NACCHO
National Association of County & City Health Officials

1100 17th Street, NW, Seventh Floor
Washington, DC 20036
Phone: 202-783-5550
www.naccho.org

2017 Model Practices

Applicant Information

Full Name: Norilyn de la Pena

Company: Public Health - Seattle and King County

Title: Program Manager III

Email: norilyn.delapena@kingcounty.gov

Phone: (206)261-8287

City: Seattle

State: WA

Zip: 98104

Model Practice Title

Please provide the name or title of your practice: *

King County partners with CHWs to provide Tobacco Interventions

Practice Categories

Model and Promising Practices are stored in an online searchable database. Applications may align with more than one practice category. Please select all the practice areas that apply.: *

- [x] Access to Care
- [ ] Advocacy and Policy Making
- [ ] Animal Control
- [x] Coalitions and Partnerships
- [ ] Communications/Public Relations
- [x] Community Involvement
- [x] Cultural Competence
- [ ] Emergency Preparedness
- [x] Environmental Health
- [ ] Food Safety
- [ ] Global Climate Change
- [x] Health Equity
- [ ] HIV/STI
- [ ] Immunization
- [ ] Infectious Disease
- [ ] Informatics
- [ ] Information Technology
- [ ] Injury and Violence Prevention
- [ ] Marketing and Promotion
- [x] Maternal-Child and Adolescent Health
- [x] Organizational Practices
- [x] Other Infrastructure and Systems
- [x] Organizational Practices
- [ ] Primary Care
- [ ] Quality Improvement
- [ ] Research and Evaluation
- [x] Tobacco
- [ ] Vector Control
- [ ] Water Quality
- [ ] Workforce
- [ ] Conference Theme: Bridging Clinical Medicine and Population Health

Other::

Is this practice evidence based, if so please explain. :

Brief Tobacco Intervention Skills (BTIS) trainings is an evidence based practice per US Public Health Service Guidelines. Typically, BTIS is delivered by healthcare providers (doctors, nurses, MAs, etc). The model practice at Public Health Seattle & King County offers trainings to Community Health Workers to equip them with skills and tools necessary to provide tobacco cessation support to patients/clients as they are in the community serving the most vulnerable. Evidence shows communities have a positive response and fully trust CHWs with their healthcare needs.

Winnable Battles

To keep pace with emerging public health challenges and to address the leading causes of death and disability, CDC initiated an effort called Winnable Battles to achieve measurable impact quickly.Winnable Battles are public health priorities with large-scale impact on health and known effective strategies to address them. Does this practice address any CDC's seven Winnable Battles? If so, please choose from the following:: *

- ☐ Food Safety
- ☐ HIV in the U.S.
- ☐ Nutrition, Physical Activity, and Obesity
- ☑ Tobacco
- ☐ Healthcare-associated Infections
- ☐ Motor Vehicle Injuries
- ☐ Teen Pregnancy
- ☐ None

Overview: Provide a brief summary of the practice in this section (750 Word Maximum)

Your summary must address all the questions below:

- Brief description of LHD- location, demographics of population served in your community
- Describe public health issue
- Goals and objectives of the proposed practice
- How was the practice implemented/activities
- Results/Outcomes (list process milestones and intended/actual outcomes and impacts.
  - Were all of the objectives met?
  - What specific factors led to the success of this practice?
- Public Health impact of practice
- Website for your program, or LHD.

