NACCHO
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2017 Model Practices

Applicant Information

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Model Practice Title

Please provide the name or title of your practice: *

Peer Power

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.: *

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

Other::

Chronic Disease, Nutrition & Physical Activity

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

No.

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. : *

Dare County is the easternmost county in North Carolina, and covers an area of over 1,000 square miles of which only one-third is land. It is home to approximately 35,000 year round residents and stretches from the northern shores of Duck, to the mainland on North Carolina's eastern coast, to the southern shores of Hatteras Island. The Dare County Department of Health & Human Services' (DHHS) Division of Public Health serves the county's estimated 35,000 residents through its commitment to meet the evolving health and social needs of the community. One of the key programs run by DHHS is Peer Power. Using a peer-to-peer teaching model, Peer Power trains local high school students to become Peer Health Educators (PHE). PHEs develop and deliver age-appropriate and culturally diverse activities, focusing on health, to elementary and middle school students. These activities educate elementary and middle school students, who account of 21.8% of the county's total population, how to lead healthier lives, and empowers students to take charge of their health. In order to educate and empower students to lead healthier lives, Peer Power's goals are broken into short-term, long-term, and ultimate. In the short-term, Peer Power seeks to change behavior, increase healthy food choices, increase physical activity, and influence students not to use alcohol, tobacco, and other drugs (ATOD). Long-term goals for Peer Power include higher rates of healthy food choices, higher rates of physical activity, and higher numbers of students who choose not to use ATOD. Ultimately, Peer Power strives to decrease the incidence of chronic disease in Dare County while also decreasing overall health care spending in the county by investing in early prevention. To achieve these goals, PHEs focus on three areas: physical inactivity, ATOD, and nutrition. Peer Power's areas of focus directly align with health concerns outlined in the 2013 Dare County Community Health Assessment (CHA): obesity and diabetes, both of which were placed on the "Watch List", which highlights areas of concern identified by survey data, while substance abuse was identified as the most serious health problem in Dare County by focus groups. Thus, prior to entering the classroom, employees of DHHS train PHEs to be effective and informative educators that are aware of the health issues plaguing Dare County. By implementing a peer-to-peer teaching model, Dare County students learn the skills and tools they need to make informed decisions to lead healthier lives. In addition to teaching classes to hundreds of students enrolled in Dare County Schools (DCS), PHEs have worked on campaigns to inform members of the community how to properly dispose of prescription drugs, have educated local restaurants on how to keep restaurants e-cigarette free, as well as helped recognize restaurants who chose to be smoke free with the 2010 smoking ban in NC restaurants. Formative evaluations are conducted each semester to ensure Peer Power is meeting its short-term goals. Such formative evaluations have shown that Peer Power routinely meets the program's short-term goals. Health Educators, who teach the Peer Power program are currently working on means to assess the long-term and ultimate goals of the program. The formative evaluations have proven just how essential the partnership between HHS and DCS is. Without the cooperation and support of DCS, PHEs would have no classrooms to teach in, nor students to teach, and PHEs themselves would not be trained. DCS teachers provide feedback on lessons, PHEs, and the impacts Peer Power has made in their classrooms. This data is essential to the functioning of Peer Power. Peer Power has already seen evidence of the success of the peer health education model. The prevalence of overweight children ages 12 – 18 dropped dramatically from 2004 to 2008, while the prevalence of obese children ages 5 – 11 dropped significantly over the same time period. Overall, Peer Power is directly participating, through early prevention methods, in decreasing the prevalence of obesity, diabetes, and substance abuse in Dare County. Please visit our website: https://www.darenc.com/health/

