



DEPARTMENT OF THE NAVY  
BUREAU OF MEDICINE AND SURGERY  
7700 ARLINGTON BOULEVARD  
FALLS CHURCH VA 22042

IN REPLY REFER TO  
BUMEDINST 6200.14D  
BUMED-M3  
30 Aug 2017

BUMED INSTRUCTION 6200.14D

From: Chief, Bureau of Medicine and Surgery

Subj: CHILDHOOD LEAD POISONING PREVENTION

- Ref:
- (a) Health Effects of Low-Level Lead, National Toxicology Program, U.S. Department of Health and Human Services, Jun 2012
  - (b) Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention, Report of the Advisory Committee on Childhood Lead Poisoning Prevention of the Centers for Disease Control and Prevention (CDC), 4 Jan 2012
  - (c) CDC Response to Advisory Committee on Childhood Lead Poisoning Prevention Recommendations in "Low Level Lead Exposure Harms Children: A Renewed Call of Primary Prevention," 7 Jun 2012
  - (d) Prevention of Childhood Lead Toxicity, Council on Environmental Health, Pediatrics, 2016; 138; 1
  - (e) OPNAV M-5090.1 of 10 Jan 2014
  - (f) OPNAV memo 5090 Ser N45/14U132588 of 8 Feb 2014 (NOTAL)

1. Purpose. To establish policy and procedures for Navy Medicine's role in the prevention of childhood lead poisoning. This instruction is a complete revision and must be reviewed in its entirety.

2. Cancellation. BUMEDINST 6200.14C.

3. Scope. This instruction applies to all medical treatment facilities (MTF) serving pediatric populations.

4. Background. Childhood lead poisoning is a serious, yet preventable disease. Low levels of lead in a child's blood may cause irreversible adverse health effects. The best way to protect children is to prevent exposure to lead. Navy Medicine personnel play an important role in the prevention of lead exposure and in the early identification and management of lead exposed children.

a. As indicated in reference (a), epidemiological studies continue to provide evidence of adverse health effects at lower blood lead levels (BLL). Reference (a) is available at: <https://ntp.niehs.nih.gov/pubhealth/hat/noms/lead/index.html>. No safe BLLs in children have been identified. Based on the growing body of scientific studies concluding that BLLs below the previously accepted level of concern of 10 micrograms per deciliter harm children, the Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP) advised the Secretary of the

U.S. Department of Health and Human Services (HHS) and the Director of Centers for Disease Control and Prevention (CDC) to use a reference level of 5 micrograms per deciliter to identify children for intervention, reducing the child's future exposure to lead, per references (b) and (c). References are available at: [https://www.cdc.gov/nceh/lead/acclpp/acclpp\\_main.htm](https://www.cdc.gov/nceh/lead/acclpp/acclpp_main.htm). The ACCLPP also recommended making the implementation of primary lead exposure prevention strategies a priority.

b. The HHS identified eliminating elevated BLL in children as a goal of utmost importance to public health. Additional information is available at: <https://www.healthypeople.gov/2020/topics-objectives/topic/environmental-health>. The CDC, a division of the HHS, has the primary responsibility to develop programs and policies to prevent childhood lead poisoning in the United States. The CDC considers childhood lead poisoning the most preventable environmental disease of young children.

c. Along with a revised reference BLL consistent with ACCLPP recommendations, and in keeping with a renewed focus on primary prevention, the American Academy of Pediatrics (AAP) has released updated childhood lead poisoning screening recommendations, reference (d), available at: <http://pediatrics.aappublications.org/content/pediatrics/138/1/e20161493.full.pdf>. Both the CDC and the AAP recommend targeted BLL screening based on medical history and risk assessments performed at well child visits between ages 6 months to 6 years, to identify children most likely to have elevated BLL. Primary care providers should also test asymptomatic children for elevated BLL per Federal, local, and State requirements. Immigrant, refugee, and internationally adopted children should have BLL tested upon arrival in the United States due to their increased risk.

d. The best approach to preventing childhood lead poisoning is to prevent exposure. Since drinking water is a common source of exposure to lead, per reference (e), as modified by reference (f), all Navy installations must administer a program for sampling and testing for lead in drinking water in priority areas (LIPA). Those priority areas include, but are not limited to, primary and secondary schools, child development centers and youth centers. This program requires coordination between the installation and the local preventive medicine service and MTFs, particularly regarding communication (e.g., notification of test results) with parents and legal guardians of children in these priority areas. Commander, Navy Installations Command (CNIC), the Navy's executive agent for drinking water, and Chief of Naval Operations (CNO N45), provide policy for this program.

