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Model Practices

What's Inside...

Prevention of Older Adult Falls through Home Assessment and Modification

By Elizabeth Warren, Health Educator, Union County Health Department

Organization

Union County (OH) Health Department

Overview

Through the years, public health has played a vital role in promoting and protecting the independence of Americans. Young children can safely bike to school because of Safe Routes to School programs. Graduated drivers-licensing policies grant teens the freedom to take the keys while providing restrictions that ensure they are safe behind the wheel. Young adults learn how to make decisions about their sexual health so that they are able to start a family only when they are ready. However, the independence that public health works so hard to promote is being threatened for many Americans aged 65 years and older.

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Prevention of Older Adult Falls through Home Assessment and Modification

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National statistics indicate that approximately 60% of older adult falls occur within the home.

Falls among older adults are increasing at alarming rates. According to the Centers for Disease Control and Prevention (CDC), every year one in three older Americans will fall. In Ohio, this equates to a fall every two minutes. Hundreds of thousands of these falls result in injuries severe enough to require emergency department treatment, hospitalization, and rehabilitative care. Thousands of these falls are fatal. The annual economic costs associated with such injuries and deaths in Ohio total $4.2 billion.

This national and state injury epidemic for the aging population is also very present in Union County, OH. Union County ranks in the top 25% of Ohio counties for senior fall-related deaths. Union County also ranks in the highest quartile of the state for self-reported falls among adults (45+ years) according to the Ohio Behavioral Risk Factor Surveillance System. In addition, national statistics indicate that approximately 60% of older adult falls occur within the home. In Union County, more than 70% of all fall-related EMS runs are made to a senior's residence.

Not only are falls increasing in Union County, but so is the senior population. Adults aged 60 years or older make up 14% of Union County's population. By 2020, this segment of the population is projected to increase by 102%. By 2040, a quarter of the county's population will be 60 years or older. With this projected boom in the senior population, the number of falls, related injuries, and deaths will also dramatically increase.

In response to these alarming trends, the Union County Health Department received funding to build a comprehensive fall prevention program for Union County seniors. In spring 2014, the health department-led Union County Older Adult Falls Coalition (Coalition) developed the Seniors Living IndePendently and Safely (SLIPS) program. SLIPS is a fall-prevention home assessment and modification program. The mission of SLIPS is to prevent falls in the home and assist seniors in maintaining their independence.

Implementation

Home assessment and modification is an evidence-based strategy that the CDC identified as a building block for a successful community-based fall-prevention program. While SLIPS is an evidence-based practice that is modeled after other home assessment programs, its design is innovative. In many communities, home modifications are offered through a single agency such as a local fire department. The assessments are completed at the request and expense of the senior. This requires seniors to identify their fall risk and take the necessary steps to participate. However, because many seniors fear losing their independence, they are often hesitant or unwilling to discuss their fall history.

In comparison to these traditional programs, Union County took a multi-pronged approach when developing SLIPS. The Coalition created an assessment tool, the Home Safety Checklist, which is completed during home assessments. Educational packets were compiled to provide information about additional steps and programs available in the county to reduce fall risk. The Union County Senior Services agency was recruited to coordinate all home modifications.

The Coalition recruited a broad group of partners to implement SLIPS. The Union County Health Department's registered sanitarians and local hospital's health center offered assessments at the request of the public. Four organizations—home health, short- and long-term rehabilitative care, and Union County Senior Services—were recruited to incorporate SLIPS assessments into existing services and organizational procedures. Through these procedural changes, home health aides, occupational therapists, and social workers from these organizations regularly conduct SLIPS assessments with their clients.

In addition, the SLIPS program is unique in that funding has been allocated to cover the modifications. When a SLIPS assessment is conducted, Union County Senior Services coordinates a contractor to visit the home if modifications such as the installation of a

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grab bar, leveling of stairs, or addition of a hand rail are needed. If the senior lacks financial resources, the modifications are completed at no expense to the senior. The work is paid for by grant dollars and funds from Union County Senior Services.

SLIPS not only prevents falls within the home through modifications but also provides an opportunity to empower seniors. According to survey data, 48% of Union County older adults worry or have anxiety that they will fall. This fear causes many of them to stay within their home and disengage from community activities. By doing so, they unknowingly increase their fall risk. Through SLIPS, seniors are encouraged to participate in other Union County fall-prevention programs including tai chi and A Matter of Balance.

Outcomes

As SLIPS was being developed, the Coalition gathered data to create the report *Falls Among Older Adults in Union County.* Injury and death data were collected from the local hospital, Ohio EMS, and the Union County Health Department. In addition, a survey was administered to seniors collecting information on their attitudes, behaviors, and beliefs about falls. The falls report is a baseline to measure long-term outcomes from the impact of the SLIPS program and other strategies in 2018 when the project is completed.

The Coalition also identified benchmarks to check annually if the program is meeting expectations. In the 14 months since the program's launch, 159 assessments have been completed and over $30,000 has been spent on home modifications. The Coalition aims to conduct 300 assessments in each of the following years. If this goal is met by 2018, the Coalition will have reached 20% of the Union County senior population.

How the Program has been Sustained

SLIPS was created by the Coalition through multiple community partnerships to enable the program to continue long after grant funding ends. The Coalition designed the program so that minimal resources are needed from each participating partner organization. These organizations reap significant benefits for their clients by participating in SLIPS. The Coalition anticipates that this motivating factor will ensure that current partners remain engaged and additional organizations will join.

