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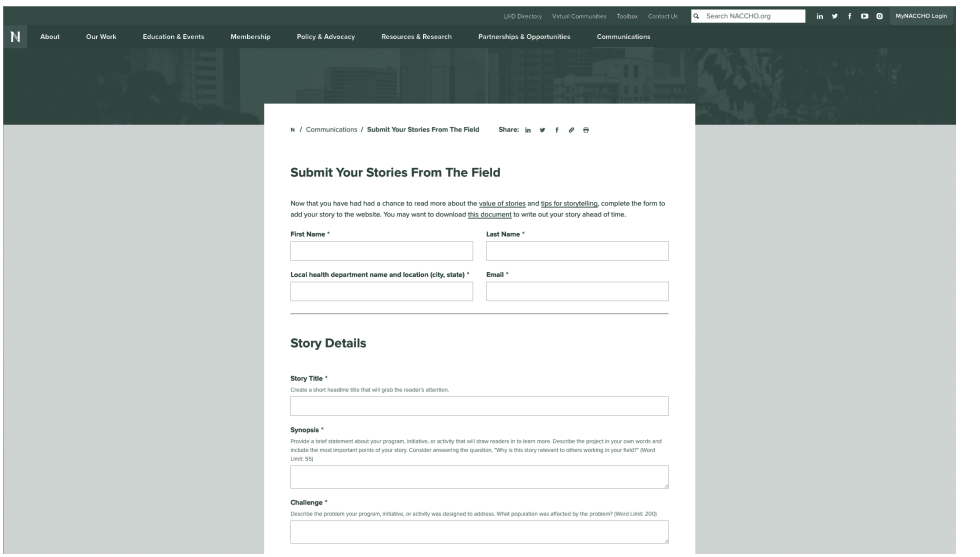
Stories from the Field

What's Inside…

NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

Introduction

Stories from the Field provides a means for local health departments to share their experiences and demonstrate the value of public health with NACCHO's members and others. Within this issue, multiple stories from the field are highlighted, covering public health areas that are important across the country. To submit a story from the field, visit https://www.naccho.org/communications/stories-from-the-field. To read more stories, visit https://www.naccho.org/blog/stories.



Emergency Department-Based, Peer-Led Substance Use Navigation Programs – A Promising Model

By Francis Higgins, Msc, Senior Program Analyst, NACCHO

Emergency departments are an important hub for overdose and prevention and response services due to the volume of patients admitted and the expertise and resources at hand. Recent reports from the Drug Abuse Warning Network estimate that there were over one million opioid-related emergency department visits in 2021.[1] For many patients, the emergency department may be their main point of interaction with medical professionals, and these visits represent a crucial opportunity to discuss the risks of drug use, harm reduction techniques, evidence-based treatment for Opioid Use Disorder (OUD), and other behavioral and social services. Despite this, there remain significant barriers to treating patients with OUD in emergency department settings. Only 11.6% of Medication for Opioid Use Disorder (MOUD) initiations occur in emergency departments and people who use drugs (PWUD) report high levels of perceived stigma during their interactions with the care system.[2,3] Additionally, clinicians commonly report a lack of training, lack of experience, and lack of specialist support as barriers to care for these patients.[4]

In an attempt to bridge this gap, the National Association of County and City Health Officials (NACCHO) has, since 2019, partnered with the Centers for Disease Control and Prevention (CDC) and the Mosaic Group (https://groupmosaic.com/) to implement the Mosaic Group's model program, *Reverse the Cycle* (RtC). The Mosaic Group has a long history of success in implementing RtC, which, broadly, has four main aims:

- Systematize the screening of patients who present in the emergency department for substance use using the Clinical Opiate Withdrawal Scale (COWS)
- Integrate consultation and substance use navigation led by peer recovery specialists (peers) for patients who positively screen for substance use[5]

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(https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peer-support-2017.pdf)

- Provide immediate access to MOUD as an evidence-based mechanism for harm reduction and recovery support
- Develop relationships with community-based MOUD clinicians, as well as harm reduction and recovery organizations, to provide ongoing support for people who use drugs (PWUD) after leaving the emergency department or other medical settings

The four evidence-based components have the potential to relieve some of the pressure on clinicians and, critically, improve the care and outcomes for PWUD who present in EDs. Systematic screening improves the ability of emergency departments to provide standardized care and ensure that patients in need of services are not missed.[6] Use of the COWS in particular has been shown to improve clinician confidence in identifying patients in, or at risk of, withdrawal, a critical step to ensuring appropriate care is provided.[7]

Substance use care navigation in emergency departments, whether delivered by peers or other staff members, has been shown to reduce readmission rates and result in cost savings for care providers.[8] However, utilizing peers has additional benefits for patients who may lack trust in traditional care providers. Peer recovery specialists are individuals with "lived experience" who have been trained to support those who struggle with mental health, psychological trauma, or substance use. This lived experience allows them to develop connections and trust with patients and allows them to serve as powerful advocates for appropriate and effective care. Interventions using peers have been shown to have positive effects on outcomes for patients with OUD, including reduced relapse rates, increased treatment retention, improved relationships with treatment providers and social supports, and increased satisfaction with the overall treatment experience.[9]

Medication for opioid use disorder has been shown to reduce future opioid use, as well as subsequent morbidity and mortality.[10] Buprenorphine and methadone treatment, in particular, are associated with reductions in overdose and serious opioid-related acute care use compared with other treatments.[11] Immediate, on-site MOUD induction is shown to have positive benefits for patient outcomes and treatment adherence but, in the event that the patient is not comfortable or medically ready for induction, at-home options and protocols are available.[12] Additionally, low-dose MOUD for withdrawal management can be provided for patients as a bridge to full induction and can also be provided to patients not prepared to cease their drug use, as a means to increase comfort and reduce the likelihood of patients leaving against medical advice.[13]