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) : *

North Carolina health statistics have shown an increase in premature morbidity and mortality caused by disease of the heart, lung disease, COPD and diabetes. Local population statistics in Dare County, North Carolina, corroborate these findings. Chronic disease prevention programs are needed at the local, state, and national levels. Although these are generally not diseases of youth, it is important to begin early to prevent types of behavior that lead to chronic diseases. The North Carolina Justus-Warren Heart Disease and Stroke Prevention Task Force identified tobacco use, nutrition, and physical activity as the core behavioral factors related to chronic disease prevention. This program started in 2001 as a result of these findings and is still being taught in 2016 in all three of the Dare County High schools. Peer Power was implemented as part of the core health education curriculum in the three Dare County middle schools beginning with the 2002-2003 school year continuing still in the 2015-2016 school year. In 2005 the curriculum grew to include 3 elementary schools in Dare County. The target populations included both middle and elementary school students in Dare County which includes 5 elementary schools and 3 middle schools. Due to proximity issues our target audience was compiled of 3 elementary and 3 middle schools. The Peer Power goal was to teach 3rd graders and 6th graders in these 6 schools. The Peer Power curriculum is taught during middle school physical education classes and is scheduled with the elementary schools when their schedules permit, which sometimes this means the program, is taught in different grades such as 2nd or 8th grade. In 2015 the program taught approximately 5228 students including both elementary and middle school. More student contacts were made with guest speakers, assemblies and health presentations. Dare County Schools are very aware of health data with their students and have implemented various programs and events to get their youth active. Before Peer Power, DCS addressed tobacco use, nutrition, and physical activity with students by implementing a variety of different programs. One of the most important things the school system has done to address the issue is fund Health and Physical Education teaching positions at each of their schools. Within these teaching positions the teachers aligned their health and physical education lessons to the state curriculum and standards, otherwise known as the North Carolina Essential Standards. Another program which addressed physical activity was called “Go Far.” This program encourages walking or running during or after school and students are rewarded for their participation. North Carolina also requires our elementary and middle schools to allow all students to have a 30 minute break for recess. Lastly, each school has a school nurse, who has also helped in the past educate students on effects of using tobacco, how to eat a healthy diet, and the importance of physical activity. The Peer Power program embraces the peer teaching model, which has become increasingly popular in public schools over the past decade. Currently high school Peer Health Educator classes are charged with teaching their younger peers the benefits of healthy eating and physical activity and the negative impacts of substance abuse. This allows the younger students to get more individualized learning, promotes active learning and allows students to feel more comfortable and open when interacting with a peer. DCS health teachers and students have also acknowledged why the Peer Power teaching method is better. One middle school student said, “We have more fun in the Peer Power class, because it is more interesting, easier to learn, hands on, and interactive.” We have also conducted focus groups with both health teachers and administrators. These focus groups have reported “Peer Power has positively benefited our middle school students and we have received recognition within the community for our school's involvement in this Peer to Peer program”. To ensure that the Peer Power program has a lasting effect on the students, DHHS Health Educators continually update the curriculum to align with current trends and best practices. Peer Power is an innovative approach to school based health education that utilizes a peer-led teaching model in an effort to improve the health behaviors of children and adolescents in three domains; nutrition, physical activity and alcohol, tobacco and other drugs (ATOD). The program provides a creative use of the peer-to-peer model through a unique partnership between DHHS and DCS. This partnership provides an elective class in the high schools taught by a qualified health educator. During an initial 10-week training period, small classes (3-8) of high school students are trained as Peer Health Educators (PHE). The PHE training includes the three health domains discussed above as well as training on public speaking, lesson planning, public health concepts and presentation development. Following the training period, the PHEs move on to developing and delivering their own lessons focused on the three domains for middle and elementary school classes. Currently, the Guide to Community Preventative Services classifies school based health education to promote nutrition and physical activity as a practice with “insufficient evidence” based on a meta-analysis of the scientific literature in 2003. This classification is largely due to the fact a majority of the data was self-reported and because the reported effect on behavior change was small. Research that is more recent has shown school based health education to be an effective means to reach children and adolescents as their personal health behaviors are being formed. The CDC also recognizes that school based programs are an opportunity to reach the majority of school age children. They recommend a comprehensive school based health education system that focuses on the whole child and the whole community by including community partners from outside the school system. While DCS does have a school based health education programs, Peer Power embodies this model as well utilizing community government support for funding, DHHS for staffing and DCS for the location and technical support. There is also a vast body of research supporting peer led health education programs. Much of the current research centers around sexual and reproductive health education but a newer systemic review of the literature conducted by Yip, M. Gates, A. Gates, and Hanning in 2016 supported the peer-led health education model for nutrition education in school aged children. Improvements in knowledge and attitudes towards healthy eating as well as self-efficacy, dietary measures and Body Mass Index (BMI) were reported. The authors called for further research into long-term behavioral changes, sustainability and feasibility as a cost-effective means to improve population level health indicators.