750 Word Maximum

Please use this portion to respond to the questions in the overview section. : *

Public Health - Seattle & King County (PHSKC) is a local health department in King County, WA providing a variety of programs and services, including 10 public health clinics. King County is a large, diverse, and complex environment with 2 million residents, 39 cities, 21 hospitals, and 12 health systems. Racial minorities are the majority of the population, including refugees and immigrants. Over 150 languages are spoken. According to Census data in 2010, more than 1 in 3 is a person of color. 1 of 5 residents lives below 138% of the federal poverty level. Medicaid's low-income beneficiaries comprise of approximately 25% of King County residents. 23% percent of residents speak a language other than English, and 19% are foreign born. Tobacco-related health disparities are a public health issue. Specific subpopulations and high poverty neighborhoods have high rates of smoking, difficulties with quitting, and disproportionate tobacco-related health disparities. Everyone is negatively affected by tobacco use, but some communities are more at risk of becoming smokers and suffering tobacco-related disease. In King County, 18% of deaths can be attributed to smoking. Tobacco is a chronic condition that often requires repeated intervention, by multiple types of healthcare providers. Tobacco dependence treatments are both clinically effective and cost-effective, related to other medical and disease prevention interventions. Studies show most smokers are not offered effective assistance in quitting. The goal is to implement systems change by integrating tobacco interventions into Community Health Worker (CHW) service models; providing tobacco screening and cessation support. Objective is to increase the number of non-profit organizations in King County, WA with capacity to integrate a brief tobacco intervention into their community health worker program from 0 to 10 between 2014 and 2016. The practice was implemented by a .85 FTE Public Health Project Manager with the Tobacco Prevention Program who offered free Brief Tobacco Intervention Skills trainings to Community Health Workers (CHWs) to incorporate into their service model. In order to systemize the practice, the following activities were conducted: • Researching of organizations that employ CHWs and key stakeholders or champions who had a vested interest in tobacco issues and who were referred to the Tobacco Program • Reaching out to community based organizations and clinics • Creating and sharing marketing materials to advertise training • Scheduling meetings with and developing relationships with new CHWs in the field and organizations who have CHWs on staff • Providing a tobacco interventions skills training • Sharing resources and materials • Providing follow up and refresher trainings 8-12 weeks, post training • Conducting information interviews to gather data and evaluate efforts • Collaborating with State Department of Health on developing a statewide CHW tobacco training module Results: The project reached 11 community organizations, trained 102 CHWs and an estimated 11,000 clients/patients. After CHWs received training, more referrals for tobacco cessation support were made, they shared stories of how it made a difference for their smoking clients, CHWs felt more comfortable discussing tobacco use, clients took advantage of using community resources to learn more/quit, and overall systems and culture change was a result. For example, one clinic recorded a spike in referrals to get additional support by a health educator within the clinic. CHWs from other organizations shared stores of how it made a difference for their smoking clients. Systems and cultural changes include organizations posting cessation materials in their lobbies, having quit line cards and materials available, and systems were in place for asking about tobacco use and assisting to quit by offering cessation referrals and materials. Objectives were met due to specific factors including the CHW organization's administration buy-in, marketing of the project, connecting with programs within the health department, and creating trust with new partnering organizations. The public health impact of helping the King County's most vulnerable communities is critical. Once given the tools, CHWs naturally link patients to health resources and community linkages. There is empirical evidence that when a primary care provider addressing tobacco use with their patient, at every visit, the chances that patient will consider quitting smoking is doubled. 70% of tobacco users want to quit. If LHDs and communities can compound this evidence-based treatment with support by Community Health Workers, the most vulnerable can quit smoking, minimize secondhand exposure, reap the benefits of quitting, and lessen the chances of contracting cancers and diseases, and prevent existing conditions in getting worse. Website for the PHSKC Tobacco Prevention Program: http://kingcounty.gov/depts/health/smoking/tobacco-vapor.aspx

Responsiveness and Innovation

A Model Practice must be responsive to a particular local public health problem or concern. An innovative practice must be (1) **new to the field of public health (and not just new to your health department)** OR **(2) a creative use of an existing tool or practice**, including but not limited to use of an Advanced Practice Centers (APC) development tool, The Guide to Community Preventive Services, Healthy People 2020 (HP 2020), Mobilizing for Action through Planning and Partnerships (MAPP), Protocol for Assessing Community Excellence in Environmental Health (PACE EH). Examples of an inventive use of an existing tool or practice are: tailoring to meet the needs of a specific population, adapting from a different discipline, or improving the content.

- Statement of the problem/public health issue
- What target population is affected by problem (please include relevant demographics)
    - What is the target population size?
    - What percentage did you reach?
- What has been done in the past to address the problem?
- Why is the current/proposed practice better?
- Is current practice innovative? How so/explain?
    - Is it new to the field of public health
      OR
    - Is it a creative use of existing tool or practice:
      What tool or practice did you use in an original way to create your practice? (e.g., APC development tool, The Guide to Community Preventive Services, HP 2020, MAPP, PACE EH, a tool from NACCHO's Toolbox etc.)
- Is the current practice evidence-based? If yes, provide references (Examples of evidence-based guidelines include the Guide to

Community Preventive Services, MMWR Recommendations and Reports, National Guideline Clearinghouses, and the USPSTF Recommendations.)