Planning for post-discharge is also an integral part of this model. Peers and other staff members who have developed community relationships are able to connect patients being discharged with community-based MOUD and other services, such as behavioral or mental health care. Referrals to other services that seek to address the social conditions that can lead to drug use, such as food, transportation, and housing supports, can also be provided. All patients, regardless of their stated plans in regard to their future drug use, are also provided harm reduction tools like naloxone and fentanyl test strips and are directed to sources for further supplies within the community. Although there may be capacity constraints on staff, peers may also follow up with patients post discharge, which has been shown to be associated with increases in treatment retention and reductions in subsequent substance use and associated negative outcomes.[14]

These four program components together represent a comprehensive response in emergency department settings to managing patients who use drugs. Since the collaboration began, NACCHO and the Mosaic Group have directly launched emergency department-based programs at 13 hospitals across four states, which have collectively contributed to tens of thousands of patient screens, thousands of peer interventions, and hundreds of patient linkages to treatment. A particular highlight comes from Appalachian Regional Healthcare (ARH), which has now expanded the model to over 90% of their emergency departments and hired a systemwide peer coordinator to provide guidance and support throughout the system.

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Despite this success, there remains more work to be done. In early 2023, in the interest of expanding this model and supporting our member local health departments (LHDs), the *Embedding Peers in Emergency Departments* (EPED) program was launched. Supported by intensive technical assistance from the Mosaic Group, the EPED program funded five local health departments to collaborate with local emergency departments to develop and implement an RtC-like program.[15] As of December 2023, three new ED-based programs have been launched, with two more expected to launch in the new year. This expansion of the model to include health departments brings their expertise in fostering community public health collaboration to bear. Crucially, the network of treatment and social service connections LHDs possess can expand the resources available to patients post-discharge. LHDs may also have more flexible hiring models than emergency departments, which can expedite the hiring and placement of peers, whose history of substance use may preclude or delay their direct hiring by emergency departments.

Shortly following launch of EPED, NACCHO contracted with five other health departments through the *Sustaining Peers in Emergency Department*s (SPED) program. SPED provided funding and technical assistance for LHDs that had already collaborated with local emergency departments to launch peer-led substance use navigation programs, with the aim of giving them time to refine their programs, gather more robust evaluation data, and develop plans for longer term, sustainable funding sources. SPED seeks to address issues with the traditional, one-year grant funding cycle that often does not provide time or funding to gather important data and resources to leave newly launched programs on durable and stable footing. While still in its early days, detailed sustainability planning has been completed and the sites are now working to disseminate information on the results of their programs and formalize future funding arrangements.

Finally, while every site NACCHO has worked with has conducted internal evaluation and each of the program components discussed are based on robust evidence, there is a lack of published academic literature on the patient outcomes associated with this comprehensive model. To address this, NACCHO has partnered with four sites to collect data and submit manuscripts examining the effects of these programs on measures including, but not limited to, treatment retention, readmission rates, emergency department cost savings, and the ability to improve care and outcomes for subpopulations disproportionally impacted by the ongoing overdose crisis. This work has the potential to massively advance the state of the evidence and, ideally, will lead to increased adoption and support of this successful model.

Emergency departments have tremendous potential to provide care for patients who use drugs. However, a lack of training, knowledge, and a formalized model often leaves this potential unrealized. By standardizing screening and care for these patients and incorporating the experience, expertise, and connections of peers and LHDs, we have the opportunity to make a meaningful difference in the health outcomes for patients who use drugs and break down the longstanding stigma that so often can prove a barrier to seeking care for those in need. NACCHO looks forward to future opportunities to continue the expansion of this vital work and encourages interested communities to reach out to the Overdose, Injury, and Violence Prevention team (ivp@NACCHO.org) for more information.

For more information, contact Francis Higgins at fhiggins@naccho.org.

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Resources

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Partnering for Health: Implementation of School-Located Vaccine Clinics with Local Health Departments

By Amiris Roberson, MPH, CHES®, Programs Analyst, NACCHO

Vaccination is a critical component of public health initiatives worldwide, playing a pivotal role in preventing the spread of infectious diseases and safeguarding community well-being. By immunizing individuals against specific pathogens, vaccines reduce the likelihood of outbreaks and limit the overall impact of diseases on public health. Vaccination is particularly crucial in protecting vulnerable populations, such as infants, elderly individuals, and those with compromised immune systems.[1]

Globally, there is an ongoing effort to improve vaccination rates, especially in light of the recent COVID-19 pandemic and the setbacks to routine coverage rates that occurred as a result. Throughout the pandemic and afterward, the role of vaccination in maintaining community health has become increasingly emphasized. Furthermore, due to the pivotal position of schools within communities and the opportunities they hold for health interventions and community engagement, the concept of school-located vaccine clinics (SLVC) has emerged as a proactive and strategic approach to enhance immunization coverage.[2]

School-located vaccine clinics offer a practical solution to overcome barriers to immunization. The school environment provides a unique opportunity to reach a large proportion of the population, including children and adolescents who are often the focus of vaccination efforts.[3] Schools have displayed their tenacity in providing families with nutrition access, social support, and being a trusted source of information for the community. School-vaccination clinics are critical access points for students and families to receive routine immunizations and other care needed, and are diverse in nature, dependent on each respective school and their capabilities and resources. Local health departments can leverage existing partnerships and look to create new, sustainable partnerships with schools to provide support and expertise, with the intention of decreasing the risk of vaccine-preventable disease infection and spread and increasing vaccine access and confidence for school-aged children and their families.

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Stories from the Field

The stories from the field that follow highlight two local health departments that have established successful partnerships with local school districts and schools in their jurisdiction to provide SLVCs in their communities. The main factors to consider for successful partnerships between local health departments and schools are planning efforts, trust, communication, and equity and access. Mahoning County Public Health and the Public Health Institute at Denver Health are strong examples of the importance of the LHD and school partnership and collaboration.