Union County Senior Services, a primary partner for the program, is highly committed to fall prevention. As demonstrated by the survey data, Union County seniors are fearful of falling. This concern will only grow as the senior population increases. With increasing demand for fall-prevention resources, the Coalition is confident that Union County Senior Services will remain committed to the SLIPS program. Annually, Union County Senior Services allocates dollars to programming that improves the health and safety of Union County seniors. Fall prevention naturally fits with that mission, making it extremely likely that the SLIPS program will sustain past 2018.

For more information, visit http://www.uchd.net or contact Elizabeth Warren at 937-645-2031 or elizabeth.warren@uchd.net.

Developing Regional Collaboration for Underserved Populations

By Amy Roberts, RN, BSN, Program Manager, Childhood Lead Poisoning Prevention/Healthy Homes Program

Organization

Kansas City, Missouri, Health Department

Overview

Lead poisoning is an environmental health disease. Treatment requires identifying and eliminating the source of exposure. Experienced risk assessors must determine hazards in the home, and in-home nurses must provide education, assessment, and referrals to help minimize the damage that lead can cause to children. Testing needs to be done on the home, soil, toys, and food. Testing must also be done on children to diagnose and follow the illness and evaluate the success of treatment. Preventing lead poisoning requires sufficient, sustained sources of funding.

In 2013, when funding from the Centers for Disease Control and Prevention for the Childhood Lead Poisoning Prevention Program was cut, many state and local lead poisoning prevention programs and services were eliminated. Such was the case in Kansas. The state's lead poisoning prevention program was eliminated, leaving local health departments (LHDs) and healthcare providers with few resources to care for lead-poisoned children.

The Kansas City, Missouri, Health Department (KCHD), which already had a Childhood Lead Poisoning Prevention Program, responded to requests from the local poison control center and the local children's hospital by developing a regional collaboration to provide services in Kansas. While Kansas was able to educate and train LHDs in the affected area before its lead poisoning prevention program was eliminated, LHDs and healthcare providers needed continued support and resources to care for lead-poisoned children. In response, KCHD's Childhood Lead Poisoning Prevention Program collaborated with the University of Kansas Poison Control Center, The Pediatric Environmental Health Center at Children's Mercy Hospital (CMH), Environmental Protection Agency (EPA) Region 7, and Kansas Department of Health and Environment to develop a triage system and resources to assist the families of lead-poisoned children and healthcare providers.

Implementation

When funding for the Childhood Lead Poisoning Prevention Program was cut, frustrated staff from LHDs and healthcare providers in Kansas began calling the Poison Control Center at the University of Kansas Medical Center for direction and resources. The center's director was familiar with KCHD's Childhood Lead Poisoning Prevention Program and requested a consultation for a seriously lead-poisoned child. KCHD established a team to collaborate with the Poison Control Center and CMH.

The director of the Poison Control Center, CMH staff, and KCHD staff developed collaborative agreements and practice guidelines for LHDs and healthcare providers and provided inspections and home visits to the most seriously lead-poisoned children. Lead-poisoned families received cleaning supplies, vacuums with HEPA filters, and

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home lead test kits to evaluate their ability to reduce hazards in the home. Staff from the agencies provided telephone support, on-site training, and education by request. Staff then brought in the Kansas Department of Health and Environment and EPA Region 7 as additional partners for enforcement and support.

KCHD reached out to its referring partner, the Poison Control Center at the University of Kansas Medical Center University, and partnered with CMH's Pediatric Environmental Health Center to put together resources and a plan to help Kansas children. First, the KCHD team visited the initial lead-poisoned child and then helped train CMH staff to increase their capacity. KCHD worked with Poison Control Center staff to develop a triage system and began seeing more patients. KCHD developed memoranda of understanding and collaborative agreements and provided phone consultations with LHDs in Kansas. The KCHD and CMH teams combined and helped increase the capacity of the LHDs in areas with the most lead-poisoned children. In addition, KCHD referred some cases to the Occupational Safety and Health Administration and worked with LHDs on workplace investigations.

Outcomes

The most compelling outcome was the improvement in blood lead level in affected children. Eight children who received in-home case management had a 46% drop in average blood lead levels. Twenty-eight children whose families had telephone consultations and education demonstrated a 46% drop in blood lead level. Five families received educational information by mail, and their children showed a 22% drop in blood lead level.

In addition, the collaboration resulted in the identification of two companies with insufficient safety practices. Their employees were being exposed to toxic lead, which they then brought home, contaminating their houses and poisoning their children. Both companies have since improved their practices, and their employees (over 80) have been educated about the dangers of lead.

In addition, many households of children exposed through lead paint in the home have since repaired those hazards. Data collection is ongoing and analysis is still in the early stages. Performance measures include number of children seen, number of homes inspected, dust wipe results, and full analysis of blood lead test results.

Project milestones are measured in processes such as the development of memoranda of understanding and scope of work agreements between partners and the development of a triage system to provide resources to the most seriously lead-poisoned children.

Through the collaboration, KCHD directly reached approximately 60 children in the past year. However, the training and support of partner agencies extends the reach of the project considerably. Some benefits for partner agencies include increased communication, which has resulted in partnerships in other projects that have had direct monetary benefits such as grants; improved capacity to review and improve internal policies and procedures; and increased problem-solving and innovation skills.

