

Purpose

To characterize the use of and need for different types of lead-related data (LD) among New Mexico’s communities and decision-makers, as well as housing, child development, and health professionals.

Background

In September 2014, New Mexico’s Child Lead Poisoning Prevention Program (CLPPP), housed in the Environmental Health Epidemiology Bureau (EHEB), received new Centers for Disease Control and Prevention (CDC) funding to support the collection, analysis and dissemination of surveillance data and other lead-related information to its partners and the public.

The NM Environmental Public Health Tracking Program (NM EPHT) has been providing surveillance support for blood lead data and indicators since 2006. Data have been shared with stakeholders via New Mexico’s Indicator-Based Information System for public health (NM-IBIS) and NMTracking, part of the national Environmental Public Health Tracking Network. Other materials related to lead data in NM have been made available on the EHEB website, in presentations, published in state epidemiology reports and CDC’s Morbidity and Mortality Weekly Report, and through EHEB responses to individual requests for data.

Through the Lead Surveillance Data Users (LSDU) Survey, the CLPPP sought to answer the following questions:

- Who is using NM lead surveillance data?
- How are they using it?
- What formats and types of data and information would be most useful to NM stakeholders?

Results from this survey are intended to help the CLPPP plan surveillance and communication activities during the next two years.

2015 Lead Data Users Survey Brief Report

New Mexico
Child Lead
Poisoning
Prevention
Program

2015 Lead
Surveillance
Data Users
Survey

Brief Report

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December 11, 2015

Survey Findings¹

Over 1,100 individuals were invited to participate in the survey, and 101 responses were received. Respondents were encouraged to forward the link to their colleagues, so the overall response rate (a little over 8 percent) is approximate.²

Profile of Respondents: Occupational/Avocational Categories

The first question in the survey asked respondents to identify themselves by the category which “best fits the work you do” and the instructions noted “This could be a paid position or volunteer work that you do in your community. (Please look over both columns of responses, and check the one that’s the best match.)” The wording of this question was based on the evaluator’s past experience with NM survey respondents who served on community health councils or volunteered for an organization as retirees. Thus the question was broadened from the usual occupational categories to include avocations, or work done that is not remunerated.³

The categories listed in Table 1 illustrate the range of survey respondents, sorted by count from largest (25) to smallest (0).

Table 1. Survey Respondents by Occupational/Avocational Category

Categories	Count	Percent
<i>Healthcare Provider (such as nurse or doctor)</i>	25	24.8
<i>Epidemiology (collecting and analyzing data about health conditions)</i>	18	17.8
<i>Early Childhood Development (Daycare, Head Start, Home Visiting)</i>	17	16.8
<i>Health Education or Health Promotion</i>	13	12.9
<i>Public Health</i>	9	8.9
<i>Social Work</i>	8	7.9
<i>Other [*not otherwise classified]</i>	6	5.9
<i>Housing (administration, remediation, counseling)</i>	2	2.0
<i>Community Services</i>	2	2.0
<i>Healthcare Administrator, Manager, Analyst</i>	1	1.0
<i>Refugee Services</i>	0	0.0
TOTAL	101	100.0

The “other” category (originally 10 responses) included “data dissemination,” “child care eligibility,” “Child and Adult Care Food Program/Summer Food Service Program,” and “WIC program manager.” “Other” respondents whose answers identified them as a part of a named group (e.g., a physician assistant is a healthcare provider) were reassigned to the appropriate category. “Other” respondents who consulted on early childhood training and development (n=3) were considered part of the Early Childhood Development category.

¹ A copy of the survey and the methodology section of this report can be found in the appendices.

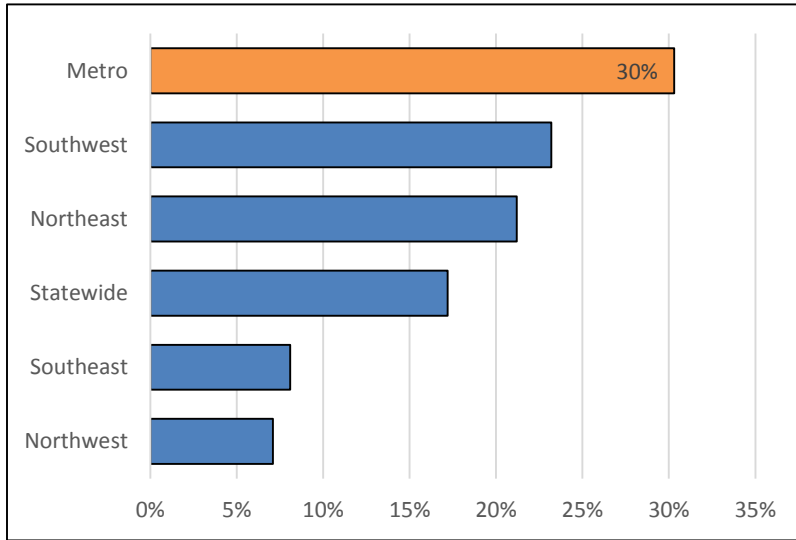
² This is low but typical for online surveys. In cases where respondents contacted the evaluator and shared the number of colleagues they sent the survey link to, this number has been included in the total.

³ This also made the categories suitable for community members who are not retirees, but do not currently have a paid position.

Profile of Respondents: Geographic Area of Work

Survey responses were strongest from the Albuquerque Metro, Southwest, and Northeast regions of the state (Figure 1).⁴ While the city of Albuquerque contains over a quarter of the state’s population, the four counties (Bernalillo, Sandoval, Torrance, and Valencia) used to define the Metro region for this survey contain over 40 percent of it.⁵

Figure 1. Geographic Areas Where Respondents Work



Some respondents listed multiple locations, as professionals working for the NMDOH, CYFD, and other organizations often split their time between Albuquerque and Santa Fe (in the NE region) or another part of the state, and many indicated multiple geographic foci for their work.

As seen in Table 2, the parallel between work location and work focus was clear for Metro and Statewide respondents.

Respondents from non-metro regions predominately focused on the county level in their work. Respondents from the Metro and Northern regions, and those who work statewide were the most likely to work in IHS, pueblo and tribal areas.