Mahoning County, Ohio

Mahoning County Public Health (MCPH), located in Youngstown, Ohio, provides all school districts in the jurisdiction the opportunity to host school-based immunization clinics each year. The health department's jurisdiction includes 13 public school districts, one county board of developmental disabilities school, and five private schools. The health department completes an annual immunization coverage disparities evaluation and report, which includes reviewing U.S. Census Bureau poverty rates and health insurance coverage; Ohio Department of Education data on free/reduced meals; Ohio Department of Health's data on school immunization coverage rates; and IMPACTSIIS, Ohio's statewide vaccine registry. A recent evaluation report from 2022 showed that children are living in poverty at a higher rate in Mahoning County compared to the rest of the state and the country. Furthermore, the report showed that African American and Hispanic populations are disproportionately impacted by poverty in Mahoning County.

Two local school districts have a higher percentage of students living in poverty than the county's overall rate, with three others close behind. Five school districts have more than half of their student bodies qualifying for free and reduced-price meals. Children within some of these same school districts had lower percentages of immunization rates for kindergarten entry. In addition, many of these same schools had higher rates of reported vaccine exemptions. Scarcity of child/adolescent vaccine providers has been identified throughout Mahoning County. Mahoning County has two townships (encompassing rural communities), one village, and one city that were identified as having lower percentages of certain immunizations.

Challenges

Since starting their school-based clinics, MCPH learned that they could benefit from expanding clinics from being held just in the springtime to adding clinics in the late summer/early fall as well. MCPH has faced challenges in hosting SLVCs that they are still working to overcome, including getting more school administrators to agree to participate in school-based vaccination clinics and getting cooperation from school districts and parents to provide immunizations during kindergarten registration.

Successes

After the evaluation from the Mahoning County immunization coverage evaluation and report is completed, MCPH develops an implementation plan to address the immunization disparities in the county. Based on the 2022 evaluation, MCPH provided all school districts in the county with the opportunity to host an SLVC. The MCPH nurses have a great partnership with the local school district nurses in providing resources throughout the year as well as an annual vaccine education training. It is because of their relationships that MCPH can hold the school-based clinics. The school nurses provide excellent outreach to the families and emphasize the importance of completing the required vaccinations for school entry. In 2023, MCPH sought out non-traditional events and activities to reach more students and their families. This included the public health nurses being present during the school's sports physical events to offer students immunizations after their examination.

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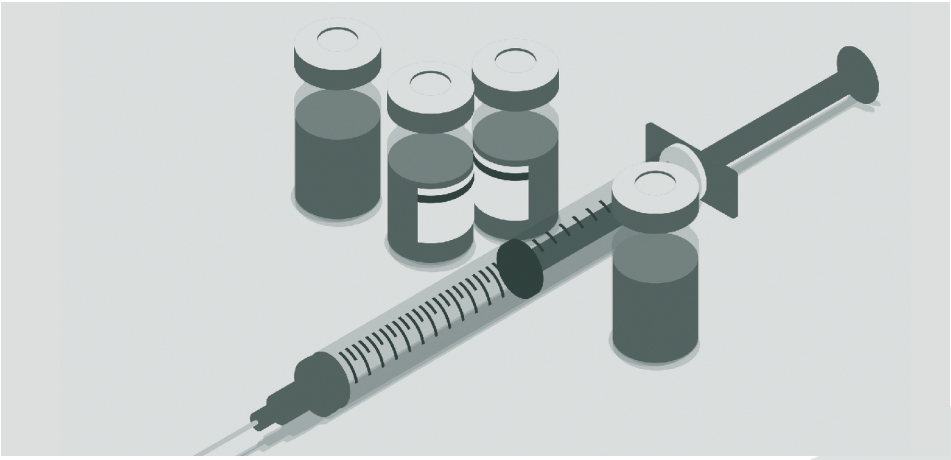

Public Health Institute at Denver Health

The Public Health Institute at Denver Health (PHIDH) began its relationship with Denver Public Schools (DPS) in 2009. In collaboration with DPS, the In-School Immunization Program (ISIP) was established. The program strategy is similar to MCPH, as they also utilized a data-driven approach. The strategy for the program included reviewing MMR vaccination rates across Denver for four- to six-year-olds. After mapping out the areas with lower vaccination coverage, schools in those areas were prioritized.

During the 2022–2023 school year, PHIDH served 377 students with 1,223 vaccinations. The most common vaccines that were administered were influenza, HPV, COVID-19, and Tdap, however, they strived to offer as many vaccines as possible. Furthermore, at the SLVCs or other events that they were invited to attend, they offered non-immunization services as well, including behavioral health resources, ensuring that they met the students' and community's needs. Of those served, almost 50% used Medicaid and around 25% were uninsured. The reported race/ethnicity of the ISIP students was 78.5% Hispanic or Latinx, 6.9% white non-Hispanic, 5.8% Black non-Hispanic, and 4.5% multiple races, other, or unknown.

Challenges

While the program has been successful, there are opportunities for growth. PHIDH would like to increase the rate of returned consent forms. During the 2022–2023 school year, most of the participating schools struggled to return the paper and electronic consent forms, averaging well under 50 returned consent forms across the schools. PHIDH also faces the challenge of the competing priorities of school nurses. School nurses are not solely focused on increasing immunization rates, but are responsible for many other health and wellness aspects for the students as well. Additionally, the school nurses often cover multiple schools or work part time, which reduces the amount of time they can focus on immunizations. PHIDH and DPS are continually working on navigating these challenges.

Successes

Over the years, PHIDH has established a successful example of SLVCs and their benefit. They have seen success in terms of their immunization uptake, but also programmatic success that has made the program run smoothly and continue to be successful each year. PHIDH has been granted access to the DPS electronic health records, which allows the health department to check for the accuracy of the student health records when compared with the health department's database. PHIDH attended school registration events and had success with handing out the consent forms. Furthermore, attending the events allows the staff to engage with parents and guardians. The ISIP program also has a designated PHIDH staff member. The program is a great help to the school nurses because the health department is able to take some of the immunizations off of their plates, allowing them to focus on their many other tasks. Overall, the ISIP program is well received in the community, 100% of respondents reported being satisfied or very satisfied with the ISIP meeting the vaccine needs of the students.