2000 Word Maximum

Please state the Responsiveness and Innovation of your practice (2000 Word Maximum) : *

The project is a creative use of existing tobacco intervention practice. Tobacco dependence is now increasingly recognized as a chronic disease, one that typically requires ongoing assessment and repeated intervention. The smoking rate among low-income adults is four times higher than the rate in more affluent residents and low-income adults are six times more likely to report smoking inside the home. King County has the largest smoking race/ethnic and income health inequities among the 15 most populous metropolitan counties. Compared to the general population, nearly three times as many low-income adults smoke, LGBT adults smoke at double the County average, Black, API, and multi-race adults have higher smoking rates, and suffering from a mental illness and substance use make quitting much more difficult. 220,800 adults in King County use tobacco and these numbers can be reduced when CHWs encounter someone that smokes. The target population is King County residents who are low income, those who receive Medicaid; the most vulnerable communities. An estimated 30% of current smokers make less than $15,000. Clearly, the high users are low income residents of King County. Medicaid recipients account for about 25% of King County residents. Often times, the most vulnerable are already suffering from a chronic disease or condition, have limited access to healthcare, and smoke twice the rate as the general population. 15% of Medicaid expenditures are attributable to smoking-related diseases. Because this is the first phase of the project, we are uncertain of the exact percentage of Medicaid recipients reached. During this pilot phase, over 11,000 residents received tobacco cessation information as a result of the CHW training. Of this group, it is assumed that 2% were county Medicaid recipients. . Future efforts will include mechanisms to capture this information. There is a need to provide continued opportunities of resources and support to address tobacco use. Data strongly indicate that effective tobacco interventions require coordinated interventions. CHWs can fill this need as they are out in the field conducting home visits and meeting with patients. A key role CHWs play is in improving health outcomes for populations suffering from chronic diseases. They assist with appropriate options for their disease and helping them through behavior change. It is a natural fit to utilize CHWs as the vehicle to reach (the often) underserved communities because they typically see folks to discuss heart disease, asthma, diabetes, etc. It is necessary to prevent these diseases to worsen. In addition, CHWs have more time with patients than medical providers and can be more accessible as well. In the past, healthcare providers and clinicians were providing tobacco treatment to some extent. Though, with limited time and resources, studies showed the practice wasn't fully integrated and providers were not following best practice guidelines. The delivery of tobacco interventions by a Community Health Worker (CHW) is promising and more cost effective than working with primary care and is a creative use of an existing practice. U.S. Department of Health and Human Services Public Health Service's Brief Tobacco Intervention Skills or the 5A's model of tobacco treatment. The 5As consist of (1) ASK-all health professionals ask all adults whether they smoke, (2) ADVISE them to quit, (3) Assess readiness to quit, (4) ASSIST in quitting, and (5) ARRANGE for follow up. It is evidence based practice and is based on science. In 2010, a report by the Institute of Medicine entitled "A Population-based Policy and Systems Change Approach to Prevent and Control Hypertension" further supported these findings by recommending the deployment of CHW as a population-based strategy for heart disease and stroke prevention. It is routine that CHWs act in the delivery of prevention and health promotion programs. Since hypertension is directly related to tobacco use, tobacco should be addressed in conjunction with their disease. CHWs typically see Medicaid recipients who remain at high risk and suffer disproportionately from tobacco-related illness and death. For example, treating tobacco users with chronic disease presents additional challenges. They can experience increased hospitalization time, complications, and increased risk of death. They continue to smoke at nearly twice the rate of the general population. CHWs are well-trained in addressing chronic diseases, many of which are the result of tobacco use. So it is critical for CHWs to directly address tobacco use as they counsel their clients on chronic disease management. U. S. Preventative Services Task Force also recommends using the 5As. Research related to CHWs as tobacco cessation counselors is limited. However, evidence shows that CHWs are influential, credible, and supportive to patients in need of health education services. CDC has compiled evidence-based research that supports the effectiveness of CHWs in the Community Health Worker Toolkit. The toolkit also includes information that state health departments can use to train and further build capacity for CHWs in their communities, as well as helpful resources that CHWs can use within their communities. Prior research utilizing conventional "outsider driven" interventions targeted to individuals has failed to show effective cessation outcomes. Ultimately the goal is for CHWs to incorporate tobacco interventions, thereby reducing high blood pressure and diabetes and other chronic disease risk factors among all participants.