Table 2. Location and Geographic Focus of Survey Respondents’ Work Cross-tabulated⁶

Location → Focus ↓	ABQ Metro (n=30)	NE (n=21)	NW (n=7)	SE (n=8)	SW (n=23)	Statewide (n=17)
City (n=46)	19	9	4	6	9	3
County (n=52)	12	10	5	7	16	6
Indian Health Service Area (n=10)	4	1	2	0	0	4
Pueblo (n=8)	2	2	1	0	0	4
Public Health Region (n=25)	7	7	2	0	5	6
Public School District (n=6)	4	1	0	0	0	1
State (n=36)	9	9	0	0	5	14
Town or Township (n=10)	1	2	0	2	2	3

⁴ Six respondents reported that they work in more than one area, and 2 respondents skipped this question, so n=99 rather than n=101. One reported working in the Metro and NE, three in the Metro and NW, and one in the Metro and NW regions plus statewide.

⁵ The estimated 2014 population of Albuquerque was 557,169 or about 27% of the total state population (factfinder.census.gov).

⁶ The highest response counts for each column and row are in **boldface**.

Location → Focus ↓	ABQ Metro (n=30)	NE (n=21)	NW (n=7)	SE (n=8)	SW (n=23)	Statewide (n=17)
Tribal area or reservation (n=8)	2	2	1	0	0	4
Other (n=10)	4	3	1	0	0	4
Totals for focus areas	64	46	16	15	37	49

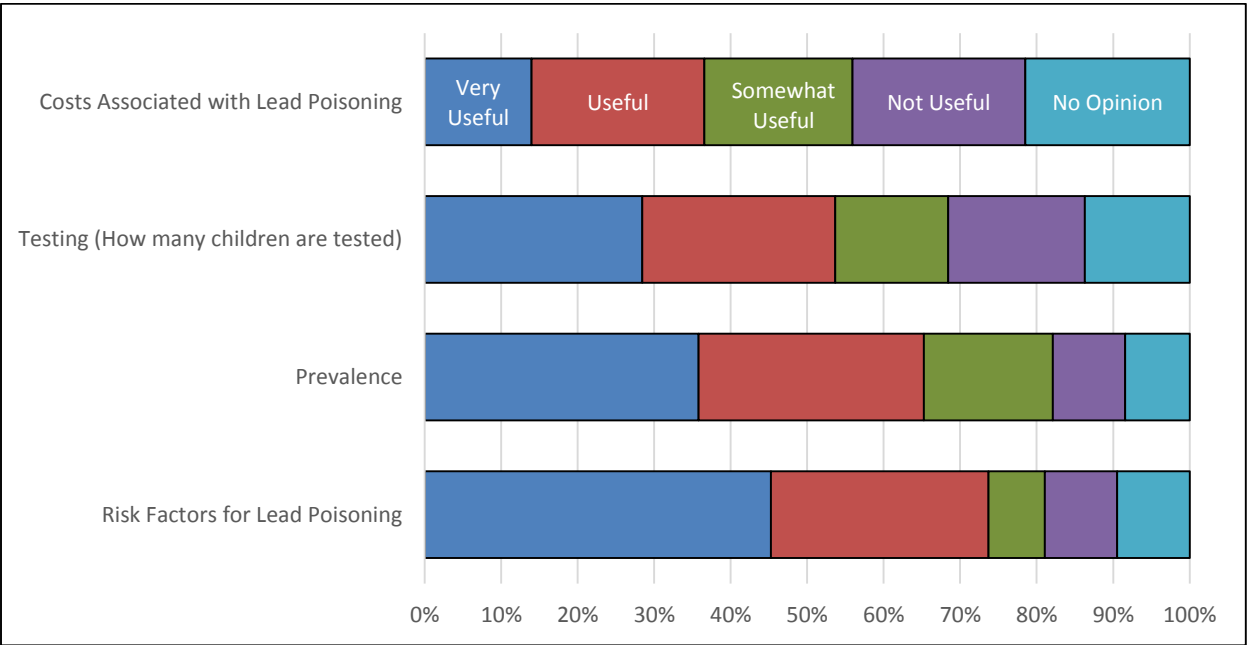
“Other” Geographic foci mentioned by respondents were: Early childhood child care programs; General; Northern New Mexico; Sub-County (GeoSpatial analyses at NMDOH Small Areas⁷ and census tracts); school health clinic; and “underserved urban [areas].”⁸

Use and Usefulness of Lead-Related Data

Among the 99 survey respondents who answered Question 4, only 8 stated that they had used lead data in the past year, while a large majority, 91 reported that they had not. All respondents were asked to rate the potential usefulness of different types of lead-related data (Q10) to them in their work and 95 respondents rated one or more of the four categories of data.

Data on risk factors had the broadest support, including not only the highest proportion of “very useful” and lowest “not useful” responses (see Figure 3), but also the largest number of survey respondents expressing an opinion. There was also general consensus (over 80% of respondents) that prevalence data was useful, although perhaps not quite as strongly useful as risk factors, with more respondents choosing “useful” and “somewhat useful.”

Figure 3. Utility of Different Types of Lead-Related Data as Ranked by All Respondents



⁷ NMDOH Small Areas were developed to improve reporting of health data. They are based on population size and meaningful community boundaries. See <https://ibis.health.state.nm.us/resources/SmallAreaMethods.html>

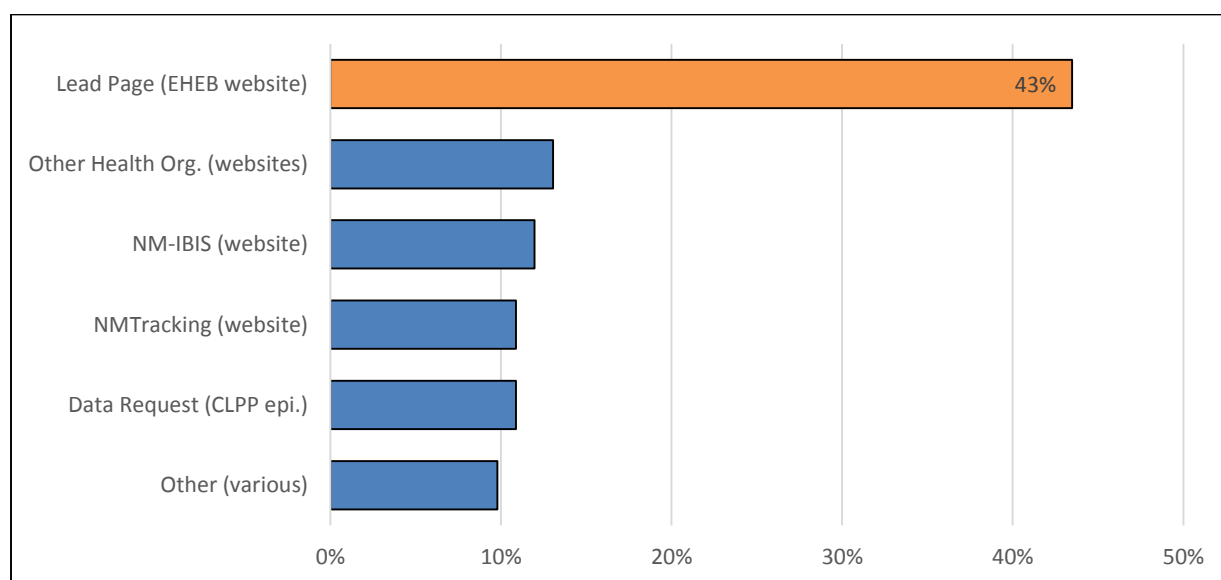
⁸ Respondents who indicated they focused on all areas have been added to the counts in Table 2.