NACCHO's SLVC Resources

To assist local health departments in conducting school-located clinics, NACCHO's Immunization team has developed the School-Located Vaccination Clinic Toolkit. The toolkit includes a variety of materials that may be relevant and useful for those considering or planning SLVCs, including sample implementation guides, vaccination laws and policies related to school settings, and educational materials that feature best practices and strategies for successful implementation and promotion of vaccination uptake within the community. This toolkit acknowledges the value of schools in communities and their status as trusted messengers. Schools serve as a point of authority in communities by bringing together audiences of parents, guardians, teachers, counselors, and administrators who have a shared interest in the wellbeing of children.

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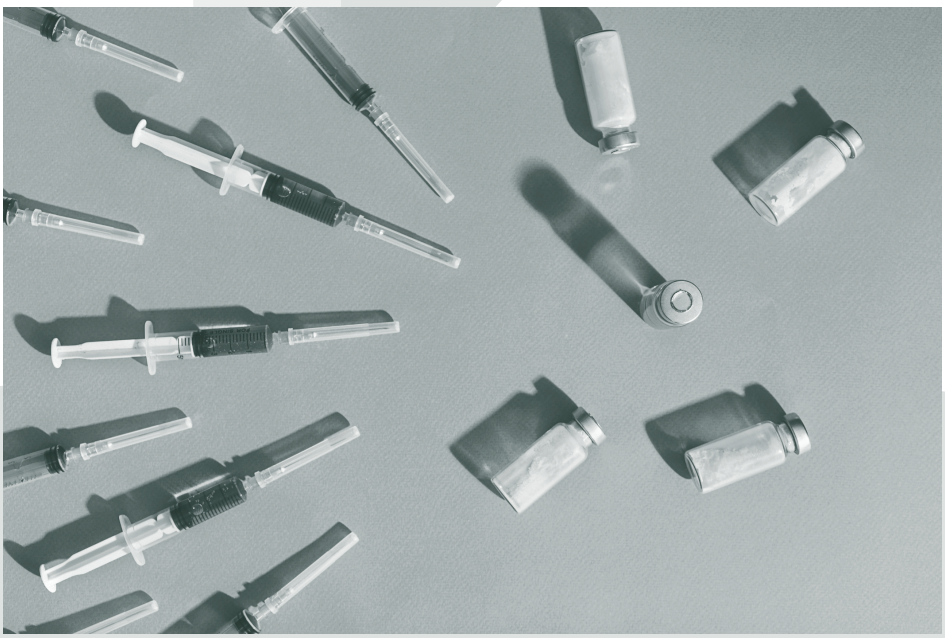
The toolkit was adapted from NACCHO's School-Located Influenza Vaccination Toolkit, which was tailored specifically to influenza vaccination. The new toolkit expands on the influenza vaccination toolkit by incorporating resources for all routine immunizations, lessons learned from the COVID-19 pandemic, and the input of local health departments. The goal of the new toolkit is to create a resource that will assist school administrators and public health practitioners in taking steps to further safeguard their communities. With the resources included in this toolkit, health departments are better equipped to facilitate a successful school-located vaccination clinic in partnership with the schools in their jurisdiction.

There are no one-size-fits-all approaches to school-based vaccination clinics, as each school is different and will have different needs, resources, and infrastructure to make use of. The toolkit is ideal for local health departments to provide as a resource to school administrators, nurses, and the greater school community. The resources are organized into the following categories: planning, relationship and communication, educational materials, implementation, and evaluation, to assist those at different points in the SLVC process or with different needs. It can serve as a point of reference for school administrators as they learn about the concept of SLVCs and the importance of access to and uptake of vaccinations among school-aged individuals and their families.

Looking to the Future

Sustainable partnerships and collaboration between schools and local health departments is imperative in effectively meeting the needs of local communities. Increasing vaccine confidence and access remains at the forefront of public health, as many adolescents and school aged-children are playing catch-up on routine vaccines after falling behind during the COVID-19 pandemic. LHDs and school-based clinics can assist in routine immunization efforts by creating bi-directional trust and communication. We encourage local health departments to leverage existing relationships and strengthen new partnerships with school systems to provide expanded services and opportunities for school-aged children and their families, meeting individuals where they are in their respective communities. At NACCHO, we encourage local health departments to continue to advocate for increased vaccine access and confidence for school-aged children and adolescents and strengthen community understanding of local health departments as a trusted messenger to ensure the public's health and protect individuals from vaccine-preventable diseases.

For more information, contact Amiris Roberson at aroberson@naccho.org.



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Shuman Juvenile Detention Center Emergency Operations Plan Update

By Alix Ware, Program Analyst, NACCHO

To support community level efforts to address the vulnerability of juvenile justice facilities during public health emergencies, the Allegheny County Health Department and the Shuman Juvenile Detention Center in Allegheny County, Pennsylvania, engaged with twelve other partners to improve, implement, and disseminate a comprehensive emergency operations plan to strengthen facility preparedness.

The United States is experiencing a growing opioid epidemic. In 2016, the CDC identified 26 st tes, including Pennsylvania, as being most vulnerable to new HIV or viral hepatitis infections due to unsafe injection drug use. Allegheny County, located in western Pennsylvania, is one of the counties most affected by the opioid epidemic, experiencing 564 overdose deaths in 2019. That same year, 1,739 confirmed and p obable cases of chronic HCV and 12 acute cases of HCV were reported among Allegheny County residents. Similar to trends seen across Pennsylvania and elsewhere, a bimodal age distribution of HCV cases in Allegheny County has emerged. The increase in cases in the younger age groups is associated with an increase in injection drug use. Shuman Juvenile Detention Center, located in Allegheny County, has reported increasing numbers of youth with substance use disorders. Although Shuman has an existing emergency operations plan (EOP) and offers health services for detained juveniles, enhanced and updated protocols were needed to address the specific and g owing public health threats presented by the opioid epidemic.