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Twenty-eight children whose families had telephone consultations and education demonstrated a 46% drop in blood lead level.

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How the Program has been Sustained

The project, which began a little over a year ago, is progressing slowly but steadily. Due to the large number of patients and the lack of financial support for the project, the partners adjusted the initial objective from providing home visits to all seriously lead-poisoned children to providing visits to those with the most persistent poisoning. The success of the practice can be attributed to the persistence of the members of the collaboration and their close partnership before the collaboration. The biggest resource necessary for success is the commitment and expertise of the partners; one way to sustain partners' interest is to continue to work closely on and communicate about multiple projects, ensuring that agencies have reasons to stay in the collaboration. As the practice evolves, more stakeholders are joining, including the Agency for Toxic Substances and Disease Registry, additional LHDs, local healthcare providers, and social work staff at CMH. Frequent communication and collaboration on other projects helps foster collaboration on this practice.

Because this practice was established with very minimal resources, it is sustainable in its current form. The types of assistance provided to families (e.g., test kits, home visits, inspections, and home repair) can expand and contract based on available resources. Diversifying projects and funding (within the environmental/healthy housing realm) also allows for sustainability. The team has applied for grants to secure funding to reach more patients.

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Improving Food Safety through the Health Education Liaison Program (HELP)

By Amanda N. Gaspard, MPH, REHS, CHEP, Environmental Health Specialist, and Corwin Porter, MPH, REHS, Division Chief, County of San Bernardino Department of Public Health

Organization

County of San Bernardino (CA) Department of Public Health, Division of Environmental Health Services

Overview

Many food facilities perform poorly inspection after inspection and commit repeat violations. Although facility operators may correct violations while an inspector is still on site, they may not proactively prevent violations from recurring. Repeat risk factor violations are of particular concern because such violations contribute significantly to foodborne illness outbreaks.

According to the Centers for Disease Control and Prevention, the top five categories of foodborne illness risk factors are poor personal hygiene, improper holding temperatures, inadequate cooking, food from unsafe sources, and contaminated equipment. The County of San Bernardino Department of Public Health, Division of Environmental Health Services (DEHS) has observed a pattern of repeat violations in which many operators make immediate short-term corrections but do not implement long-term practices to minimize foodborne illness risk factors. This problem of repetitive noncompliance highlights the need for an innovative approach to help facilities reduce risk factor violations. Education of owners, operators, and food handlers helps to prevent foodborne illness outbreaks. Many poorly performing facilities are private "mom and pop" restaurants that cannot afford to hire a private consulting firm to help them learn more about food safety practices and intervention strategies.

To help meet this need in the community, DEHS launched the Food Safety Health Education Liaison Program (HELP) in 2012. The goal of HELP is to educate food facility operators about food safety practices and ways to reduce the possibility of foodborne illness. HELP consultations promote effective strategies to reduce repeat risk factor violations, improve inspection scores, raise food safety standards, and strengthen operators' active managerial control measures to meet long-term compliance objectives.

Implementation

Planning for HELP began in 2010 and focused on combatting the pattern of repetitive noncompliance and low scores on routine inspections. In San Bernardino County, a grading system is used for retail food facility inspections. The grades are based on the following scores: 100–90 (A), 89–80 (B), 79–70 (C), 69–0 (Closure). A lower score indicates a lower level of compliance with food safety regulations, and a score that is lower due to critical violations indicates a greater risk of foodborne illness. A re-score inspection is a billable, non-routine, scored inspection, which is requested by a facility that fails to achieve an A during the routine inspection.

A poorly performing facility is defined as a facility that scores 89 points or lower during a routine inspection (failure to achieve an A grade). Through data analysis, DEHS observed a pattern of facilities' scoring poorly on the unannounced routine

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Improving Food Safety through the Health Education Liaison Program (HELP)

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Each food facility in San Bernardino County is eligible for one free consultation per year. HELP provides education and recommended strategies for the facility to reduce the risk of foodborne illness.

inspection but then re-scoring to an A grade a few days later. Because the operator is expecting this re-score inspection, the facility is typically operating at a more compliant level and therefore scores higher during the inspection. However, by the time the next unannounced routine inspection is conducted several months later, the facility again scores poorly. DEHS has termed this pattern the "roller coaster" effect. The idea for HELP developed from the desire to protect public health and break the roller coaster pattern of poorly performing facilities.

Start-up costs for the program were covered through the Food Handler Card Compliance Program, a training program that is mandated for all food handlers working in San Bernardino County. A team of Registered Environmental Health Specialists (REHS) designed the program, including aspects such as outreach strategies, consultation parameters, and data analysis. The initial start-up cost for brochures and request forms totaled approximately $1,700. One week of an employee's time was allocated for creating new electronic reports to track statistical trends and program effectiveness.

One REHS serves as the HELP consultant full-time. HELP consultations are offered to facilities that would like to improve their grades and to new operators that want to understand health and safety regulations. District inspectors are required to refer to the HELP consultant any facility that scores 89 points or lower or an A with major violations. The HELP consultant then telephones the facility operator to offer the free consultation.