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 Peer Power program was designed to produce positive health behavior changes in youth and reduce long-term incidence of chronic diseases of the heart and lung by teaching youth about the dangers of tobacco use, poor nutrition and inadequate physical activity. Peer Power has far exceeded the anticipated outcomes and proven to be a catalyst for improved health behaviors throughout the community. Positive unintended consequences of Peer Power include the development of an effective social marketing campaign, reduction in tobacco sales to minors, and an increase in smoke-free restaurants in Dare County initially to a totally smoke free restaurants established in 2010. The Dare County team analyzed the industry of chronic disease prevention, looking at best practices and trends in existing initiatives. Because of the program's focus on youth, the team decided it should utilize innovative methods, including technology, to deliver its message, and should have a peer-education orientation to best engage the target audience. The team created a program for high school and middle school students, in which the latter are taught lessons about nutrition, physical activity, and tobacco use by teams of local high school students, who would receive academic credit for participating. DHHS personnel would train the high school students in an appropriate curriculum, and these students would be expected to create behavior change projects, mentor middle school students about their health-related choices, and design and produce resource displays at the middle schools and area libraries. High school students were recruited for Peer Power on the basis of academic achievement, emotional maturity, and desire to participate. School counselors charged with ensuring the federal No Child Left Behind standards are met and developing student schedules in three different high schools in Dare County are the primary source for recruitment to Peer Power. High school clubs were also leveraged to recruit students into the program, such as the "hurricane watch" at Cape Hatteras Secondary School and Rachael's Challenge clubs throughout Dare County. Peer Power was launched in July 2001; it was a fully integrated part of the core health education curriculum in Dare County's three middle schools beginning with the 2002–2003 school year and continuing since then. The first step of implementation was to hire personnel. Health educators were hired to train peer health educators (students); the students developed behavior modification assignments and lesson plans, classroom activities and established the Wealth of Health Resource Areas in libraries in each school. By fall 2005, 79 high school peer health educators had participated in the program, teaching a total of 805 middle and elementary school students. The high school Peer Power students worked with the health educator to learn health content and devise teaching strategies for sharing that content with middle and elementary school students. Two to five times each week, Peer Power students visited middle and elementary schools to conduct educational sessions. An activity report for the period from July 1, 2001, to December 31, 2005, listed a total of 588 service delivery activities, including classes and other events; 102 out- reach activities, including exhibits, news releases, presentations, and other disseminating activities; and 467 training activities, including skill building/training for high school peer health educators in the areas of nutrition, physical activity, and alcohol, tobacco, other drugs (ATOD). Annually the Peer Power program is assessed for relevancy with school and community needs and trends, continuity and impact. In 2013 the need for additional education of tobacco with the emergence of electronic cigarette's and increasing Rx drug use was apparent in the community. The program was adjusted to contain this additional educational need. More recently for FY 2016, 51 training lessons were delivered, 190 educational messages delivered, 31 students trained to be peer health educators and a total of 5,228 students contacts made. In North Carolina, the Dare County Department of Health & Human Services -Public Health Division (DHHS) in 2000 joined forces with its long-time ally, the Dare County Schools, to improve the long-term health status of young people in its county by addressing their health-related behaviors. The DHHS has long had a successful collaboration with the Dare County Schools. For example, all local schools have a nurse employed by DHHS. This partnership allows for in- creased health services to youth, but health education in schools has not been as effective. In recent years, an increased emphasis on showing outcomes in academic courses subject to state testing has made health education a low priority. An assessment in 2000 showed delivery of health education to be inconsistent, uncoordinated between schools, and not comprehensive. In response to this assessment and the long-term health challenges facing the region, the DHHS and the Dare County Schools emerged as leaders to plan and deliver a program to modify risk factors for chronic disease among youth. Involving other community stakeholders was a key factor in our success. Dare Coalition Against Substance Abuse (CASA), the Dare Center, Project Purple which is a national anti-substance abuse initiative of The Herron Project, launched to break the stigma of addiction, bring awareness to the dangers of substance abuse and shed light on effective treatment practices was started in Dare county, and the Outer Banks Hospital Nutritionists coming to speak and educate the high school students. These stakeholder relationships still continue today. Using the comprehensive business plan developed for the Management Academy, the Dare County team applied for and received funding for Peer Power through a 5-year, $395,336 grant from the Kate B. Reynolds Chari- table Trust's SELF (Smoking, Education, Lifestyles, and Fitness) Improvement Program.