LHD and Community Collaboration

The LHD should have a role in the practice's development and/or implementation. Additionally, the practice should demonstrate broad-based involvement and participation of community partners (e.g., government, local residents, business, healthcare, and academia). If the practice is internal to the LHD, it should demonstrate cooperation and participation within the agency (i.e., other LHD staff) and other outside entities, if relevant. An effective implementation strategy includes outlined, actionable steps that are taken to complete the goals and objectives and put the practice into action within the community.

- Goal(s) and objectives of practice
- What did you do to achieve the goals and objectives?
    - Steps taken to implement the program
- Any criteria for who was selected to receive the practice (if applicable)?
- What was the timeframe for the practice
- Were other stakeholders involved? What was their role in the planning and implementation process?

- What does the LHD do to foster collaboration with community stakeholders? Describe the relationship(s) and how it furthers the practice goal(s)

- Any start up or in-kind costs and funding services associated with this practice? Please provide actual data, if possible. Otherwise, provide an estimate of start-up costs/ budget breakdown.

5000 words maximum

Enter the LHD and Community Collaboration related to your practice (5000 words maximum): *

The goal is for LHD to create systems change where integrated efforts of health systems and CHWs provide an opportunity to increase rates of delivering tobacco dependence treatments, quit attempts, and successful smoking cessation. Objectives: •Outreach, research, and create clinical linkages promoting tobacco cessation via PHSKC programs, community organizations and services. Reaching 11 community based organizations and clinics that have CHWs on staff. (Target 10 organizations) •Train CHWs to provide evidence-based tobacco cessation support. Providing trainings and cessation education, materials, and resources to equip 102 CHWs to successfully deliver the intervention. (Target 90 CHWs) •Providing tobacco treatment, counseling and cessation referrals to 11,120 KC residents. (Target 10,000). Steps taken to implement the practice include: •Researching within the health department who in the community offers CHWs •Scheduling meetings to offer tobacco education and learn tobacco can be incorporated into current programming •Networking with social service agencies in our communities' •Developing a tobacco module for statewide CHWs to access, provide follow trainings and refresher courses. •Providing follow-up trainings and refreshers To achieve the goals and objectives, it was necessary to research which organizations (typically serving high Medicaid utilizers) in the community had CHWs, finding out where they were in the county and what services they provide. Collaborating with our Asthma CHWs and networking with partners they had already developed a relationship was key. Along the way, the project lead for the program reached out to others within Public Health department to perform informational interviews. Once contacts were established the project lead reached out to the various organizations to set up a one hour detailer (assessment). The detailer was an opportunity to learn what services the organizations provided to the community, who was being served and discuss expectations of the program. It is important to gather information and tailor the training to what was culturally appropriate and interesting. After evaluation of the first year of the project, CHWs requested materials to share with patients. Materials were then created and translated, and props and handouts were disseminated. A flyer that could be electronically shared and printed was an ideal way to outreach and market the project. The infographic flyer included details on the training, the value of addressing tobacco use poor, disparate communities, and resources. The criteria for who was selected revolved around whether or not CHWs were part of their service delivery. The timeframe for the practice is Sept 2014- Sept 2017. Numerous stakeholders were involved, including an Evaluations Lead (developed the logic model and provided evaluation support), Communications Lead (created marketing and outreach materials for dissemination), Tobacco Project Manager (conducted outreach and trainings), Site Champions (primary contact at agency who coordinated training date), CHW and housing providers, social services and clinics (implemented 5A's in practice) and Department of Health (funded an online tobacco module). The following organizations received the training and were key stakeholders: •Public Health Asthma Program- a program of PHSKC that works with clinics, health plans, and with patients in their homes to improve asthma care for residents who are low-income and people of color. •Neighborhood House- multi-service center that serves the needs of families, with a focus on low-income community members, public housing residents, immigrants and refugees. •Mercy Housing- a housing provider that services low-income individuals and families and offers supportive services •First Steps Network- a network of prenatal care providers with a focus on providing medical insurance •International Community Health Services- community health center that offers affordable health care services to Asian, Native Hawaiian, and Pacific Islander Communities •Entre Hermanos- promotes the health and wellbeing of Latino LGBT community through disease prevention, education, community building, and support service. •Sea Mar Maternal Support Services- supports families by providing WIC nutrition services, health education, infant case management •NeighborCare Health- the largest provider of primary and dental care in the Seattle area for low income and uninsured families •Public Health Maternal Support Services- provides health education and counseling during pregnancy and is part of the First Steps Program available to pregnant women through Medicaid. •WithinReach- builds healthy communities by providing support in obtaining health insurance, WIC, SNAP, immunization, creating systems change, etc. Building a trusting relationship and emphasizing the practice can be delivered in a short time was key in fostering collaboration with community stakeholders. The project is based on enhancing health equity and social justice; therefore it is framed in that context. When stakeholders hear messages about how tobacco disparities are harming their communities, they are more open to hearing what they can do to prevent and eliminate tobacco use. Following up with stakeholders and following through have helped create solid relationships, thereby furthering practice goals; integrating tobacco into their model. Funding was provided by the Partnerships to Improve Community Health grant. Costs associated by stakeholders include staff time only and the trainings were provided at no charge.