Each food facility in San Bernardino County is eligible for one free consultation per year. HELP provides education and recommended strategies for the facility to reduce the risk of foodborne illness. The consultant also provides printed and electronic food safety resources to the operator, along with a written report documenting

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Improving Food Safety through the Health Education Liaison Program (HELP)

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behaviors and processes that need improvement. Some operators want their food handlers to participate in the consultation, as well. In these cases, the HELP consultant also provides strategies tailored to food handlers, focusing on ways they can prevent risk factor violations in day-to-day tasks.

For more information, contact the County of San Bernardino Department of Public Health, Division of Environmental Health Services, at 800-442-2283 or visit http://www.sbcounty.gov/dph/dehs.

Challenges

DEHS encountered a few challenges after implementing HELP. HELP is a voluntary program, and therefore some facilities refuse the consultant's offer of a free consultation. One strategy to overcome this challenge is to have the district inspector verbally explain HELP to the operator at the time of an inspection and to leave a HELP brochure at the facility. If operators are already familiar with the program, they are less likely to feel like they are receiving a "cold call" from a HELP consultant.

Another challenge encountered is language barriers. San Bernardino County is a diverse community of over 2 million people, with Spanish being the most predominant language after English. The HELP consultant's responsibilities rotate periodically. At times, the consultant may not be a native Spanish speaker. To educate facilities successfully about food safety practices and overcome potential language barriers, the HELP consultant may be accompanied by a DEHS staff member who is fluent in Spanish.

Outcomes

Facilities that participated in HELP have increased their grades, decreased the potential risk of foodborne illness, and reduced risk factor violations within their establishments. In the first two years of the program, 67% of poorly performing facilities scored an A grade on their next routine inspection after a HELP consultation. Risk factor violations decreased by 40.8% when comparing violations on routine inspections of poorly performing facilities before and after a HELP consultation.

How the Program has been Sustained

Ongoing funding for HELP is provided through the Food Handler Card Compliance Program. Approximately 49,000 food handlers take the training course and exam each year. This funding stream is sustainable because food handlers are required to become recertified every three years in San Bernardino County.

The budgeted annual expense for employing one full-time REHS to run HELP is approximately $89,000 (salary and benefits). Approximately 10% of a supervisor's time is spent providing direct supervision to the REHS at an annual cost of approximately $10,500 (salary and benefits).

By using existing inspection database software (Envision Connect) to produce consultation reports and track data, DEHS was able to keep technological operating costs to a minimum. Because DEHS staff members already used the software daily, no additional training was needed for the HELP consultant.

District inspectors play a major role in marketing HELP. As inspectors perform routine inspections, they encourage operators to take advantage of a free consultation. More than 75% of facilities participating in HELP have been referred by district inspectors. A next step for HELP is to integrate fully with the Food and Drug Administration's Voluntary National Retail Food Regulatory Program Standards. Program Standard 9, Program Assessment, specifies that a jurisdiction must design a targeted intervention strategy to address the occurrence of the risk factors identified in the Risk Factor Study. DEHS anticipates that HELP will be one of multiple intervention strategies to decrease the occurrence of risk factor violations. The HELP consultant will be an integral part of designing additional intervention strategies to help food facilities.

National Diabetes Prevention Program in the Panhandle

By Tabi Prochazka, Regional NDPP Coordinator, Panhandle Public Health District

Organization

Panhandle Public Health District

Overview

The diabetes epidemic is significantly affecting the health and economy of the United States and the Panhandle of Nebraska. In the United States, one in nine adults has diabetes and one in five healthcare dollars is spent caring for someone diagnosed with diabetes. The Centers for Disease Control and Prevention estimates that, if current trends continue, as many as one in three Americans could develop diabetes in a lifetime.

Panhandle Public Health District (PPHD) is located in western Nebraska. It serves 11 counties with a population of 51,433 residents and covers over 1,400 square miles. Communities are classified as either rural or frontier with some areas being declared as food deserts. The current rate of adults in PPHD's jurisdiction with diabetes is 6.8 compared to 8.3 nationally.

The National Diabetes Prevention Program (NDPP) is a year-long evidence-based lifestyle change program that helps participants eat healthier and include physical activity in their daily lives. Participants meet weekly for 16 weeks, then monthly for the remainder of the year. The goal of the NDPP in the Panhandle is to reduce the number of residents who develop type 2 diabetes and chronic illnesses through four primary objectives:

- Recruit and train partner organizations with the capacity and infrastructure in place to deliver the evidence-based lifestyle change intervention;
- Identify strategies targeting people at risk for diabetes to raise awareness of risk factors and the availability of the lifestyle change program;
- Facilitate relationships between partner organizations delivering the lifestyle change intervention and referring clinical partners; and
- Develop a healthcare provider protocol that facilitates referrals into the program.

Implementation

The initial steps of implementing the program involved planning internally and building support for NDPP. PPHD set up training for lifestyle coaches and developed a contract. Early on, PPHD decided to partner with organizations throughout the Panhandle to make classes available in each community in the district. Organizations were chosen for partnership based on a shared interest in and commitment to reducing the burden of type 2 diabetes. Key partners and representatives from organizations convened to develop a framework for the delivery of NDPP in the Panhandle. Each entity identified which employees should attend the training to become lifestyle coaches. At the first training, 17 people from eight organizations were trained to be lifestyle coaches. Since then, PPHD has trained an additional 20 lifestyle coaches, three of whom are bilingual in Spanish. PPHD has also gained partner organizations and coaching staff to better serve the jurisdiction. There are now 20 active lifestyle coaches covering the 11

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National Diabetes Prevention Program in the Panhandle

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counties of the district.