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): *

Evaluation of the Peer Power program has been a priority since its inception in July of 2001. DHHS initially collaborated with The University of North Carolina at Chapel Hill School of Public Health in 2004 to evaluate perceptions of the program among participating PHEs, parents, teachers and administrators. The evaluators utilized one on one interviews and focus groups and the response was overwhelmingly positive. Another evaluation completed in 2005 for the Kate B. Reynolds Charitable Trust's SELF improvement program measured nutrition and physical activity behavioral changes in the PHEs and their middle school students in a pre-post survey format. Significant improvements in both categories were reported as well as a 4% decrease in BMI in 66% of the students. In 2012, Ashley Tucker B.S., an MPH candidate from East Carolina University's Brody School of Medicine Department of Public Health, conducted an intermediary outcome evaluation of the Peer Power program. Her methods included surveying 9th and 10th grade students from First Flight High School in the 2012-2013 academic year on their nutrition, physical activity and tobacco use behaviors. Using statistical analysis Ms. Tucker to compare students who had received peer power lessons from PHEs in 7th grade to those who had not received any lessons. The results of the survey revealed that students who received peer power lessons in middle school were significantly more likely to exercise frequently, eat more fruits and vegetables, and abstain from using tobacco products. Starting in 2013, Peer Power added substance abuse to the curriculum, which in turn led the Health Educators to add this component to their evaluation measures. Since adding this component results have shown students understanding in how harmful tobacco, marijuana, prescription pills, inhalants and alcohol is to their bodies. In the most recent report done in Spring of 2016, students unanimously agreed that it is very wrong for someone their age to smoke or use tobacco products. As well as showed a better understanding in thinking that inhalants, prescription pills and alcohol were very harmful for their bodies. Evaluation of Peer Power internally on an outcome level began in 2011 with surveys of the PHEs on their overall experience with the program and their suggestions for improvement. This evaluation method continued through 2013 when a more comprehensive process and outcome evaluation was developed. Beginning in 2014, both process and outcome measures were evaluated utilizing quantitative and qualitative data sets. Quantitative data is collected using pre and post surveys administered to the middle school students before and after receiving peer power lessons. We measure knowledge of USDA dietary and physical activity recommendations for Americans, dietary behavior, physical activity behavior, attitudes towards the use of ATOD substances and tobacco use. Qualitative data is collected through surveys completed by the PHEs and the middle school teachers regarding their experience with the Peer Power program. Process measures included training logs completed by the Peer Power teacher during the initial PHE training period to ensure fidelity to the outlined training program for PHEs. Logs were also created for the PHEs to ensure that the lesson they develop meet the North Carolina Essential Standards for Health Education. This process and outcome data has been collected every semester since 2014 and is analyzed by an internal staff person whose position is unrelated to the Peer Power program. Pre/post surveys are compared to quantify changes in knowledge, attitudes and behavior and our results have consistently shown improvements in all three indicators. Qualitative surveys of the PHEs and the middle school teachers have also consistently shown positive impressions of the program for all the students involved.

