WITH LEAD SCREENING GUIDELINES AT 18 MONTHS OF AGE**

YEAR BORN	CORE CITIES		STATEWIDE	
	TOTAL # CHILDREN BORN	# CHILDREN SCREENED AT LEAST ONCE BY 18 MONTHS OF AGE	TOTAL # CHILDREN BORN	# CHILDREN SCREENED AT LEAST ONCE BY 18 MONTHS OF AGE
2001	7,353	5,470 (74.4%)	12,884	9,278 (72.0%)
2002	7,609	5,689 (74.8%)	13,178	9,229 (70.0%)
2003	8,023	5,981 (74.5%)	13,471	9,640 (71.6%)
2004	6,386	4,728 (74.0%)	13,277	9,447 (71.2%)

**TABLE 1B. COMPLIANCE WITH LEAD SCREENING GUIDELINES AT 36 MONTHS OF AGE**

YEAR BORN	CORE CITIES		STATEWIDE	
	TOTAL # CHILDREN BORN	# CHILDREN SCREENED AT LEAST ONCE BY 18 MONTHS OF AGE	TOTAL # CHILDREN BORN	# CHILDREN SCREENED AT LEAST ONCE BY 18 MONTHS OF AGE
2001	7,353	3,240 (44.1%)	12,884	5,134 (39.8%)
2002	7,609	3,382 (44.4%)	13,178	5,177 (39.3%)
2003	8,023	3,483 (43.4%)	13,471	5,454 (40.5%)
2004	6,386	2,736 (42.8%)	13,277	5,286 (39.8%)

**TABLE 2A. NEW LEAD POISONING CASES OVER TIME IN CORE CITIES**

YEAR	NUMBER OF CHILDREN WITH BLL $\geq$ 10 $\mu$ /gDL FOR THE 1ST TIME	NUMBER OF CHILDREN SCREENED WITH NO PREVIOUS ELEVATED BLL	INCIDENCE
1998	1,273	12,372	10.3%
1999	1,410	12,787	11.0%
2000	1,200	12,400	9.7%
2001	1,277	14,164	9.0%
2002	1,041	14,003	7.4%
2003	811	14,493	5.6%
2004	799	14,581	5.5%
2005	498	14,522	3.4%
2006	387	14,625	2.6%
2007	297	14,392	2.1%

**TABLE 2B. NEW LEAD POISONING CASES OVER TIME IN NON-CORE CITIES**

YEAR	NUMBER OF CHILDREN WITH BLL $\geq$ 10 $\mu$ /gdL FOR THE 1ST TIME	NUMBER OF CHILDREN SCREENED WITH NO PREVIOUS ELEVATED BLL	INCIDENCE
1998	606	15,861	3.8%
1999	623	16,476	3.8%
2000	550	16,077	3.4%
2001	597	17,756	3.4%
2002	509	18,018	2.8%
2003	364	17,143	2.1%
2004	377	17,107	2.2%
2005	123	17,142	0.7%
2006	113	16,953	0.7%
2007	91	16,597	0.5%

**TABLE 2C. NEW LEAD POISONING CASES OVER TIME STATEWIDE**

YEAR	NUMBER OF CHILDREN WITH BLL $\geq$ 10 $\mu$ /gdL FOR THE 1ST TIME	NUMBER OF CHILDREN SCREENED WITH NO PREVIOUS ELEVATED BLL	INCIDENCE
1998	1,870	28,170	6.6%
1999	2,025	29,187	6.9%
2000	1,740	28,419	6.1%
2001	1,857	31,848	5.8%
2002	1,535	31,954	4.8%
2003	1,161	31,579	3.7%
2004	1,167	31,610	3.7%
2005	624	31,669	2.0%
2006	500	31,578	1.6%
2007	388	30,989	1.3%