The types of data most often ranked “not useful” were testing (18%) and costs associated with lead poisoning (23%). Over 20% of respondents chose “No opinion” when asked about the usefulness of cost-related data, and two respondents who answered the question about other data types skipped rating this category of data, suggesting uncertainty.

Preferred Source or Method and Format for Getting Lead-Related Data

When asked where they would prefer to find the LD they need (Q12), the largest proportion of survey respondents (43%) chose the CLPPP website. Support was fairly evenly divided among the other options, with 10 to 13 % of respondents choosing NM-IBIS, NMTracking, Other Health Organization Websites, or data requests to the CLPPP epidemiologist as preferred methods.

Figure 3. Preferred Source for Finding LD by Percentage of Survey Respondents



The “other” responses included requests for e-mail updates (n=3) or faxes, through the regional epidemiologist, via the New Mexico Community Data Collaborative, or “all [of the above].”

When asked which format would be most useful to them (Q11), nearly half of survey respondents (n=46, 48%) chose a short, summary format (factsheet, brochure, or newsletter). A written report or a presentation were each selected by more than 10 percent of respondents, and webinars, data workshop/roundtables, and newspaper articles/radio broadcasts/PSAs by less than 10 percent.

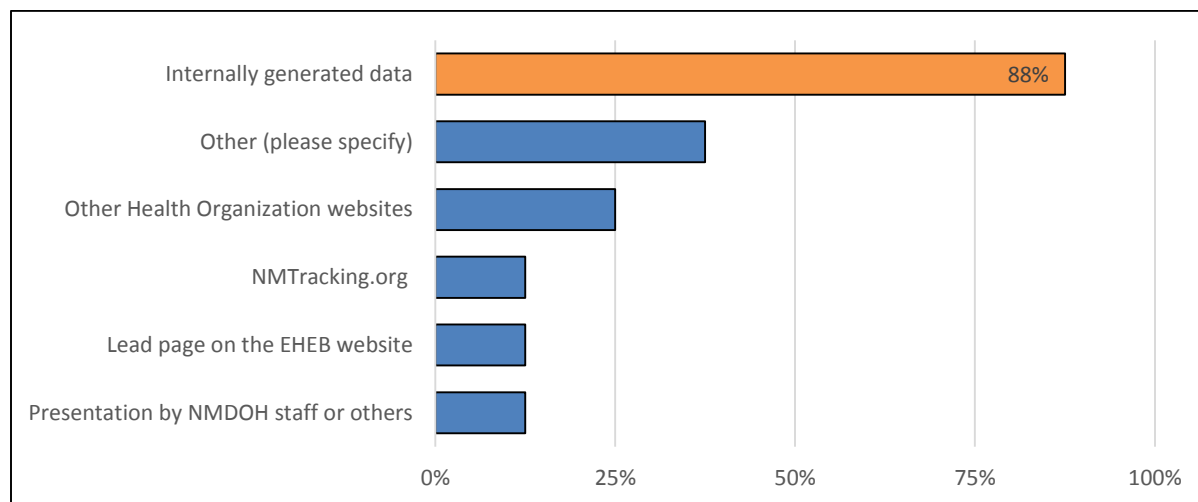
Other suggestions made in response to Q11 (under “Other”) were:

- Web-based but not specific about format (n=3, website or list serve, website, “website that is continuously accessible”)
- Data shared using e-mail (n=2, “information with appropriate links,” a periodic report),
- Datasets (n=2, “publicly available” and “queryable ... on IBIS at the sub-county level”)
- A statewide database “like immunizations”
- An article in the NMDOH epidemiology report

Questions for Data Users

Survey respondents who reported using lead-related data during the past year were asked a short series of questions (Q6-Q9) about the data they had used. Question 6 asked how they had found the data, and multiple responses were allowed (totaling 14 responses from 8 respondents). Note: The very small number of respondents who reported using lead data within the past year limits the applicability of these findings.

Figure 4. Percentage of Data Users Reporting Use of Various Data Sources



The majority of the data users (n=7) reported using internally-generated data,⁹ and one-quarter used other health websites (e.g. CDC). No respondents reported using data from NM-IBIS, other professional or non-profit organizations, or making a specific data request to an NMDOH epidemiologist.

The “Other” responses provided more detail: “we bought our own lead testing equipment” (healthcare provider), “from our screening results: 12-month, 24-month, and 4-6 year-old visits” (healthcare provider) and “Did not find county level or sub-county level data. Lead poisoning data is not geo-coded, but it should be” (from an epidemiologist).

Most of the respondents who reported using lead data during the past year were healthcare providers, and recent lead data users were much more likely to be from the Albuquerque metro area (63% versus 28%) than the non-users.

Respondents were also asked how they had used their lead data (Q7) and how useful they had found it to be (Q8). The most commonly-reported use of lead data was “to understand the scope of the health problem or community need” (57%). Just under 15% of respondents used LD “to create or update educational materials,” “to program priorities and plan activities,” “to advocate for or justify program resources needed,” or “to advocate for policy change or policy development.” No one reported using it

⁹ An “other” answer which indicated use of internally-generated data was included in this count.

to write grant applications. One respondent used it to follow Head Start guidelines. Once again, the “other” category was used to make comments about lead testing and data generally:

- “Have not officially looked at it, but in >10 years of testing I have had one elevated case. Period. And that patient was high risk (from Mexico).”
- “Not useful for the community partners we work with.”