## 5. Policy

a. Clinicians will provide anticipatory guidance concerning lead hazards and assess the risk for exposure to lead as a part of routine well child care.

b. Clinicians will conduct BLL screening in children when indicated. Clinicians will also monitor the health status of all children with a confirmed BLL  $\geq$  5 micrograms per deciliter, and take further action or administer treatment, as indicated.

c. Universal BLL screening of all children is not required. BLL screening will be offered to children determined to be at risk based on medical history.

d. The use of point of care blood lead test devices is not authorized for compliance with this program. Those devices have shown an unacceptable number of false positive results, requiring a second test, subjecting children to two needle sticks.

e. Navy Medicine personnel will advocate for lead safe environments for children and will provide expert consultation to the management of military-owned or leased, child-occupied facilities in support of lead elimination efforts.

## 6. Responsibilities

### a. Deputy Chief, Readiness and Health, Bureau of Medicine and Surgery (BUMED) will:

(1) Advocate for the mitigation of lead hazards in child-occupied facilities before children are exposed.

(2) Direct MTFs to use universal BLL screening when indicated by analysis of local BLL data.

(3) Ensure appropriate distribution of information regarding childhood lead exposure, such as the annual reports from the Navy and Marine Corps Public Health Center (NAVMCPUBHLTCEN) identified in paragraph 6b(2).

### b. Commanding Officer, NAVMCPUBHLTCEN will:

(1) Provide epidemiology and data analysis support from the Epidemiological Data Center to BUMED, when requested.

(2) Provide an annual analysis, based on calendar year, of childhood BLL data for Department of the Navy beneficiaries in the form of a report from the Epidemiological Data Center to BUMED Healthcare Operations (BUMED-M3).

(3) Provide risk communication consultation and services to Navy Medicine regions and MTFs, upon request, for incidents of confirmed BLLs  $\geq 5$  micrograms per deciliter.

### c. Regional Commanders will:

(1) Ensure MTFs are providing the prevention, education, screening, and management services prescribed herein.

(2) Ensure each MTF identifies a point of contact (POC) for the LIPA program. POC requirements are described in paragraph 6d(7).

(3) Identify a regional POC for the LIPA program to assist the MTF POCs and to advise the commander on the program.

d. MTF Commanding Officers and Officers in Charge will:

(1) Provide the prevention, education, screening, and management services prescribed herein.

(2) Use certified laboratories for BLL analysis.

(3) Report incidents of confirmed BLLs  $\geq 5$  micrograms per deciliter in cases of children who reside in military-owned or leased housing, including public private venture housing, to the command responsible for the management of the housing (e.g., Navy Region Housing Department).

(4) Ensure additional required reporting is completed, as delineated below.

(5) Ensure mechanisms are in place to communicate BLL results to clinicians and preventive medicine personnel in a timely manner.

(6) Be prepared to respond to high drinking water lead sampling results, per the LIPA program, with greater public interface, increased pediatrics/primary care and occupational medicine appointments, and additional blood lead testing as necessary.

(7) Identify a LIPA POC who is knowledgeable of the LIPA policy and program, is trained or experienced in risk communication, and can respond to questions from facility staff and parents regarding health risks and testing results above the Environmental Protection Agency's recommended lead screening level of 20 parts per billion in drinking water.

(a) The LIPA POC should be a specialist in public health, occupational medicine, pediatrics, or environmental health.

(b) The POC will coordinate with regional CNIC and installation representatives prior to initiation of sampling and testing.