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): *

When Peer Power was in the development stages, the 4 managers from the Dare County Department Health and Human Services (DHHS) and the Director of Student Services with the Dare County Schools attended the UNC Management Academy to ensure a long-term sustainable program was created. Upon receiving the knowledge that the management academy provided, the team used the data management training to gather and analyze a great deal of in-depth information about some of the program needs, such as expenses, revenue, and risk to long-term feasibility. The team created what a potential budget would look like including daily operations, personnel projections and annual operational costs going forward for 6 years as well produced a month-by-month operations budget for year 1.The long-range plan addressed how to expand the program to include additional risk factors for premature disability and disease which would return the investment by improving health behaviors in the long run and lowering healthcare costs. The potential budget for the expected revenue and expenses included operating costs as well as revenue costs. In regards to the operating costs, the budget took many things into consideration, but the most important things were the Peer Power educator salary, the program assistant salary, DCHHS and DCS program support staff, employee travel, student travel, office space, computer equipment, resource materials and supplies. The revenue portion took into consideration grant funds, reinvested revenue, business donations, website subscriptions, curriculum sales and consultative services. Subsequently the team applied for grant funding to launch the program, in which the Kate B. Reynolds Charitable Trust grant was received, providing funding for Peer Power over a 5-year period with $395,336 dollars. Throughout the 5 year period, funding was used adequately while the team worked effortlessly with local government to ensure that Peer Power would continue to be funded. After the 5 year grant period of KB Reynolds, the Dare County Health Department was awarded the NC Health and Wellness Trust Fund Grant, which would provide funding for the following 3 years. After 8 years of being a grant funded program the community came forward with ideas on how to fund the popular program and in ensure effective sustainability. Therefore in 2009, local stakeholders and Dare county commissioners decided that Peer Power should be funded using state and local funding to ensure the sustainability of the program to remain in the schools. Presently the Dare County commissioners remain dedicated to supplying money to fund Peer Power. Throughout the 16 year duration of the Peer Power program, the curriculum has been consistently evaluated and monitored because of lessons learned in relation to practice. In the summer of 2014, a team within DHHS was established to help to ensure the curriculum was continually evolving. This team consists of the two Public Health Education Specialists that teaches Peer Power as well as two additional Public Health Education Specialists and the communication health assessment coordinator. The team met weekly for 10 weeks to revise and update the curriculum based on student's feedback and experience as well as to ensure the curriculum was meeting our community's ever changing needs. In order to properly evaluate and make sure the curriculum remains current and relevant the team meets every 6 months. In addition to these semi-annual meetings, each semester Peer Power students are asked short answer questions to get additional feedback after completing the course about the lessons they learned as well as their likes and dislikes of the program. The curriculum meetings and student feedback are essential because helps ensure that our curriculum is not out of date which in turns allows the team to learn lessons in relation to practice. Lastly team also learned in 2013, that the substance abuse content needed to be updated and there was a need to add additional content in regards to prescription pills, inhalants, marijuana and alcohol to ensure student were benefiting from the program. During the years in which Peer Power has been implemented, Dare County and it's community and partners began to catch on to the idea and excitement surrounding Peer Power. When the program was in the developing stages, the most important partners were the schools; the superintendent, principals, teachers and guidance counselors. Throughout the planning process the team acknowledged that DCS willingness to partner with them was critical to the success and longevity of the program. In addition to the schools partnership, Peer Power has created a variety of partnerships over the years, including Dare County Libraries, Regional Medical Center, Outer Banks Hospital, NCSU Cooperative Extension, Dare County Parks and Recreation, YMCA, Dare Coalition against Substance Abuse, Project Purple, and North Carolina Department of Transportation. Partnerships have been essential to the growth of Peer Power by allowing individuals to collaborate with the Peer Power Teachers as well as allowing some of the partners speak to the students in the class to help further their knowledge on certain subjects. In efforts to continually better the partnership with the schools and the community, Peer Power Teachers are encouraged to get involved in school and community events. Some events would include getting involved with leading school based clubs, taking students on field trips in the community, helping with school wide events such as field day, and leading events for the school to participate in such as the Great American Smoke Out. The program also allows the Peer Power students to create partnerships within their school, at the schools in which they are teaching at as well as with community members. Peer Power students are introduced to younger students when teaching and those younger students create relationships with Peer Power. They also get introduced to many school members as well as community members in which they get to network and create partnerships to help them down the road. In addition to Peer Power teachers being involved with school wide events, they are also expected to know school wide policies communicate with administration and are held to the exact standards expected from all Dare County teachers. The hiring and training of Peer Power teachers whom excel in teaching the curriculum also helps with the sustainability of the program.

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