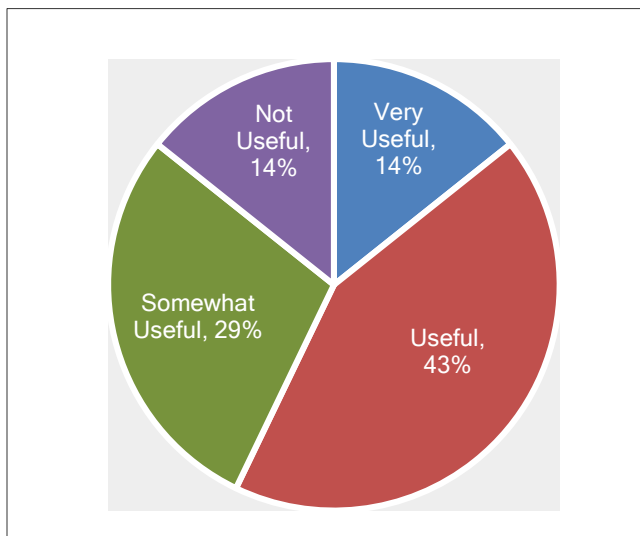


Figure 5. Usefulness of LD Rated by Data Users

Among survey respondents who had used LD during the past year and answered this question (n=7), a majority (57%) reported finding it “useful” or “very useful.” A minority found it “somewhat useful” and one respondent (14%) rated it “not useful” (Figure 5).

Recent users were asked how LD could be more useful to them (Q9, open-ended) and two provided suggestions:

- More testing, geocoding and aggregating data for analysis at the sub-county

level, particularly the neighborhood level, which is what community organizations want

- A reliable, accessible statewide data resource (respondent noted “the IHS and HMOs in ABQ don’t share a common database”).

One respondent (healthcare provider, Northeast Region) commented more generally: “Anecdotally, I do not feel lead testing is worthwhile in our area.”

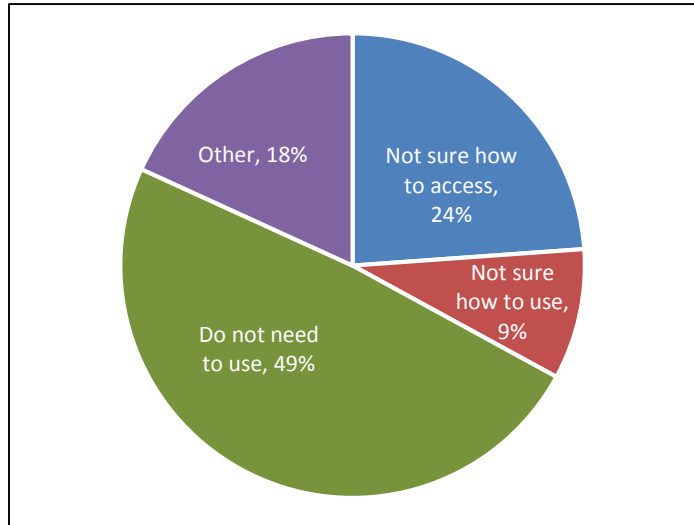
A Question for Non-Users

Survey respondents who said they had not used any lead-related data during the past year (over 90% of respondents) were asked one additional question (Q5): Why not? They were provided with a range of response options, including “Other.”¹⁰

¹⁰ “Other” responses which indicated that they did not need to use lead-related data have been added to the count for the “do not need” category.

Figure 6. Reasons Given for Not Using LD during the Previous Year

A majority of survey respondents who indicated they had not used LD recently (n=88) chose one response (Figure 6). Those who reported being unsure how to access information about lead or unsure how to use LD (33%, n=29) were more likely to be HCPs from the Metro or Southwest regions, and be particularly interested in risk factors and prevalence.



Other reasons given for not using data recently (18%, n=16) included:

- No current requests or apparent need for lead-related data in the programs or communities respondents serve (n=5, examples: “not much work going on,” “no referrals”)
- Not part of respondent’s direct job responsibilities (n=3, examples: “I don’t do routine well visits but I think this surveillance should be done,” “the clients/cases we have are already diagnosed”)
- Respondent is new to NM or to their current position (n=3)

Other respondents used the open response field to describe what they or their organization do:

- We inspect all pre-1978 homes and buildings for lead regardless of whether children are present or not
- I test every child for lead exposure at age 1 and then treat/monitor as needed
- We have an NMDOH epidemiologist come and speak at our home provider trainings

Finally, two respondents posed broader concerns:

- Didn’t think it was population-based
- Need a process to access data and disseminate information in a meaningful way into communities, both to families and service providers

Comparison between Respondents Based on Their Use of Lead Data

Overall, respondents from certain occupations and geographic regions were more likely to report recent LD use. Among occupational/avocational categories, healthcare providers were the most likely to report having used LD (5 out of 8 responses, or 62.5%). A few respondents from early childhood development, epidemiology, and health promotion or health education (1 each, 12.5%) also reported using lead data recently.

Data users reported working in the Albuquerque Metro area (62.5%), the Northeast and Northwest (25.0% each), Statewide and in the Southwest (12.5% each). No data users identified themselves as working in the Southeast region. Data users were more likely than non-users to focus on city, IHS,

Pueblos and Tribal areas, and to indicate other areas of focus. They were less likely to be focused on state, county, public school district, or township areas. Roughly one quarter of both data users and non-users reported a focus on NM public health regions.

Although the number of lead data users is small, there are suggestive differences between user and non-user groups in their responses to Q10, which asked them to rate the usefulness of different types of data (see Figure 7). Among those who have used LD recently, the highest number of “very useful” responses (71%) was for prevalence. Among those who have not used LD recently, the data type most often ranked “very useful” was risk factors for lead poisoning (44%).¹¹ Data users were much more likely to rate all 4 categories of data “very useful” (range 50-71%) than non-users were (range 12 – 44%).

Figure 7. Usefulness of Different Types of Lead Data: Users versus Non-Users



As seen in Figure 7, users and non-users also diverged on the usefulness of cost-related and testing data.

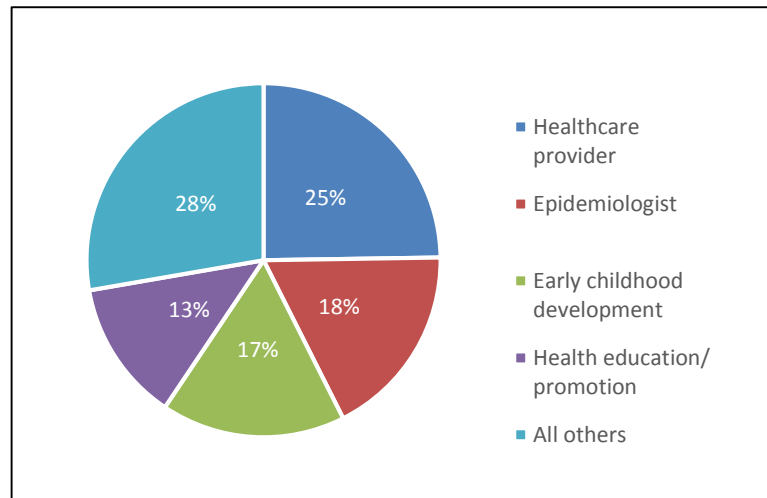
Both users and non-users preferred the factsheet/brochure format for reporting data and finding data on the Lead Page in the EHEB web site over the other options listed. However users were more likely to want to request data from the CLPPP epidemiologist and non-users were more likely to want to use NM-IBIS, NMTracking, or other health organization websites like CDC.