**TABLE 3A. NEW LEAD POISONING CASES BY AGE IN CORE CITIES 2007**

AGE	# CHILDREN WITH BLL $\geq$ 10 $\mu$ g/dL FOR THE 1ST TIME	% OF CHILDREN WITH BLL $\geq$ 10 $\mu$ g/dL FOR THE 1ST TIME
<12 months	23	7.7
12-23 months	100	33.7
24-35 months	90	30.3
36-47 months	44	14.8
48-59 months	28	9.4
60-72 months	12	4.0
<b>Total</b>	<b>297</b>	<b>100.0</b>

**TABLE 3B. NEW LEAD POISONING CASES BY AGE STATEWIDE 2007**

AGE	# CHILDREN WITH BLL $\geq$ 10 $\mu$ g/dL FOR THE 1ST TIME	% OF CHILDREN WITH BLL $\geq$ 10 $\mu$ g/dL FOR THE 1ST TIME
<12 months	27	7.0
12-23 months	141	36.3
24-35 months	117	30.2
36-47 months	54	13.9
48-59 months	34	8.8
60-72 months	15	3.9
<b>Total</b>	<b>388</b>	<b>100.0</b>

**TABLE 4A. NEW LEAD POISONING CASES BY BLOOD LEAD LEVEL IN CORE CITIES 2007**

BLOOD LEAD LEVEL	# CHILDREN WITH ELEVATED BLL FOR THE 1ST TIME	% OF CHILDREN WITH BLL ≥ 10 µg/dL FOR THE 1ST TIME
10-14 µg/dL	186	62.6
15-19 µg/dL	59	19.9
20-24 µg/dL	23	7.7
25+ µg/dL	29	9.8
<b>Total</b>	<b>297</b>	<b>100.0</b>

**TABLE 4B. NEW LEAD POISONING CASES BY BLOOD LEAD LEVEL STATEWIDE 2007**

BLOOD LEAD LEVEL	# CHILDREN WITH ELEVATED BLL FOR THE 1ST TIME	% OF CHILDREN WITH BLL ≥ 10 µg/dL FOR THE 1ST TIME
10-14 µg/dL	238	61.3
15-19 µg/dL	80	20.6
20-24 µg/dL	31	8.0
25+ µg/dL	39	10.1
<b>Total</b>	<b>388</b>	<b>100.0</b>

**TABLE 5A. PREVALENCE OF LEAD POISONING OVER TIME IN CORE CITIES**

YEAR	NUMBER OF CHILDREN WITH BLL ≥ 10µg/dL	NUMBER OF CHILDREN SCREENED	PREVALENCE
1998	2,584	15,648	16.5%
1999	2,402	15,407	15.6%
2000	2,030	14,511	14.0%
2001	2,068	16,295	12.7%
2002	1,801	16,074	11.2%
2003	1,331	16,275	8.2%
2004	1,210	14,955	8.1%
2005	793	15,626	5.1%
2006	615	15,617	3.9%
2007	475	15,149	3.1%

**TABLE 5B. PREVALENCE OF LEAD POISONING OVER TIME IN NON-CORE CITIES**

YEAR	NUMBER OF CHILDREN WITH BLL ≥ 10µg/dL	NUMBER OF CHILDREN SCREENED	PREVALENCE
1998	874	17,127	5.1%
1999	819	17,503	4.7%
2000	729	16,948	4.3%
2001	775	18,666	4.2%
2002	676	18,853	3.6%
2003	503	17,938	2.8%
2004	493	17,280	2.9%
2005	188	17,460	1.1%
2006	154	17,200	0.9%
2007	139	16,812	0.8%

**TABLE 5C. PREVALENCE OF LEAD POISONING OVER TIME STATEWIDE**

YEAR	NUMBER OF CHILDREN WITH BLL ≥ 10µg/dL	NUMBER OF CHILDREN SCREENED	PREVALENCE
1998	3,437	32,684	10.5%
1999	3,208	32,816	9.8%
2000	2,741	31,382	8.7%
2001	2,813	34,865	8.1%
2002	2,450	34,835	7.0%
2003	1,811	34,130	5.3%
2004	1,685	33,839	5.0%
2005	981	33,086	3.0%
2006	790	32,838	2.4%
2007	614	31,961	1.9%