Evaluation

Evaluation assesses the value of the practice and the potential worth it has to other LHDs and the populations they serve. It is also an effective means to assess the credibility of the practice. Evaluation helps public health practice maintain standards and improve practice. Two types of evaluation are **process** and **outcome**. Process evaluation assesses the effectiveness of the steps taken to achieve the desired practice outcomes. Outcome evaluation summarizes the results of the practice efforts. Results may be long-term, such as an improvement in health status, or short-term, such as an improvement in knowledge/awareness, a policy change, an increase in numbers reached, etc. Results may be quantitative (empirical data such as percentages or numerical counts) and/or qualitative (e.g., focus group results, in-depth interviews, or anecdotal evidence).

- What did you find out? To what extent were your objectives achieved? Please re-state your objectives.
- Did you evaluate your practice?
    - List any primary data sources, who collected the data, and how (if applicable)

- List any secondary data sources used (if applicable)
- List performance measures used. Include process and outcome measures as appropriate.
- Describe how results were analyzed
- Were any modifications made to the practice as a result of the data findings?

2000 Words Maximum

Please enter the evaluation results of your practice (2000 Words Maximum): *

The evaluation set out to answer these questions: a. Between 2014 and 2016, to what extent and how well did we achieve the objective of increasing the number of non-profit organizations in King County, WA with capacity to integrate a brief tobacco intervention into their community health worker program from 0 to 10 organizations? b. To what extent and how well did we increase capacity among CHWs to deliver brief tobacco interventions? c. Did it make a difference for any clients who received the intervention? Methods The Tobacco Program project manager who carried out the implementation activities collected the following data using both a spreadsheet and a post-training evaluation form completed by CHW participants: # of organizations contacted, # of organizations who agreed to invite CHWs to attend tobacco intervention trainings, # of CHWs who attended trainings, % participants who improved knowledge and skills to deliver brief tobacco intervention after participating in training. The manager and evaluator together developed an interview guide which was used to collect qualitative data via interviews and group discussions with CHWs and their managers to get input on how well the training achieved its objective, how the training could be improved, and whether it made a difference for clients who received the intervention and why/not. Beginning December 2016, CHWs will have the option to complete an online tobacco module as part of the Washington State Department of Health (WSDOH) Statewide CHW Competency Training program. By September 2017, DOH will provide an evaluation of the module and share a summary of results of the module, participant characteristics, completion rate, and feedback from participants for the project manager. Analyses The project manager updated spreadsheets as new organizations and CHWs received trainings. Notes taken from interviews and group discussions with CHWs and their managers were transcribed and analyzed for common themes. Results and modifications made The LHD achieved the objective of providing training to CHWs in 10 organizations within the 2 year period. The LHD partnership with DOH succeeded in adding a tobacco module to the existing CHW training curriculum offered statewide. All CHWs demonstrated an increase in knowledge and skill with delivering the brief tobacco intervention to clients. CHWs described moving examples of how clients moved from to another stage of change toward tobacco cessation. Feedback from CHWs who participated in the first year of trainings led to these changes in the second year of trainings: extend training from 1 to 2 hours; include visuals on-hand for CHWs to see and touch (such as jars of tar); tobacco cessation quit kits (lip balm, quitline card, bookmark on money spent on tobacco, a button stating "Be nice to me, I'm quitting," rubberbands and toothpicks, and a stressball, and a pen with a resource printed on it. In addition, feedback included role play (which was more valuable for newer CHWs than for seasoned CHWs); each organization received 100 translated cessation bookmarks (i.e., Spanish, (will soon have Korean, Somali, and Vietnamese)) and two separate tear off sheets (each pack came with 100 sheets) on “Stress and Smoking” and “Chemicals in a Cigarette” to leave with clients; offer in-person refresher trainings within 6 months of first training; and accompany CHW for home visits upon request (two were requested in year 2). An example of a challenge that could not be addressed in this timeframe included having strategies or options to offer communities of color who do not trust or will not use the Quitline.