To increase access and reduce barriers, NDPP in the Panhandle partnered with the Panhandle Worksite Wellness Council to provide NDPP classes on-site for member companies. PPHD facilitates the contracts between businesses and the partner organization that will be conducting the sessions. This has been a strong partnership thus far and an opportunity for employers to promote employee health and wellness.

To facilitate relationships between partner organizations delivering NDPP and clinical partners and to increase physician referrals, a PPHD staff member and local lifestyle coaches met with the physicians at each hospital and clinic in the Panhandle. Two forms were created to facilitate referrals from physicians—(1) Lifestyle Prevention Referral Form, used by physicians to refer prediabetic patients to the program; and (2) HIPAA Release Form, which, when signed by the participant, authorizes the lifestyle coach to request results from prior lab work.

PPHD coordinates all activities related to NDPP in the Panhandle and is the hub for all data required for recognition by the Centers for Disease Control and Prevention. PPHD continues to cooperate with partner organizations to ensure efficient operations and to collaborate with partners and lifestyle coaches to address challenges and new opportunities. Internally, PPHD staff track contracts, screen participants, connect with businesses, provide technical assistance, request supplies, send news releases, and submit data.

Outcomes

NDPP in the Panhandle has progressed in three years of operation. Participants are reducing their risk for diabetes and other chronic illnesses. The program is not only positively affecting the participants but also affecting their families and coworkers.

Interest in NDPP has grown largely through word of mouth. As participants experience success, they inform others. Several communities have established waiting lists to keep up with demand for the program. As of December 2014, NDPP in the Panhandle had completed 36 community classes and 13 business classes, with 457 participants losing over 2,700 pounds. An additional 13 classes have been started since then.

Classes start throughout the Panhandle many times a year. A coach does not have to wait for the first class to finish before starting another group. Classes starting in September and early October, or January and February, show the most success. Classes can be established prior to the holidays or to coincide with resolutions to improve health after the New Year.

The regional NDPP program continues to grow with support from the lifestyle coaches and outreach to new and existing community partners, hospitals, and clinics. Monthly conference calls allow lifestyle coaches to collaborate to improve the process. They can discuss successes, challenges, new ideas for recruitment, and opportunities that are available.

How the Program has been Sustained

To make the Panhandle a healthier place to live, learn, work, and play, PPHD and community partners are committed to sustaining the NDPP. Support for the program, which has always been shared among partners, is becoming embedded in communities and worksite wellness programs. The program coordinator continues to build relationships and support for the program, support the lifestyle coaches, and evaluate ongoing classes to hold the program to the Centers for Disease Control and

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As participants experience success, they inform others. Several communities have established waiting lists to keep up with demand for the program.

National Diabetes Prevention Program in the Panhandle

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Prevention's Standards for Recognition.

The Panhandle has one overarching community health improvement plan (CHIP), and each hospital has a CHIP that outlines priorities and strategies. Eighty-eight percent of the local hospitals have committed to sustaining NDPP in their communities by including it as a strategy in their CHIP.

Sustainability is a key consideration when choosing new partners. PPHD discretionary funds, federal chronic disease prevention and control funds, Nebraska Lifespan Health Services, and the Panhandle Worksite Wellness Council support the following: small contracts to sustain NDPP in the partner organizations, curriculum binders, Calorie King books, basic marketing, technical assistance, and data analysis. The contracted amount does not cover the costs of the class. Organizations conducting the interventions must support the additional cost for staff time, the room rental for holding the class, and advanced marketing. Partner organizations' missions must have an aspect of community outreach or education. The mission, coupled with the success of the program, lends itself to sustainability.

For more information, contact Tabi Prochazka at tprochazka@pphd.org or visit www.pphd.org/dpp.html.

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Utilizing Incident Command to Address Congenital Syphilis in Broward County, Florida

By Renée Podolsky, MBA, Community Health Director, and Terri Sudden, Community Health Planning Manager, Florida Department of Health in Broward County

Organization

Florida Department of Health in Broward County (DOH-Broward)

Overview

Reported cases of congenital syphilis in Broward County rose from to zero in 2010, to 10 in 2011, and to 15 in 2012. Cases of infectious syphilis in Broward County rose from 13.4 per 100,000 in 2011, to 16.2 per 100,000 in 2012, with the rates among men increasing from 25.1 per 100,000 in 2011 to 30.2 per 100,000 in 2012. To address this public health threat, DOH-Broward activated an incident management team using the Incident Command Structure (ICS). The team developed an Incident Action Plan (IAP) to conduct targeted epidemiological investigation and study, including retrospective analysis; implement continuous quality improvements to sexually transmitted disease (STD) program activities; manage internal and external teams of subject matter experts; recruit and train competent STD program staff; develop and implement a social marketing campaign; conduct provider and community outreach and education; and monitor the effectiveness of mitigation strategies and campaign activities. The overarching goal was to reduce the transmission of infectious and congenital syphilis in Broward County. As a result, new congenital syphilis cases were reduced by 40% from 2012 to 2013, and for the period Jan. 1–Aug. 31, 2015, there was one new case of congenital syphilis.