The partnership between ACHD and Shuman Juvenile Detention Center led to a more comprehensive understanding of partner roles and challenges associated with responding to the public health threats presented by the opioid epidemic.

Juvenile justice residential facilities are charged with the responsibility of providing youth with safe, secure environments and must adequately prepare for and respond to potential overdoses and infectious disease outbreaks among juvenile detainees. The Allegheny County Health Department (ACHD) has partnered with several county agencies to provide information, education, and resources to reduce and prevent overdoses as well as infectious disease outbreaks in their community. The ACHD recognized that a coordinated EOP among the county's juvenile justice residential facility, the health department, and other relevant emergency personnel was necessary to adequately prepare for, respond to, and recover from the public health threats presented by the opioid epidemic to juvenile detainees.

Partners met at the ACHD in May 2019 to share their experiences working with the current Shuman EOP. NACCHO staff facilitated discussion to identify where updates were needed and prioritize next steps. An interdisciplinary planning team, representing 13 partner agencies ranging from nonprofi organizations to city and county government offices defined communic tion pathways and established hazard priority areas. The team participated in monthly planning calls, facilitated by NACCHO. Hazard vulnerability groups were created for each identified priority a ea. These groups met outside of the regular monthly calls to develop specific haza d plans. Five hazard plans were developed and discussed during monthly calls: infectious disease, overdose

prevention and response, evacuation, security active threat, and medical active threat. Using an EOP and functional annex from a local school district, Shuman staff took the lead in updating their EOP. Subsequently, Allegheny County Emergency Services developed a tabletop exercise. This weather-related exercise was designed to test various components of the EOP. However, the exercise was not completed due to the closing of the Shuman Juvenile Detention Center.

Infectious disease preparedness planning at the juvenile justice residential facility in Allegheny County had not previously been assessed. The ACHD identified a need for a multidisciplinary eme gency preparedness planning team to assist Shuman Juvenile Detention Center with the review, refinement and implementation of infectious disease policies and procedures.

The partnership between ACHD and Shuman Juvenile Detention Center led to a more comprehensive understanding of partner roles and challenges associated with responding to the public health threats presented by the opioid epidemic. In addition to refining policies and p ocedures relating to drug use, such as screening for infectious diseases like HCV, the relationships built throughout the course of the project led to a more robust response to the challenges of the COVID-19 pandemic. Defining communic tion pathways, recognizing the variety of tools and resources available to each agency, and understanding unique challenges allowed for a rapid and coordinated response during an infectious disease pandemic.

For more information, contact Geoff Mwaungulu at GMwaungulu@NACCHO.org.

The partnership between ACHD and Shuman Juvenile Detention Center led to a more comprehensive understanding of partner roles and challenges associated with responding to the public health threats presented by the opioid epidemic.

Strengthening Disability Inclusion Efforts within Local Health Departments: Successes and Challenges — Yellowstone City-County Health Department (dba RiverStone Health), Billings, MT

By Melissa Henderson, Director, Health Promotion Division, RiverStone Health

Background

The Yellowstone City-County Health Department, dba RiverStone Health (RSH), serves anyone and everyone who lives, works, learns, plays, or accesses services within Yellowstone County, Montana, and our surrounding area. Yellowstone County is the most populous county in Montana (~167,000 people). A regional hub for healthcare, education, business, social services, and entertainment, we support 650,000+ residents in Montana, Wyoming, Dakotas, and Crow and Northern Cheyenne reservations. Many individuals with diverse healthcare and service needs relocate to our community to be close to resources and family.

RSH has undertaken several previous disability inclusion activities. Historically, these activities have been project-specific and ad hoc in nature. Examples include the inclusion of individuals with disabilities on project advisory committees, including the Yellowstone County Community Health Assessment and Community Health Improvement Plan, Safe Routes to Schools committee, audits of campus construction, trainings, and technical assistance in program planning, evaluation, and communications design. RSH is the fiscal agent of the Healthy By Design Coalition, which has also partnered with the local independent living center, Living Independently For Today and Tomorrow (LIFTT) to host a city council candidate forum on accessibility and inclusion. In addition, the Coalition partnered with LIFTT to pilot a community health worker program.

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Strengthening Disability Inclusion Efforts within Local Health Departments: Successes and Challenges — Yellowstone City-County Health Department (dba RiverStone Health), Billings, MT *continued from page 12*

Project Description

Our project focused on developing a comprehensive approach to disability inclusion in organizations' policies and procedures, communications, physical accessibility, and program delivery. While our primary goal was improving these efforts within the Yellowstone City-County Health Department, our unique organizational structure allowed us to develop recommendations for our broader services impacting residents in and around Billings, Montana. Our goals focused on completing a baseline assessment of current efforts in these areas, developing an initial action plan for our organization, and creating a multi-faceted training plan for staff. The action plan was developed by an inclusion work group of representatives from public health, HR, facilities, organizational leadership, and communications. We also recruited staff from across the organization who self-identified as having lived experience with disability. Our work group partnered with staff from Living Independently For Today and Tomorrow (LIFTT), our region's independent living center. They provided valuable guidance on our vision for this project, action plan, and assessments. In addition, they connected us with other regional disability inclusion resources.

Challenges

The primary challenges we faced included staff capacity over the short, summer timeframe of the grant as well as reeling in our focus for the project. While we recognize that this is a foundational step for future work, staff were energized and eager to recognize the myriad ways we could innovate and improve our inclusion efforts. That, combined with summer travel among staff and community partners, made it challenging to meet all of the goals we set for ourselves in the relatively short four-month timeframe.

Solutions to Challenges

LIFTT representatives provided essential guidance on our goals and action plan, helping us to prioritize what to address first and foremost. We are treating this project as an initial step to identify themes and needs for deeper work in the future.

Results

Our project resulted in several outcomes including 1) a completed physical accessibility audit of our main campus, 2) preliminary assessments of our communications, policies, procedures, and program delivery, 3) training resource inventory, and 4) an action plan for the coming year, including facilities upgrades, training plans, and in-depth audits of other areas. Furthermore, the project helped to reinforce our positive relationship with LIFTT and set us on a path for authentic, long-term disability inclusion.