Sustainability

Sustainability is determined by the availability of adequate resources. In addition, the practice should be designed so that the stakeholders are invested in its maintenance and to ensure it is sustained after initial development (*NACCHO acknowledges that fiscal challenges may limit the feasibility of a practice's continuation*.)

- Lessons learned in relation to practice
- Lessons learned in relation to partner collaboration (if applicable)
- Did you do a cost/benefit analysis? If so, describe.
- Is there sufficient stakeholder commitment to sustain the practice?
    - Describe sustainability plans

1500 Words Maximum

Please enter the sustainability of your practice (2000 Words Maximum): *

Many lessons were learned in relation to practice. Every CHW program is set up different and each conducts and document differently. Some have systems in place, some do not. Depending on the setting and organization, CHWs have either a one-shot contact with the client or more frequent contacts. Some have electronic health records or medical records, some use paper files. CHWs have a variety of titles (Health Navigators, Promotoras, Health Advocates, Health Educators, Health Assistants, Health Advisors, etc.), but all have one goal and that is in linking their patient/client to services. In working with CHWs in Maternal Support Services, their biggest issue was not pregnant moms smoking, but the dads or partners that were continuing to smoke. It was an issue of secondhand smoke. CHWs can be found in every setting; community clinic, housing, health insurers, churches, etc. What's unique about our LHD is we have CHWs housed within our health department. Another lesson was collaborating with LHD CHWs was key in meeting objectives and goals. Creating a solid ground for relationship building and building trust with communities for the first time takes time and persistence. A cost benefit for this project was not performed. There is sufficient stakeholder commitment to sustain the practice. One of the housing organizations has built in a tobacco cessation support group on site. They have a budget to provide dinner and incentives for people who want to come together to learn about wellness and quit smoking. The CHW/facilitator for the group has mentioned great receptivity, quit attempts, and some residents have completely quit. A collaborative effort between the LHD and State Department of Health to create an online tobacco module for sustainability is a promising resource for all CHW to access. The online module hosts a variety of case studies, best practices, techniques in motivational interviewing, information on medication options, the psychological, biological, and cultural addiction of nicotine and tobacco use, and quizzes. Also available are resource links and forums to discuss tobacco issues with CHWs, statewide. There is a pre-post test and evaluation as part of this program. In addition, King County has submitted a Medicaid waiver that would include support for CHW strategies such as this project. The waiver would allow CHWs to be reimbursed for tobacco cessation and other chronic disease prevention services similar to how providers are reimbursed. Currently, only physicians, Mas, nurses, and other licensed providers' services are reimbursable. If this Medicaid waiver was to be accepted, there could possibly be a significant increase in cessation interest and support for services.

Additional Information

How did you hear about the Model Practices Program:: *

- ☐ I am a previous Model Practices applicant
- ☐ At a Conference
- ☐ NACCHO Website
- ☐ Public Health Dispatch
- ☑ Colleague in my LHD
- ☐ Model Practices brochure
- ☐ NACCHO Exhibit Booth
- ☐ NACCHO Connect
- ☐ Colleague from another public health agency
- ☐ E-Mail from NACCHO
- ☐ NACCHO Exchange