¹¹ Those who had not used LD recently were also more likely to choose “no opinion,” but this was true across all categories.

Differences in Data Usage and Perceived Utility among Major Occupational/Avocational Categories
 Stratification by user category supports anecdotal knowledge that occupational/avocational groups use and value surveillance data and related health information differently. The four largest categories, which when combined comprise 72% of all survey respondents, were healthcare provider (n=25), epidemiologist (n=18), early childhood development (n=17), and health education/promotion (n=13).¹²

Figure 8. Major Occupational/Avocational Categories

Comparison of group responses suggests differing patterns of LD access and use. The proportion reporting recent LD usage was highest for healthcare providers (20%). Less than 10% of those in epidemiology, early childhood development, and health education/promotion (a single respondent in each group), reported using lead data in the past year.



Other key differences appear in responses to the demographic questions and to their preferred format and method for accessing lead-related data (Table 4).

Table 4. Most Common Responses (Mode) for Selected Questions among Top Four Occupation Types

Occupation	Geographic Area of Work	Geographic Focus of Work	Preferred Method to Find LD	Preferred Format
<i>Healthcare Provider</i>	Metro (52%)	City (60%)	CLPPP website (60%)	Factsheet (52%)
<i>Epidemiologist</i>	Statewide (67%)	Statewide (78%)	NM-IBIS (31%)	Factsheet or Other (tie, 17%)
<i>Early Childhood Development</i>	Metro (35%)	City or County (tie, 65%)	CLPPP website (29%)	Factsheet (59%)
<i>Health Education/Promotion</i>	Northeast (46%)	County (77%)	CLPPP website (50%)	Factsheet or Presentation (tie, 25%)

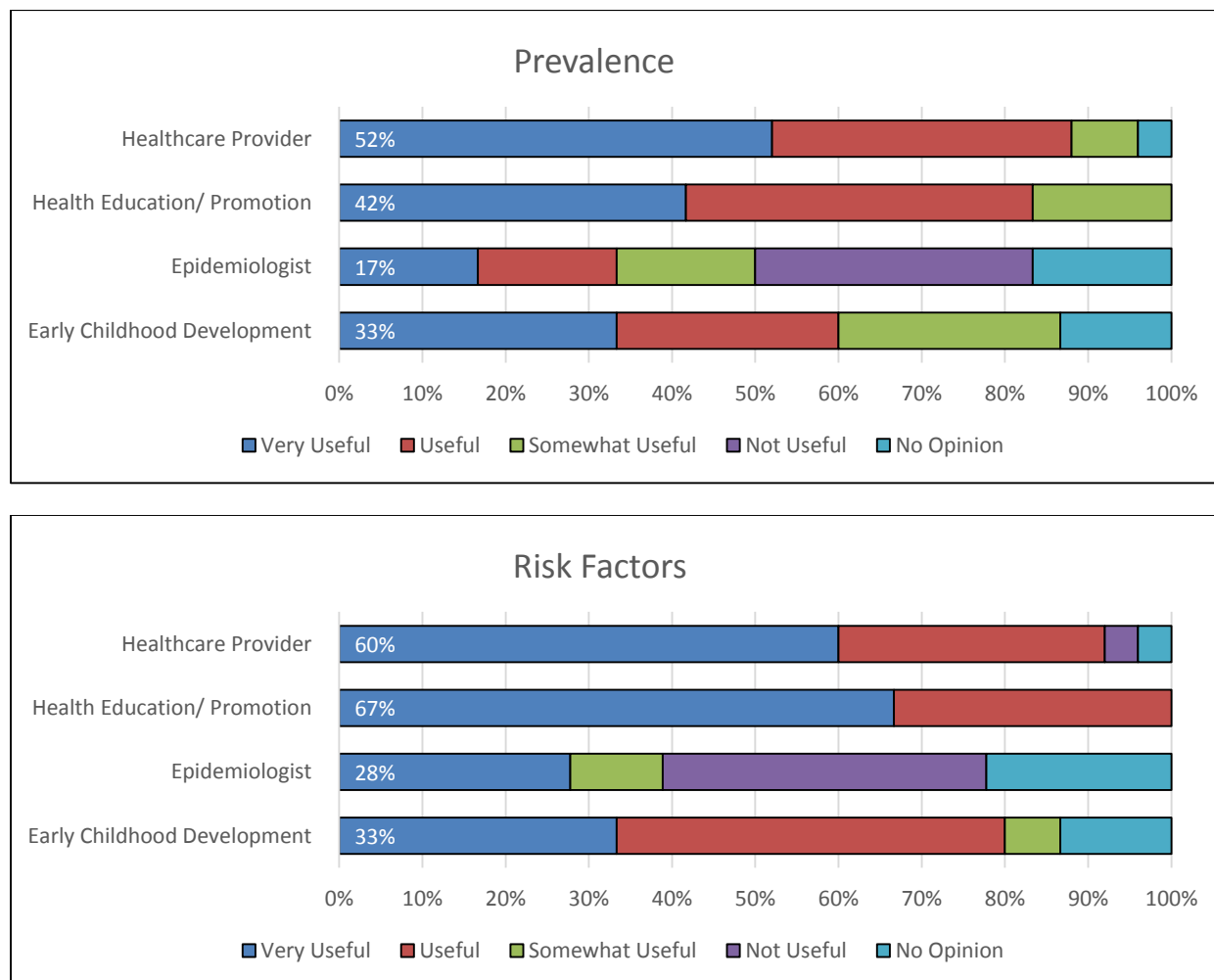
As seen above, some of the modes are dominant (>50%), while others are relatively weak. For example, 25% of the responders in the Early Childhood Development group would prefer getting their data from “Other Health Organization websites,” only one respondent less than those who preferred the CLPPP website (29%). Among healthcare providers, a substantial minority (nearly one quarter, 24%) preferred getting a written report.

¹² Responses from participants in major categories (e.g., healthcare provider) who misclassified themselves as “other” are included.