Organizational leaders and staff alike are eager to go beyond compliance with the ADA to continued innovation for meaningful inclusion of individuals with disabilities in our workforce and community members served. Our disability inclusion task force is eager to lead that innovation and is currently developing a disability visibility campaign for staff and community members alike to reduce the stigma around disabilities.

Lessons Learned

Our project succeeded in large part because of our positive, longstanding partnership with LIFTT. We were able to ask for feedback in a non-threatening, open-minded environment that they created. Health department staff did not pretend to have all of the answers and were serious about this project improving our impact within our community, which allowed us to be open to areas for improvement. Our advice to others would be to recruit genuine partners who can provide you with the expertise needed to develop an impactful, action-oriented plan. Even if the plan's development takes longer than you might expect, taking the time to identify gaps in service delivery and listening to individuals with lived experience will make your action plan that much more effective.

For more information, contact Melissa Henderson at melissa.hen@riverstonehealth.org.

NACCHO Observes Falls Prevention Awareness Week and Honors Local Health Department Actions to Prevent Falls Among Older Adults

By Katherine Palm, MSW, Senior Program Analyst Injury & Violence Prevention, NACCHO; Hannah Loynds, MPH, Program Analyst Injury & Violence Prevention, NACCHO; Bailey McInnes, MPH, Program Analyst, Injury & Violence Prevention, NACCHO

During the week of September 18 through September 22, 2023, NACCHO recognized the importance of fall prevention programming for older adults, which can greatly impact quality of life and independence as we age. Read the statement by NACCHO's Chief Executive Officer Lori Tremmel Freeman in the press release at https://www.naccho.org/blog/articles/naccho-observes-falls-prevention-awareness-week-and-honors-local-health-department-actions-to-prevent-falls-among-older-adults-2.

According to the CDC, falls are the leading cause of unintentional injury and death among adults 65 and older. More than three million older adults in the United States visited the emergency department in 2020 because of an unintentional fall, resulting in one million hospital stays and about $50 billion in medical costs. This rise in older adult falls is expected to continue as the Baby Boomer generation ages, increasing the number of older adults aged 65+ in the U.S. population, according to the U.S. Census Bureau. Without intervention, it is projected that the cost of treating falls will reach about $101 billion by 2030, according to the National Library of Medicine.

During Falls Prevention Awareness Week, NACCHO praised the country's local public health departments that work diligently each day to prevent older adult falls and mitigate fall risk factors in their communities. NACCHO is proud to share the ways in which local health departments are working to prevent and respond to older adult falls:

Since 2008, the **Knox County Health Department** (KCHD) in Knoxville, Tennessee has been the leader in fall prevention efforts. This coincided with the first year that the National Council on Aging (NCOA) made falls prevention awareness a national focus.

From that time, KCHD has spearheaded efforts to highlight and promote fall prevention in Knoxville, Knox County, and beyond. KCHD has received widespread support through a variety of community partners, offering fall prevention information and education throughout the year. A three-pronged approach is used to maximize efforts. First, a community fall prevention task force and committee meet monthly to plan community events focused on fall prevention with a special focus in September, coinciding with National Fall Prevention Awareness Week (https://www.ncoa.org/page/falls-prevention-awareness-week-toolkit). Second, a best practice, evidence-based program, called SAIL (Stay Active and Independent for Life), a strength and balance exercise and fall prevention program, is delivered in five senior centers and two community centers (https://www.sailfitness.org/). This is a year-round offering for the senior community. Third, KCHD partners with two physical therapy companies that conduct free, year-round balance screening events in the community.

Last year for Falls Prevention Awareness Week, KCHD and community partners hosted three community events. For Falls Prevention Awareness Day on September 23, 2022, the Knox County Senior Safety Task Force had contributions from ten community organizations and businesses and 17 volunteers with an in-kind amount totaling over $6,500. At the one-day event, balance and vision screenings were offered free to attendees, along with complimentary consultations from local experts on exercise, home safety, and medication safety. For more information on the Knox County Senior Safety Task Force, visit https://www.knoxcounty.org/health/sail_safety_task.php.

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NACCHO Observes Falls Prevention Awareness Week and Honors Local Health Department Actions to Prevent Falls Among Older Adults *continued from page 14*

KCHD has a strong social media presence, and the fall prevention efforts are highlighted along with education and information on preventing falls throughout the year.

The **Farmington Valley Health District** (FVHD) serves ten towns in north central Connecticut and provides essential public health services to the approximately 110,000 residents in these communities. One of FVHD's central focuses is fall prevention and promoting healthy aging among older adults. FVHD has been actively addressing healthy aging and injury prevention through various initiatives such as Fall Prevention and Healthy Aging presentations, conducting fall risk assessments, and implementing the evidence-based program A Matter of Balance. Their 2022 Community Health Assessment indicated that the FVHD (26.1%) had a higher percentage of the population who fell in the past year than in Connecticut (23.1%). In addition, 33.8% of deaths from accidents in FVHD residents were the result of a fall compared to just 22.7% in Connecticut. This data furthered FVHD's commitment to fall prevention programming in their communities. Read the full assessment at https://fvhd.org/wp-content/uploads/2023/01/2022-FVHD-Community-Health-Assessment-Copy.pdf.

Most recently, FVHD convened a coalition of community agencies, including fire, police, EMS, social and senior services, and the visiting nurse association in one of their towns to address the high prevalence of falls and fall-related morbidity and mortality. The goal of this coalition, named Steps to Safety, is to promote the safety and well-being of the aging population in their homes for as long as possible. Residents who receive help from EMS for a fall receive a leave-behind card with information about the services offered by each member of the coalition. These wrap-around services include home safety assessments for fall hazards, A Matter of Balance classes (https://www.mainehealth.org/care-services/older-adult-care-geriatric-medicine/fall-prevention-matter-balance), access to the town medical equipment loaner closet, medication reviews, and other services. Residents can also self-refer to the Steps to Safety program. Therefore, Steps to Safety aims to both prevent residents from having an initial fall and for other residents, from having a repeat fall. FVHD aims to keep seniors where they want to be: at home.