Implementation

DOH-Broward used the ICS and National Incident Management System to manage the response (see figure on page 15). To guide the response, DOH-Broward referred to the Program Collaboration Service Integration Model, Centers for Disease Control and Prevention guidelines, and American Congress of Obstetricians and Gynecologists recommendations regarding the early detection, adequate treatment, and timely reporting of communicable diseases, with a focus on the interruption of perinatal transmission. The IAP goals and objectives were incorporated into the Broward County Community Health Improvement Plan (CHIP), which used Healthy People 2020 and Mobilizing for Action through Planning and Partnerships in its development.

DOH-Broward formed an integrated team for the response including STD, tuberculosis, hepatitis, HIV, and epidemiology professionals. The team held ICS meetings from May 30, 2013, through Jan. 2, 2014. The initial IAP was prepared on May 30, 2013. A total of 22 IAPs and 46 situation reports were developed over the course of the event. The ICS structure assisted in tracking and documenting progress for the goals and objectives identified in the IAP. An electronic survey was distributed to gather feedback from the 11 ICS team members. A final after-action meeting took place on March 13, 2014, to develop the after-action report. Activating the ICS also allowed DOH-Broward to test its All-Hazards Response Plan and Communications and Epidemiology Annexes in a real-world event scenario.

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Utilizing Incident Command to Address Congenital Syphilis in Broward County, Florida

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The team developed a descriptive analysis of the characteristics of mothers of live infants with congenital syphilis in Broward County from 2007 to 2012 using a data set of all STDs reported from 2007 through 2012 in the county. For missing variables, the data set was supplemented with information extracted from the narrative section of reported cases in the Florida STD database, PRISM. The team also searched other databases, such as Florida Shots, Vital Statistics, Man Driver and Vehicle Express, and Health Management System, and attempted to contact clients. The trimester of prenatal test frequency was calculated using the gestational calculator and the estimated date of delivery.

The team analyzed syphilis data trends from 2007 to 2012 and developed maps depicting the location of congenital syphilis, infectious syphilis, and HIV cases occurring in 2012 in Broward County. The team also developed a GIS map overlay of 2012 chlamydia, gonorrhea, and syphilis cases. The analysis and mapping assisted the team to understand the incidence and the geographic concentration of cases to develop targeted strategies for prevention and education.

DOH-Broward developed and implemented two social marketing campaigns promoting awareness of STDs, including HIV/AIDS. "Protect Your Baby" targeted pregnant women, and "Protect Yourself" targeted adults. In addition to initial stand-alone activities, the campaigns were later combined with the "Broward is Greater than AIDS" campaign to promote awareness of STDs including HIV/AIDS. Campaign materials were culturally and linguistically appropriate. During fiscal year 2013–2014, promotional materials included educational signage on storefronts, ads on benches at bus stops, displays on the sides of buses and trolley cars, 200,000 palm cards, and three rotating billboards. Advertisements were placed in culturally and linguistically appropriate print and broadcast media, and physician ambassadors recorded television advertisements. Staff, physician, and legislative ambassadors and a local elected official also participated in live events including Caribbean radio talk shows and local festivals and outreach events.

The team also targeted provider outreach to affected communities. The duties of the perinatal prevention staff position at DOH-Broward were enhanced, redefined, and resourced, which then positively impacted the campaign efforts, including the outreach and education to every obstetric and pediatric provider and delivering hospital in Broward County in an extremely short timeframe. A "Syphilis 101" pocket guide was created for physicians, along with standing orders for labor and delivery for clients diagnosed with HIV and syphilis. These tools assisted in consistent application of standards in the community.

DOH-Broward uses a database of contact information for physicians to e-mail and fax information. This database helps DOH-Broward initiate communication to the target audience quickly and consistently. In addition, increased outreach to providers and physicians through grand rounds, physician groups, meetings, conferences, and other presentations provides ongoing opportunities to present the public health mission and vision.

With respect to collaboration, DOH-Broward has strong relationships with public and private healthcare providers, faith-based organizations, local governmental agencies, civic associations, and the Miccosukee and Seminole tribal nations. Staff serve on many committees, boards, and provider networks that address minority health and health disparities in Broward County. In addition, DOH-Broward presents quarterly progress reports about CHIP implementation to a community planning group that assisted in the development of the community health assessment and subsequent improvement plan.

Such partnerships were important because multiple stakeholders assisted in implementing activities from the IAP. For example, local government officials championed messages to their constituents. Physician ambassadors worked within their communities to create awareness of and reduce stigma associated with syphilis. In addition, Broward County delivering hospitals and obstetric, gynecologic, and pediatric physician practices were receptive to in-person discussions and educational sessions regarding testing and treatment protocols. Reductions in infectious and congenital syphilis could not have been achieved without these collaborations.

continued on next page

Utilizing Incident Command to Address Congenital Syphilis in Broward County, Florida

continued from page 14

Outcomes

Using the ICS to provide structure to a multidisciplinary team was extremely effective in targeting, tracking, and documenting progress in meeting all identified goals and objectives. From 2012 to 2013, a 40% reduction in new congenital syphilis cases occurred; for the period Jan. 1–Aug. 31, 2015, there was one new congenital syphilis case.