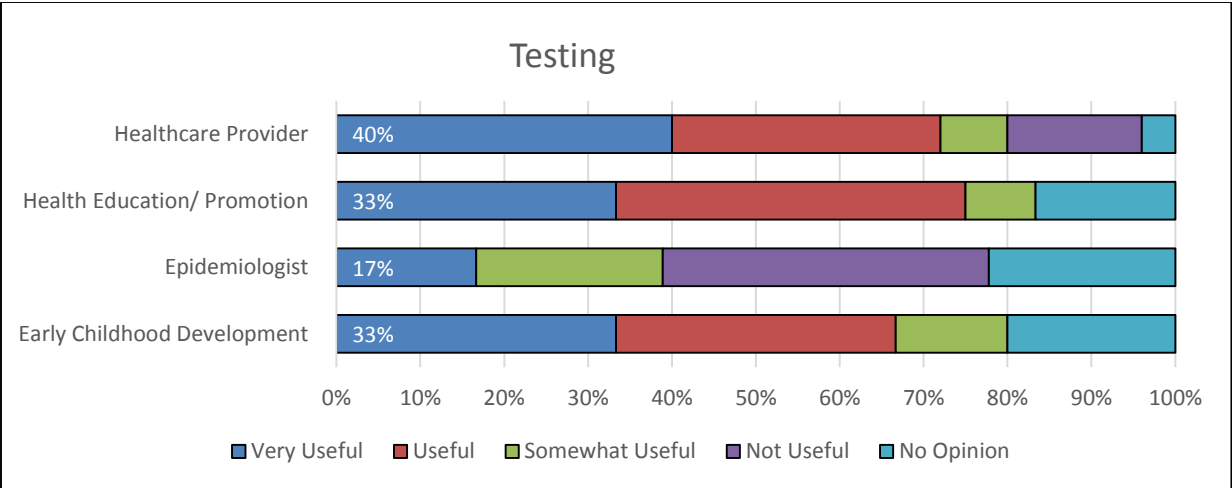
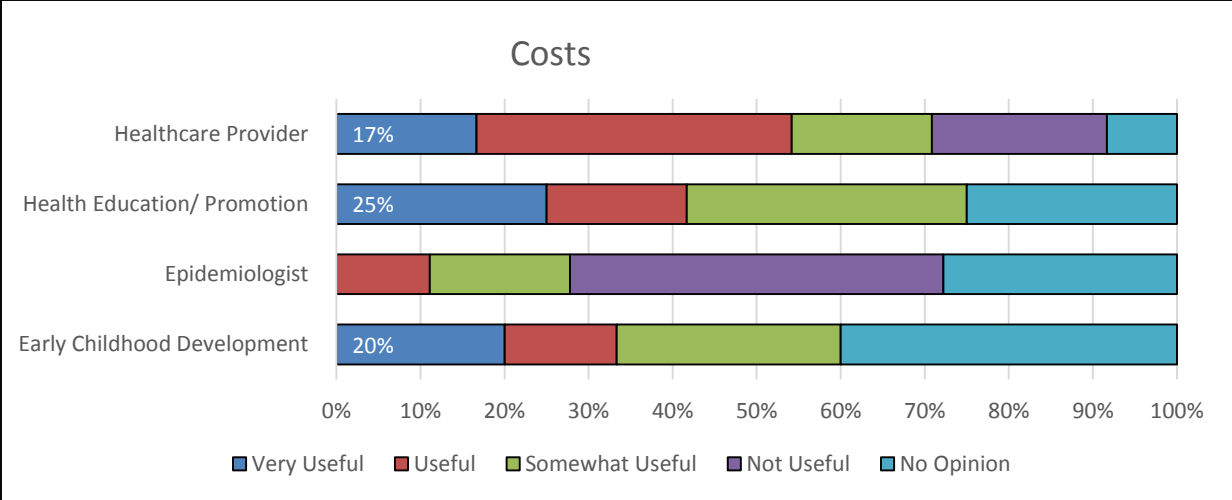
Differences are also apparent in group rankings of the utility of different types of LD.

Risk factors were favored by respondents overall, although a substantial minority of the participating epidemiologists ranked risk factor data (and all types of data being valued in the LSDU survey) as “Not Useful” to them in their work. This may reflect a lack of awareness of the continuing impacts of lead poisoning in NM, coupled with historical lack of funding for program education and outreach related to lead. Most NMDOH epidemiologists do not work with lead-related data and are not asked about it by their community health partners, and thus do not find it useful to them.

Figure 9. Usefulness of Types of Lead-Related Data Ranked by Top Four Groups¹³



¹³ One healthcare provider did not rank cost data and one health education/promotion respondent did not answer any of the the data utility questions, so in these rows n=24 and n=12, respectively.



When designing lead-related materials and publications, and developing partnerships with different stakeholder groups, it is worth keeping these distinctions in mind.

Suggestions from Survey Respondents

Close to one-third of respondents (n=30) provided an answer to the final open-ended question, which asked how the CLPPP could help them use lead-related data in their work.¹⁴

Several responses (n=7) related to *accessibility and relevance of data* and information:

- Keeping stakeholders informed periodically (“latest information”)
- Using professional organizations like the NM Pediatrics Society to disseminate information (“webpage, newsletter, meetings, etc.”)
- Creating an accessible statewide database like the one for immunizations
- Creating a list serve “or other way to get data out regularly to people”

¹⁴ Their responses were also used to generate the WordCloud used in the image on the first page of this report.

- Improving data quality by including race/ ethnicity for cases “if possible”

Two responses combined data suggestions with other common topics (materials for parents, and issues related to testing, screening, and HCPs):

- “It would be useful to know what the prevalence of Childhood Lead Poisoning is statewide in the WIC population by county and for example by different parts of Albuquerque. It would also be nice to have up to date brochures to give WIC clients to raise awareness on prevention.”
- “Generate specific reports, be more helpful when a case of lead poisoning is identified such as levels between 10ppm and 20ppm. NMDOH pretty much just wants me to follow. Program is much weaker than in other states I've experienced. Such as Louisville Metro Hlth Dept.”

Five additional responses addressed *testing, screening, and HCP actions*, and the need for improved communication and interaction:

- “Promote screening as option to testing when high prevalence exists in certain areas”
- “[Need] clinics to provide testing for lead poisoning in counties where prevalence is higher”
- “To reinforce lead testing practice wide”
- “I would like to have more information ... as it relates to the specific patients I see in my practice”
- “Is there a lead questionnaire that we should be using in clinics in New Mexico? I would love to see the Lead Poisoning Program communicate better with clinics and healthcare providers. I know you all exist, but have never had contact with you in the 17 years I have been practicing in Santa Fe.”