NACCHO published a new guide called *Developing the Capacity to Support Clinical Older Adult Fall Prevention: A Guide to Local Health Departments* and a corresponding workbook (https://www.naccho.org/uploads/downloadable-resources/Guide_Workbook_v5.pdf). These resources were designed to help local health departments engage in clinical fall prevention work by creating or expanding existing programs to meet the needs of older adults living in their communities. NACCHO's website also houses a list of resources in the NACCHO Older Adult Fall Prevention Toolkit at https://www.naccho.org/programs/community-health/injury-and-violence/older-adult-falls-prevention/toolkit-older-adult-fall-prevention to help local health departments develop their capacity to identify older adults at risk for falls and to implement evidence-based fall prevention programs and practices in their communities.

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Sharing LGBTQ2IA+ Texans' Tobacco Prevention and Cessation Stories

By Shimarah Mehrotra, MPH and Ashley LeMaistre, MPH

Background

Austin Public Health's (APH) Breathe With Pride (BWP) program aims to reduce LGBTQ2IA+ communities' commercial tobacco use rates through tailored messaging on the risks of tobacco use, cessation benefits, and free, affirming resources. This story demonstrates the importance of collaborating with coalitions, stakeholders, and community partners when creating and disseminating public health campaigns for this community.

Challenges

Commercial tobacco use remains the leading preventable cause of death in Travis County. The Texas Behavioral Risk Factor Surveillance System (BRFSS) survey (2015–2020) found that LGBT tobacco use rates were nearly 1.5 times higher than Travis County's general population. In 2021, researchers at University of Texas at Austin conducted focus groups for "LGBTQ2IA+ Community Health Needs Assessment" (CHNA), finding that 48% of participants felt that tobacco use is prevalent in LGBTQ2IA+ communities.[1] However, for community members who experience ongoing, immediate threats to their safety and wellbeing, prioritizing tobacco prevention and cessation is challenging.

The CHNA found that 52% of respondents reported stress as a trigger for tobacco use and 84% attempted to quit at least once. LGBTQ2IA+ individuals frequently experience barriers to seeking and accessing primary care, and only 8% of respondents knew of cessation resources available to them. Due to barriers and mistrust of healthcare systems and government entities among the diverse LGBTQ2IA+ community, it is important to be intentional about who is included in the creation and dissemination of campaigns and

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Sharing LGBTQ2IA+ Texans' Tobacco Prevention and Cessation Stories

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ensure that the resources being promoted are inclusive and affirming. Lastly, the constantly changing digital and social media landscapes and policies create challenges to target specific demographics for extended periods of time, requiring creative thinking to connect with the community.

Solutions to Challenges

BWP tackles tobacco prevention and cessation ambivalence in the LGBTQ2IA+ community by framing tobacco use as a social justice issue with systemic roots, leveraging relationships to feature local LGBTQ2IA+ community members in campaigns, and financially compensating participants.

In 2017, APH worked with a local media agency to film a PSA with Cynthia Lee Fontaine, an Austin-based drag performer. The PSA promotes SmokefreeTXT, a free text message-based cessation resource, and is available in English and Spanish.

Solutions to Challenges

In 2021, APH collaborated with a media agency to create two more PSAs starring community members with lived experience using and quitting tobacco products. BWP staff received feedback from their Coalition that shaped the content, setting, and tone of the PSAs.

The prevention PSA educates audiences about the predatory marketing and sponsorship tactics of the tobacco industry. The cessation PSA features Mr. Austin Pride 2022, Alexander the Great, sharing his motivations, resources, coping mechanisms, and the positive impact of quitting tobacco. Both videos direct audiences to the BWP website with more information and links to videos with English and Spanish subtitles.

Each campaign utilized different media platforms including radio, print, digital, streaming TV, and social media. In early 2023 APH partnered with local LGBTQ2IA+-serving organizations to promote the PSA on their social media. Unfortunately, due to hate-based comments, one organization had to remove their PSA post sooner than intended.

BWP used the same community-driven approach to create four posters that highlight similar topics discussed in the PSAs and effects of tobacco use on gender-affirming care, sexual health, and pleasure. So far, posters have been delivered to over 300 businesses, organizations, and community spaces across Travis County and Texas universities.

Results

Since BWP is not a service provider and cannot measure the number of clients who have received services from existing tobacco prevention and cessation resources, one of the most effective ways to measure the program's reach is to look at metrics from paid and organic (unpaid) campaigns. The PSA campaign that ran from March–May 2022 had the highest budget of the three campaign runs and received a total of 1,207,588 impressions (i.e., non-unique views), through radio, print, digital, streaming TV, and social media.

From May–December 2022, BWP shared over 20 posts on APH's Facebook page that received about 1,815 impressions. Approximately 14 of those posts were shared on APH's Instagram account, which has over 7,700 followers. Limitations in staffing capacity allowed for pulling metrics for five of those posts, which received about 3,440 impressions.

BWP has received feedback from community members and APH staff acknowledging the program's strong presence on social media. Media outlets will continue to be a cornerstone for program promotion. BWP staff has started working with APH's marketing team to track metrics on an ongoing basis. This will allow the program to adjust media plans as needed and increase the accuracy when reporting metrics for all media campaigns.

Lessons Learned

The process of creating and distributing meaningful, relevant, research-based health campaigns by and for the LGBTQ2IA+ community tends to be slow and weighted by many systemic and community factors. Risk factors inform BWP's work with LGBTQ2IA+ communities, but these campaigns aim to highlight community strengths and stories to encourage people to find tobacco prevention and cessation resources.