The ICS provided an effective structure to manage, track, document, and evaluate a non-emergency response. Internal agency program coordination and integration of STD, tuberculosis, hepatitis, HIV, and epidemiology provided a team approach to reaching clients who may otherwise have been lost to care and follow-up. Clients are now tracked across programs rather than being "siloed" into a single program. Biweekly integrated program meetings continue to be held to discuss cases and coordination of services.

How the Program has been Sustained

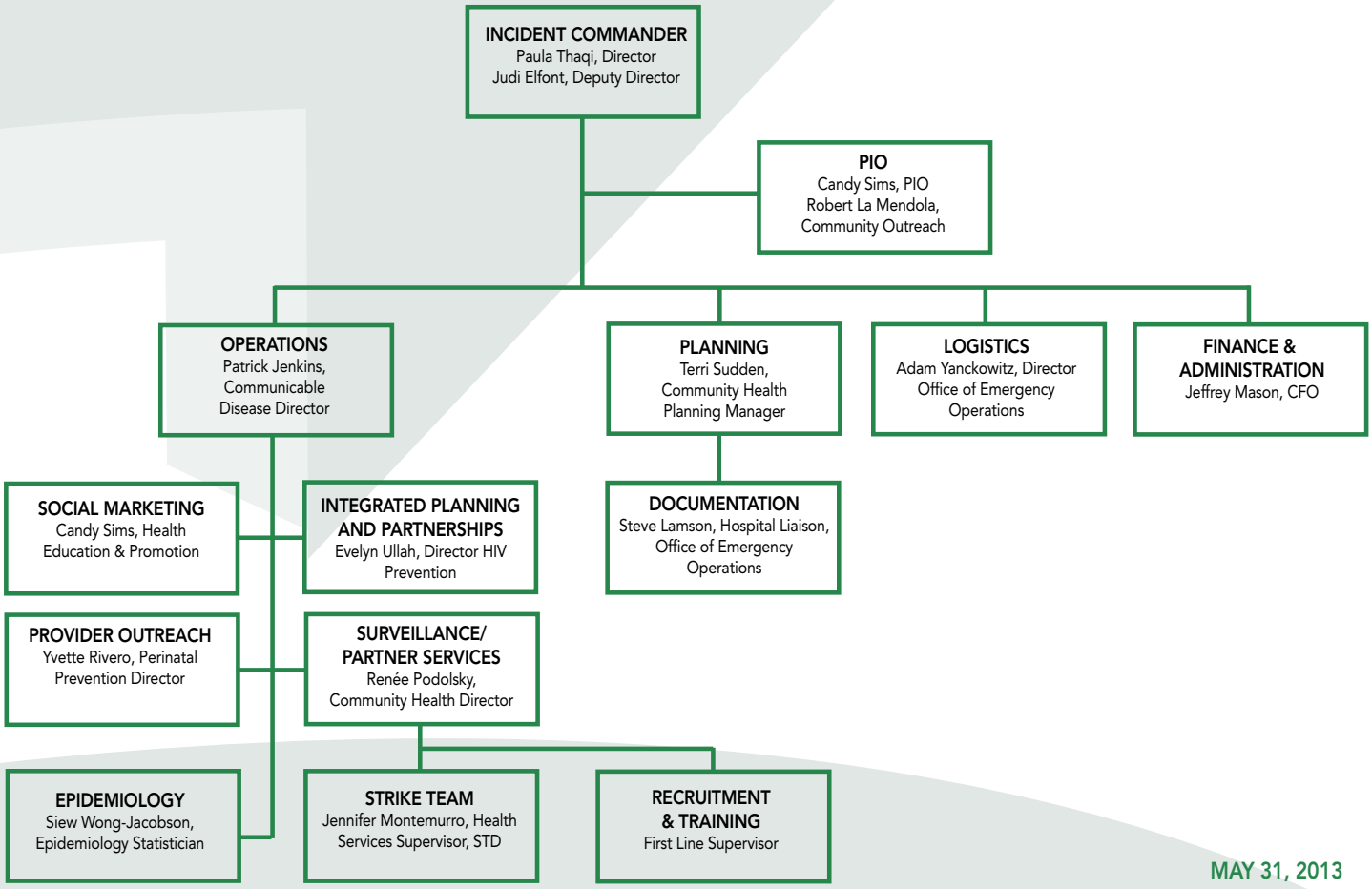
Continued collaboration across programs (epidemiology, HIV, STD, and tuberculosis) and integration of perinatal prevention with HIV and hepatitis have been accomplished.

The Syphilis101 guide and the development, training, and implementation of standing orders for labor and delivery for HIV and syphilis that began during the campaign continue to assist in consistent application of standards in the community.

The use of an existing physician contact database to e-mail and fax information to physicians was beneficial to initiating communication to the target audience quickly and consistently. The database has been sustained and used for disease outbreaks and educational awareness.

For more information, contact Renée Podolsky at 954-467-4700, Ext. 4005, or renee.podolsky@flhealth.gov or visit http://www.browardchd.org.