Five responses suggested that the NM CLPPP could help in *making connections* with other services and organizations, both inside and outside of NMDOH:

- “Information and discussion should occur where applicable. Housing/building inspectors and health agencies could be a good place to start.”
- “Assist clients in determining medical eligibility to provide medical assistance.”
- “Connect with early childhood initiatives and child safety efforts in the state and local communities.”
- “Nutrition and home safety programs.”
- “By knowing the number of children who are at risk for lead poisoning or identifying children who have been exposed to lead poisoning, the appropriate services could be offered to families and the appropriate treatment can be coordinated with the help of CMS [Children’s Medical Services] Social Workers.”

Similarly, another respondent suggested “We need greater awareness and understanding of the issue and how it impacts our work. Also how our program can be of assistance (CMS).”

Three responders requested materials that could be used with *parents* they see in their programs: “signs of lead poisoning in a handout,” “pamphlets available.” Another three made suggestions relating to *training and presentations*:

- “Providing a presentation to our staff so that we are informed and can pass on the information to childcare providers.” (Childcare Licensing professional)
- “I would like to know about events where this information is being presented in order to incorporate presentation of other health data that would be applicable to the intended audiences.” (Data Dissemination coordinator)
- “I design and provide training for early childhood educators. I could include information on childhood lead poisoning prevention in some of my training materials to inform individuals who work directly with children and their families.” (Early Childhood Training & Development consultant)

Two respondents used this free response question to share *concerns about lead poisoning risks* in NM from food, water and pottery:

- “Some of the candy brought from Mexico has traces of lead, mostly if it has *chile* or is coated with it. For awhile we didn't as much. But now it has worked its way back again. Plus the pottery, brought from Mexico and other countries.” (Social worker)
- “Concerning water testing, it would be good to know where testing of water for lead should be encouraged and/or where flushing of lines before using water for drinking/cooking should be encouraged.” (Epidemiologist)

One respondent (a housing professional) noted that lead surveillance data could potentially be used by their organization “for legislative finance purposes,” referring to the NM Legislature’s Legislative Finance Committee.

Discussion and Recommendations

The very low number of data users among 2015 survey respondents is noteworthy.¹⁵ Combined with comments from respondents who had difficulty finding suitable lead data for their needs, and rely almost exclusively on internal data, this suggests that the CLPPP must build on the interest in data and prevention expressed by many of the HCPs surveyed and also investigate ways to productively share its data with more organizations involved in housing, early childhood development, environmental health, and related community initiatives. The survey response rate was particularly low for housing professionals, and survey response levels suggest CLPPP ties to housing organizations and refugee services need strengthening.

Healthcare providers who responded revealed a range of opinions about lead testing, including some who want to promote additional testing and some who may resist it. The survey questions asked were

¹⁵ In comparison, the 2014 Asthma Surveillance Data Users survey conducted by EHEB showed 35% of respondents had used asthma data in the past year. Asthma survey results also indicated a much higher perception of usefulness of data among NM epidemiologists surveyed. Although the two survey populations were not identical, these differences are suggestive.

not specific enough to discover what the potentially resistant respondents considered an elevated BLL, and if they are aware of the full range of lead sources which may put a child in NM at risk.

The recommendations which follow are drawn from the survey findings.

- Continue updating and linking lead data through NM-IBIS and NMTracking, and expand the timeliness and variety of data available
- Continue to collaborate with other programs within NMDOH and EHEB, including NMTracking, Biomonitoring, and the Private Wells Program which can share audiences and resources
- Educate HCPs and others about the Healthy Homes Lead Poisoning Surveillance System (HHLPPS) for both data collection and data dissemination
- Develop a procedure to efficiently handle HCP and other stakeholder queries regarding BLL test results for patients and communities
 - Support HCPs advocating for testing and screening in their clinics and other organizations
- Support lead poisoning prevention training for housing, early childhood and healthcare professionals which includes awareness of and skills needed to access and use lead-related data
 - Provide NM CLPPP data and information to trainers who can use it in their programs
- Increase the number and timeliness of NM-specific materials the NM CLPPP makes available through its website, particularly factsheets targeting specific audiences with different data and information needs and levels of understanding, particularly parents of children at risk
 - Consult with WIC and NM's early childhood development organizations about what would be useful to them and their clients
- Present the latest NM lead-related data and resources to stakeholder groups
 - Explore ways to make lead data more useful to those seeking legislative or grant-based funding for projects related to LPP in NM
- Make additional use of media options for communicating significant updates about lead surveillance data for NM

Conclusion

With minimal funding over the past decade, the EHEB's Lead Program has successfully tracked and shared basic surveillance data with stakeholders. Since 2006 this has been done through the NM Tracking website. However, the 2015 survey results suggest that program connections with many key stakeholder groups need to be strengthened. Many potential users are unaware of CLPPP data, uncertain how to access or use what's available, or find that the (limited) data currently provided do not meet their needs.

As the CLPPP works to expand awareness and support prevention activities to combat child lead poisoning in New Mexico using CDC funding, it will need to develop additional surveillance data resources and increase program efforts involving outreach, training, and education in collaboration with program partners.

Appendices

I. Survey Form

Lead Surveillance Data Users Survey - Summer 2015

Thank you for taking the time to complete this brief survey!

Recently, the Centers for Disease Control and Prevention awarded the NMDOH funding to help prevent child lead poisoning in NM. Although lead paint is no longer used in homes and schools, it may still be present in older buildings and there are many other ways children can be exposed, including imported toys and candy, traditional pottery, and dust from work sites or from areas where leaded fuel was heavily used in the past.

What you can tell us (the Childhood Lead Poisoning Prevention Program) about the kinds of lead-related data and information you need and use will help us support the many organizations and individuals working to protect New Mexico's children from lead poisoning and making sure that children who are exposed to lead get proper treatment.

Because different groups of people have different needs, please provide a little information about yourself by answering the first few questions. We'd like to be sure we hear from a variety of people, not just one group.

Please note: Depending on the answers you give, you may not be asked all of the survey questions (for example, if you tell us you didn't use any lead-related data last year, we won't ask you where you got the data you used).

* 1. Which category best fits the work you do? This could be a paid position or volunteer work that you do in your community. (Please look over both columns of responses, and check the one that's the best match).