(c) When LIPA program lead levels exceed the EPA screening level of 20 parts per billion, medical POCs should contact NAVMCPUBHLTHCENC, and be available to assist installation staff in addressing concerns of staff and parents. Installation staff will likely request medical POCs to accompany them to the affected facilities and interact with staff and parents to address their concerns. POCs should be prepared to describe the potential health risks due to

lead exposure, information on blood lead testing, when and how to obtain an appointment for a clinical evaluation, and resources for learning more about the health effects of lead in drinking water. Additional resources and communications tools are available at: <http://water.epa.gov/infrastructure/drinkingwater/schools/guidance.cfm#3ts>.

e. Clinicians Providing Care to Children will:

(1) Educate families about preventing lead exposures and provide information on lead hazards.

(2) Assess the risk for lead exposure, when appropriate, during well child visits from age 6 months through 6 years, using the Tri-Service Workflow Electronic Health Record template, the NAVMED 6200/2 Lead Exposure Risk Assessment Questionnaire, or a similar tool.

(3) Recommend environmental assessments for children at risk for lead exposure.

(4) Screen children who are at increased risk for lead exposure based on the history obtained during well child visits with whole BLL.

(5) Notify the family of all affected children of BLL test results in a timely and appropriate manner.

(6) Monitor the health status of all children with a confirmed BLL  $\geq 5$  micrograms per deciliter.

(7) Use specific code from International Classification of Diseases, 10<sup>th</sup> Revision for elevated BLLs, R78.71, "abnormal lead level in blood."

(8) Take further action or administer treatment, as indicated, for children with confirmed elevated BLLs, per current medical practice standards.

f. Preventive Medicine Personnel will:

(1) Collaborate with management of military-owned or leased, child-occupied facilities to assist in the identification of lead hazards.

(2) Coordinate and collaborate with clinicians to provide families with the information needed to protect their children from lead hazards.

(3) Report childhood BLLs  $\geq 5$  micrograms per deciliter to the MTF Director of Public Health (or equivalent).

(4) Report childhood BLLs to civilian public health authorities according to state and local regulations.

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(5) Collaborate with Navy Region Housing Department in the investigation of elevated BLLs in which military-owned or leased, child-occupied facilities may be involved.

(6) Confirm investigations of elevated BLLs and any required housing remediation (military-owned, leased, and Public Private Venture housing) is completed.

(7) If appointed as the MTF's POC for the LIPA program, coordinate with regional CNIC and installation representatives prior to initiation of sampling and testing, and be available to go to affected facilities and interact with staff and parents to address their concerns (see paragraph 6d(7)).

7. POC

a. Public Health, Emergency Preparedness & Response (BUMED-M37), (703) 681-9654/5467.

b. NAVMCPUBHLTHCEN, Epidemiological Data Center, (757) 953-0955/0970.

c. NAVMCPUBHLTHCEN, Risk Communication Service, (757) 953-0664.

8. Records Management. Records created as a result of this instruction, regardless of media and format, must be managed per SECNAV Manual 5210.1 of January 2012.

9. Review and Effective Date. Per OPNAVINST 5215.17A, Bureau of Medicine and Surgery will review this instruction annually on the anniversary of its effective date to ensure applicability, currency, and consistency with Federal, DoD, Secretary of the Navy, and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction.

10. Information Management Control. The reports required in paragraphs 6b(1), 6b(2), 6d(3), 6d(5), 6f(3), and 6f(4) are exempt from reports control per SECNAV M-5314.1 of December 2005, Part IV, Paragraph 7p.

11. Form. NAVMED 6200/2 Lead Exposure Risk Assessment Questionnaire is available at: <http://www.med.navy.mil/directives/Pages/NAVMEDForms.aspx>.

  
TERRY J. MOULTON  
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Releasability and distribution:

This instruction is cleared for public release and is available electronically only via the Navy Medicine Web Site at: <http://www.med.navy.mil/directives/Pages/BUMEDInstructions.aspx>.