INCIDENT COMMAND STRUCTURE—STD 2013



MAY 31, 2013

NACCHO Congratulates the 2015 Model Practice Winners

Cumberland-Vineland Health Department
South Jersey Mobile Unit Task Force
Vineland, NJ

District 3, Unit 1: Cobb-Douglas Health District
Cobb County Safety Village—Interactive Health and Safety Education
Marietta, GA

Florida Department of Health in Broward County
Identifying Children Eligible for Low Cost Health Insurance through Free and Reduced Lunch Applications
Fort Lauderdale, FL

Florida Department of Health in Broward County
Managing Organizational Performance by Aligning SMART Expectations through a System of Shared Accountability
Fort Lauderdale, FL

Florida Department of Health in Broward County
Utilizing Incident Command (IC) to Address Congenital Syphilis in Broward County, Florida
Fort Lauderdale, FL

Florida Department of Health in Pinellas County
Obesity Treatment for Uninsured/Low Income Populations
St. Petersburg, FL

Florida Department of Health in Seminole County
Screening Process and Data Collection Improvements Increased Efficiencies for School Health Program
Sanford, FL

Grand Forks Public Health Department
Alliance for Healthcare Access
Grand Forks, ND

Hennepin County Public Health
Pre-Exposure Prophylaxis (PrEP) Program within a Public Health Clinic: An Innovative HIV Prevention Option for Men who have Sex with Men
Minneapolis, MN

Houston Department of Health and Human Services
The State of Health of Houston/Harris County
Houston, TX

Kane County Health Department
Assessing and Improving Routine Food Inspection Report Completeness
Aurora, IL

Kane County Health Department
Implementing Quality Improvement Projects with Medical Providers to Increase Smoking Cessation among Low Income Patients
Aurora, IL

Kansas City, Missouri, Health Department
Developing Regional Collaboration for Underserved Populations
Kansas City, MO

Maricopa County Environmental Services Department
The Cutting Edge Program: A Food Safety Partnership
Phoenix, AZ

Panhandle Public Health District
National Diabetes Prevention Program in the Panhandle
Hemingford, NE

San Bernardino County Department of Public Health: Division of Environmental Health Services
Improving Food Safety through the Health Education Liaison Program (HELP)
San Bernardino, CA

Tri-County Health Department
Alternate Care Facility Functional Annex Emergency Preparedness and Response
Greenwood Village, CO

Tri-County Health Department
Anthrax Prophylaxis Streamlined Population Screening Form
Greenwood Village, CO

Union County Health District
Prevention of Older Adult Falls through Home Assessment and Modification
Marysville, OH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Q & A with Awardees

Why should local health departments that have developed innovative programs apply for a Model Practice Award?

"[The Model Practices Program] is a good forum to exchange ideas and is recognized as a reward by administration. It legitimizes projects that otherwise might not be valued. It encourages programs to take risks that could pay off in the end."
—Amy Roberts, Kansas City (MO) Health Department

"…This is the best way for [local health departments] to share what they have learned with others and encourage others to develop innovative programs of their own."
—Steven Goode, Maricopa County (AZ) Environmental Services Department

"…The recognition is very validating. If you are not selected for the award, [the application process] does provide an opportunity for quality improvement and reflection."
—Debbie Swanson, Grand Forks (NE) Public Health Department

"The Model Practices Program is a wonderful program for being recognized by public health peers. Winning the award also helps raise morale amongst agency staff and puts the hard work of great programs in the spotlight for the jurisdiction."
—Corwin Porter, San Bernardino County (CA) Department of Public Health, Division of Environmental Health Services

"…The process for submission and reviewing the practices is credible, and health departments should feel that they can contribute. The Model Practices Program sets a bar (high) so health departments are encouraged to think of new ways to meet the needs of our communities and receive recognition for that work. It encourages [quality improvement] on a national level with a healthy amount of competition, and it shows that we all have a lot to learn from one another."
—Emily Frantz, Cobb & Douglas (GA) Public Health

How can local health departments write a successful application for a Model Practice Award?

"Plan ahead so you have enough time to write the application. Documentation throughout your program's implementation will help when it comes time to write the application and show outcomes and ability to replicate [the practice]."
—Debbie Swanson, Grand Forks (NE) Public Health Department

"…Applicants [should] start the process early so that they can submit the application before the deadline and reduce stress….We would recommend that multiple people in the agency read through the document to ensure thoroughness, accurate content, etc. It is especially important to ensure that the document is free of grammatical and punctuation errors. A document can discuss a great practice, but if the application itself is poorly written, it can ruin the chance of winning the award."
—Corwin Porter, San Bernardino County (CA) Department of Public Health, Division of Environmental Health Services

"Follow the process laid out in the application and have a model practice achievement in mind when you start a new practice. Keeping your documentation and data aligned with the application needs is helpful when applying."
—Theresa Heaton, Kane County (IL) Health Department

"Make sure you can demonstrate effectiveness—how are you evaluating and do you have results? It's easy to think of a lot of wonderful things we work on, but results matter to push the practice from promising to model."
—Emily Frantz, Cobb & Douglas (GA) Public Health

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 nation. 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 Caren Clark, Director of Publications, at 202-507-4258 or cclark@naccho.org. To report changes in contact information or to check your 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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Nov. 1–30	**American Diabetes Month**
Dec. 1–31	**Safe Toys and Gifts Month**
Jan. 1–31	**Thyroid Awareness Month**
Jan. 1–31	**National Birth Defects Prevention Month**

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Public Health

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1,242 lbs wood	A total of 4 trees that supplies enough oxygen for 2 people annually.
1,814 gal water	Enough water to take 105 eight-minute showers.
1mln BTUs energy	Enough energy to power an average American household for 5 days.
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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