**TABLE 6A. PREVALENCE OF LEAD POISONING BY AGE IN CORE CITIES 2007**

AGE	# CHILDREN WITH BLL ≥ 10 µg/dL	% OF CHILDREN WITH BLL ≥ 10 µg/dL
<12 months	23	4.8
12-23 months	117	24.6
24-35 months	138	29.1
36-47 months	94	19.8
48-59 months	67	14.1
60-72 months	36	7.6
<b>Total</b>	<b>475</b>	<b>100.0</b>

**TABLE 6B. PREVALENCE OF LEAD POISONING BY AGE STATEWIDE 2007**

AGE	# CHILDREN WITH BLL ≥ 10 µg/dL	% OF CHILDREN WITH BLL ≥ 10 µg/dL
<12 months	27	4.4
12-23 months	170	27.7
24-35 months	180	29.3
36-47 months	112	18.2
48-59 months	83	13.5
60-72 months	42	6.8
<b>Total</b>	<b>614</b>	<b>100.0</b>

**TABLE 7A. PREVALENCE OF LEAD POISONING BY BLOOD LEAD LEVEL IN CORE CITIES 2007**

BLOOD LEAD LEVEL	# CHILDREN WITH ELEVATED BLOOD LEAD LEVELS	% OF CHILDREN WITH ELEVATED BLOOD LEAD LEVELS
10-14 µg/dL	299	62.9
15-19 µg/dL	93	19.6
20-24 µg/dL	39	8.2
25+ µg/dL	44	9.3
<b>Total</b>	<b>475</b>	<b>100.0</b>

**TABLE 7B. PREVALENCE OF LEAD POISONING BY BLOOD LEAD LEVEL STATEWIDE 2007**

BLOOD LEAD LEVEL	# CHILDREN WITH ELEVATED BLOOD LEAD LEVELS	% OF CHILDREN WITH ELEVATED BLOOD LEAD LEVELS
10-14 µg/dL	383	62.4
15-19 µg/dL	120	19.5
20-24 µg/dL	55	9.0
25+ µg/dL	56	9.1
<b>Total</b>	<b>614</b>	<b>100.0</b>

# GLOSSARY

## **Abatement**

An activity that reduces the risk of human exposure to lead.

## **BLL**

Blood lead level.

## **CDC**

Centers for Disease Control and Prevention

## **Elevated Blood Lead Level**

One blood lead test result between 10-19 µg/dL.

## **Incidence**

The proportion of new cases of a disease that develop during a specified period of time among the population at risk for developing the disease. For example, the incidence of lead poisoning in Rhode Island in 2008 is the proportion of children with a first-time blood lead level  $\geq 10$  µg/dL among those at risk for developing lead poisoning (i.e. children under age six who have never been lead poisoned in the past).

## **Lead Center**

A non-profit agency funded by Medicaid that offers comprehensive case management services to families of children with lead poisoning.

## **Prevalence**

The proportion of people in a population who have a given disease at a specific point in time. For example, prevalence of lead poisoning in 2008 is the proportion of children who had a blood lead level  $\geq 10$  µg/dL in 2008.

## **RI CLPPP**

The Rhode Island Childhood Lead Poisoning Prevention Program.

## **Screening**

A mandatory test that involves collecting a blood sample from a child under the age of six, either through a finger stick or a venipuncture, who does not show any signs or symptoms of lead poisoning, and then analyzing the sample to determine the amount of lead in the child's blood.

## **Significant Lead Poisoning**

A venous blood lead level  $\geq 20$  µg/dL in a child under six years of age, or two venous blood lead levels 15-19 µg/dL from a child under six years of age, done between 90 and 365 days apart.

## **µg/dL**

Micrograms per deciliter of blood. The measurement used to estimate the amount of lead in a sample of blood. This measure is sometimes represented as mcg/dL.

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Additional lead poisoning data can be found at [www.health.ri.gov/lead](http://www.health.ri.gov/lead)