Staff working with LGBTQ2IA+ communities should bring experience, knowledge of community spaces and dynamics, and skills to build and maintain relationships with organizations, coalitions, and individuals to ensure campaigns align with community needs and reflect its vibrancy and diversity. Additionally, staff should be prepared to adjust strategies to protect the people and messages featured in their campaigns and optimize use of ever-changing media platforms. For example, to mitigate the risk of campaigns receiving hate-based comments that disrupt their primary health message, BWP is shifting paid campaigns from social media to a digital platform; for example, banner advertisements on websites. Other city and county health departments can use these strategies to replicate similar projects that resonate with LGBTQ2IA+ communities in their area. Together, we can pave the way for healthier, safer, and more joyful futures for our communities.

For more information, visit livetobaccofreeaustin.org.

New Resource: Building an Equitable Workplace at Local Health Departments

By Andrea Grenadier, Senior Marketing and Communications Specialist, NACCHO

NACCHO and HealthTeamWorks, with funding from the CDC, have paired up to create a robust toolkit for our local health department members to address the pressing topics of diversity, equity, and inclusion in local health departments: *Building an Equitable Workplace at Local Health Departments.* Download the toolkit at bit.ly/3QXrcA5.

The purpose of this toolkit is to support the ability of LHDs to look inward, to consider how policy, practice, and culture are advancing equity and inclusion within their department and among their staff, and to take action toward positive change. This toolkit is intended for anyone working within or for a government agency, and while some aspects will be geared more toward those in leadership or other decision-making or managerial positions, readers across all roles who are interested in advancing equity in their workplace will find the content of this toolkit beneficial to their efforts.

What does an equitable workplace look like? It's where every employee has fair treatment, access, support, and advancement and where the historical and present factors impacting those opportunities to thrive are actively addressed to meet the unique needs of each individual. The equitable workplace is also one that is inclusive, supports the wellbeing and morale of staff, and is able to both attract and retain a diverse, talented, and motivated workforce. However, the journey to building such a workplace can feel daunting, even for health departments that have or are engaging in equity efforts or have publicly committed to advancing equity in the communities they serve.

Create a Vision for Equity

The Guide features stories from the field, case studies, how to assess workplace equity, creating an action plan, the role of leadership, professional development, applying equity to policy development, overcoming resistance to change, resources, a glossary, and examples of how to begin this work.

One way is to begin with a vision of what your health department could look like, when adopting an equity model. A vision provides the overarching motivation, or "north star" for actions related to diversity, equity, and inclusion. Casting a vision specific to internal equity efforts defines, for all staff, what you aspire to achieve as well as a future in which everyone can envision themselves. Once understood and defined, visions should be documented in a statement that relates to the team or department and referred to regularly.

Convene equity champions or teams and brainstorm on the following questions:

- What are our hopes and goals connected to our work to increase equity in our workplace?
- What concrete actions would we like to take to achieve our hopes and goals?

Group answers into themes and select a core group of individuals to craft an initial vision statement based on those themes. Ensure the statement supports the LHD's overall mission, vision, and strategy. In doing so:

Keep it brief and straightforward. It should be simple to understand and easy to recall.

Specify, but do not constrain. It should capture your ultimate outcome but not define a single strategy for achieving it. Instead, it should allow for multiple routes to the desired outcome and promote stakeholder teamwork.

Make it motivating. It should be about a goal the entire team is enthusiastic about achieving.

Avoid becoming too detailed. Write it down with room for revisions. Since it is hard to predict what will occur in the future, keeping it broad ensures it will remain relevant.

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Write about your identity. The most effective vision statements discuss who you are as an organization or department and who you hope to become.

1. Test the vision with staff and solicit feedback. Ask them to paraphrase the vision in their own words and compare responses for discrepancies which indicate a lack of clarity and the need to revise.

2. Present the vision and test results to the group of equity champions and gain consensus on it.

3. If you haven't already, involve senior or executive leadership to secure commitment throughout.

4. Create a plan to communicate the vision to the rest of the organization or department.

Examples of Equity-Specific Vision Statements

The examples below illustrate the different ways LHDs may approach creating vision statements:

- "Clackamas County is a place where people thrive, have a sense of safety, connection, and belonging, so that everyone is honored and celebrated for the richness in diversity they bring." (https://www.clackamas.us/diversity)
- "To build and sustain a workforce reflective of the many unique cultures, voices, backgrounds, ideas, and talents of the residents and communities we serve." (https://dol.ny.gov/dei-dol-strategic-plan)
- "Safety, trust, and belonging." (https://multco-web7-psh-files-usw2.s3-us-west-2.amazonaws.com/s3fs-public/workforce%20equity%20strategic%20plan%202018%20final%204_9_18.pdf)
- "Dane County as a community with equal access to opportunity and a County organizational structure that is rooted in equity and inclusion, revealed through hiring, contracting, and service delivery." (https://equity.countyofdane.com/)

Building an equitable workplace requires widespread change – from culture and norms to policy and practice – and will require patience and perseverance as well as a commitment to continued learning, growing, and change. Every department, and the people in them, are at different places in their journey to becoming stewards of equity and developing a workplace where all employees can thrive. Use this toolkit as a resource from which you can build up your own strategies in a way that addresses your unique needs, challenges, and opportunities.

For more information, contact Andrea Grenadier at agrenadier@naccho.org.

About NACCHO Exchange

NACCHO Exchange, the quarterly magazine of the National Association of County and City Health Officials (NACCHO), reaches every local health department in the country. It presents successful and effective resources, tools, programs, and practices to help local public health professionals protect and improve the health of all people and all communities.

Mailing and Contact Information

Please direct comments or questions about *Exchange* to Emily Jatczak, Publications Manager, at ejatczak@naccho.org. To report changes in contact information or to check membership status, please contact NACCHO's membership staff at 877-533-1320 or e-mail membership@naccho.org. Additional copies of *NACCHO* Exchange may be ordered at http://www.naccho.org/pubs.

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January: National Birth Defects Prevention Month

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1,242 lbs wood	A total of 4 trees that supplies enough oxygen for 2 people annually.
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377 lbs emissions	Carbon sequestered by 4 tree seedlings grown for 10 years.
110 lbs solid waste	Trash thrown away by 24 people in a single day.

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