- | | |
|--|---|
| <input type="radio"/> Community Services | <input type="radio"/> Health Education or Health Promotion |
| <input type="radio"/> Early Childhood Development (Daycare, HeadStart, Home Visiting) | <input type="radio"/> Housing (administration, remediation, counseling) |
| <input type="radio"/> Epidemiology (collecting and analyzing data about health conditions) | <input type="radio"/> Public Health |
| <input type="radio"/> Healthcare Provider (such as a nurse or doctor) | <input type="radio"/> Refugee Services |
| <input type="radio"/> Healthcare Administrator, Manager, Analyst | <input type="radio"/> Social Work |
| <input type="radio"/> Other (please describe) | |

2. In which geographic area(s) do you work?

- Metro (Bernalillo, Sandoval, Torrance, & Valencia Counties)
- Northeast (Colfax, Guadalupe, Harding, Los Alamos, Mora, Rio Arriba, San Miguel, Santa Fe, Taos, & Union Counties)
- Northwest (Cibola, McKinley, & San Juan Counties)
- Southeast (Chaves, Curry, De Baca, Eddy, Lea, Lincoln, Quay, & Roosevelt Counties)
- Southwest (Catron, Dona Ana, Grant, Hidalgo, Luna, Otero, Sierra, & Socorro Counties)
- Statewide (all over New Mexico)

3. What kind of geographic area do you focus on in your work? (check all that apply)

- City
- County
- Indian Health Service Area
- Pueblo
- Public Health Region
- Other (please specify)
- Public School District
- State
- Town or Township
- Tribal area or reservation

Lead-Related Data Use in Past Year

* 4. Have you used lead-related data in the past year? (For example, have you looked for the percentage of children who have been tested for lead in your community or the number of children with elevated blood lead levels in specific counties?)

- Yes No

5. If you haven't used lead surveillance data during the past year, why not?

- I am not sure how to access information about testing and lead exposure in my area
- I am not sure how to use lead surveillance data
- I do not need to use lead surveillance data in my work
- Other (please specify)

6. How did you find the lead surveillance data that you used? (check all that apply)

- From a presentation (by NMDOH staff or others)
- On IBIS (New Mexico's Indicator-Based Information System for Public Health, online)
- Internally generated data (from within your program, clinic, local health department, or DOH bureau)
- From the Lead page on the Environmental Health Epidemiology website (NMDOH)
- At NMTracking.org (the NM site for Environmental Public Health Tracking)
- Other Health Organization websites (such as CDC's Healthy Homes or Lead pages)
- Other Professional or Non-Profit Organizations (such as LeadSafe America)
- Requested specific data from an NMDOH epidemiologist
- Other (please specify)

7. How did you use the lead-related data? (check all that apply)

- To advocate for or justify program resources needed
- To set program priorities and plan activities
- To advocate for policy change or policy development
- To understand the scope of the health problem or community need
- To create or update educational materials (worksheets, presentations, etc.)
- To write a grant
- Other (please specify)

Usefulness of Lead Data

8. How useful was the lead-related data you found?

- Very useful
- Useful
- Somewhat Useful
- Not Useful

9. How could it have been more useful to you? (Please make any suggestions you have).

Types of Data

* 10. Below is a list of different types of surveillance data. Please rate how useful each type of information would be to you in your work.

	Very Useful	Useful	Somewhat Useful	Not Useful	No Opinion
Costs Associated with Lead Poisoning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prevalence (Children Who Have Measurable Amounts of Lead in Their Blood)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Risk Factors for Lead Poisoning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Testing (How Many Children Are Tested for Lead)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Preferred Formats and Sources for Lead-Related Data

* 11. What format for sharing lead-related data would be MOST useful to you in your work? (check only one)

- Data Workshop/ Roundtable Discussion
- Fact Sheet/Brochure/Newsletter
- Newspaper Article/Radio Broadcast/PSA
- Other (please specify)
- Presentation
- Webinar
- Written Report

12. Please choose the method you'd prefer to use to find lead-related data for New Mexico.

- Data request to the Lead Poisoning Prevention Program epidemiologist
- Lead Page on the Environmental Health Epidemiology (NMDOH) Website
- NM Indicator-Based Information System (IBIS)
- NMTracking.org
- Other Health Organization Websites (e.g., CDC)
- Other (please specify)

13. How else could the NMDOH Childhood Lead Poisoning Prevention Program help you use lead surveillance data in your work?

Thank you again for participating. Your time and your suggestions are appreciated!

II. Methodology

The 2015 Lead Data Users Survey was created using Survey Monkey, a provider of web-based survey services. It was based on an EHEB survey used in 2014 to evaluate asthma surveillance data use and modified to reflect differences in data categories and key stakeholder groups. The survey form was pilot tested by EHEB staff, including epidemiology, health education, data analysis, and administrative services personnel.

E-mails briefly explaining the survey with a link to the site (using SSL encryption) were sent via e-mail. Initial contact with groups outside of the New Mexico Department of Health (NMDOH) was typically made by phone, encouraging the group's leader or administrator to send the survey invitation and link to their members. The survey opened during the second week of July and remained open through the first week of December.¹⁶

Recruitment of Respondents

The majority of the survey pool was contacted collectively, using invitation messages tailored to their professional or community group and to their likely experience with lead poisoning prevention and using lead data. Members of the Evaluation Planning Group for the CLPPP, including housing (NM Mortgage Finance Authority and Healthy Homes), refugee services, social work and social research, public health (PRAMS), and early childhood development professionals, were encouraged to forward the survey to their colleagues and members of their organizations.

Invitations were sent to e-mail contact lists within NM state government for programs which have partnered with the CLPPP or share common interests including Children's Medical Services (CMS), the Children, Youth and Families Department (CYFD), and NM's Women, Infants and Children Program (WIC). All NMDOH epidemiologists were invited to participate, as were all NMDOH health promotion staff. The evaluator also e-mailed staff members at organizations around NM which received recent HUD grants (examples: Homewise, Inc.; the Navajo Partnership for Housing), and contacted the New Mexico Kids Network Early Childhood Training and Technical Assistance Programs (TTAPs) supported by the University of New Mexico, Western NM University and Eastern NM University.

Organizations who shared member or staff lists, or sent invitations to their members, include the NM Alliance of Health Councils, the NM Pediatric Council, and the NM Pediatric Society, whose president and members helped make "healthcare provider" the largest occupational/avocational category among all responses received. Their support is greatly appreciated.

¹⁶ The initial survey design called for 3 months of data collection. The data collection period was extended due to technical difficulties which restricted use of the Survey Monkey site for 3 weeks in August, and in order to increase participation from housing and early childhood development stakeholders.