

# Building Quantifiable Chronic Disease Assessments and Interventions During Clinical Visits

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## REACH (Racial and Ethnic Approaches to Community Health)

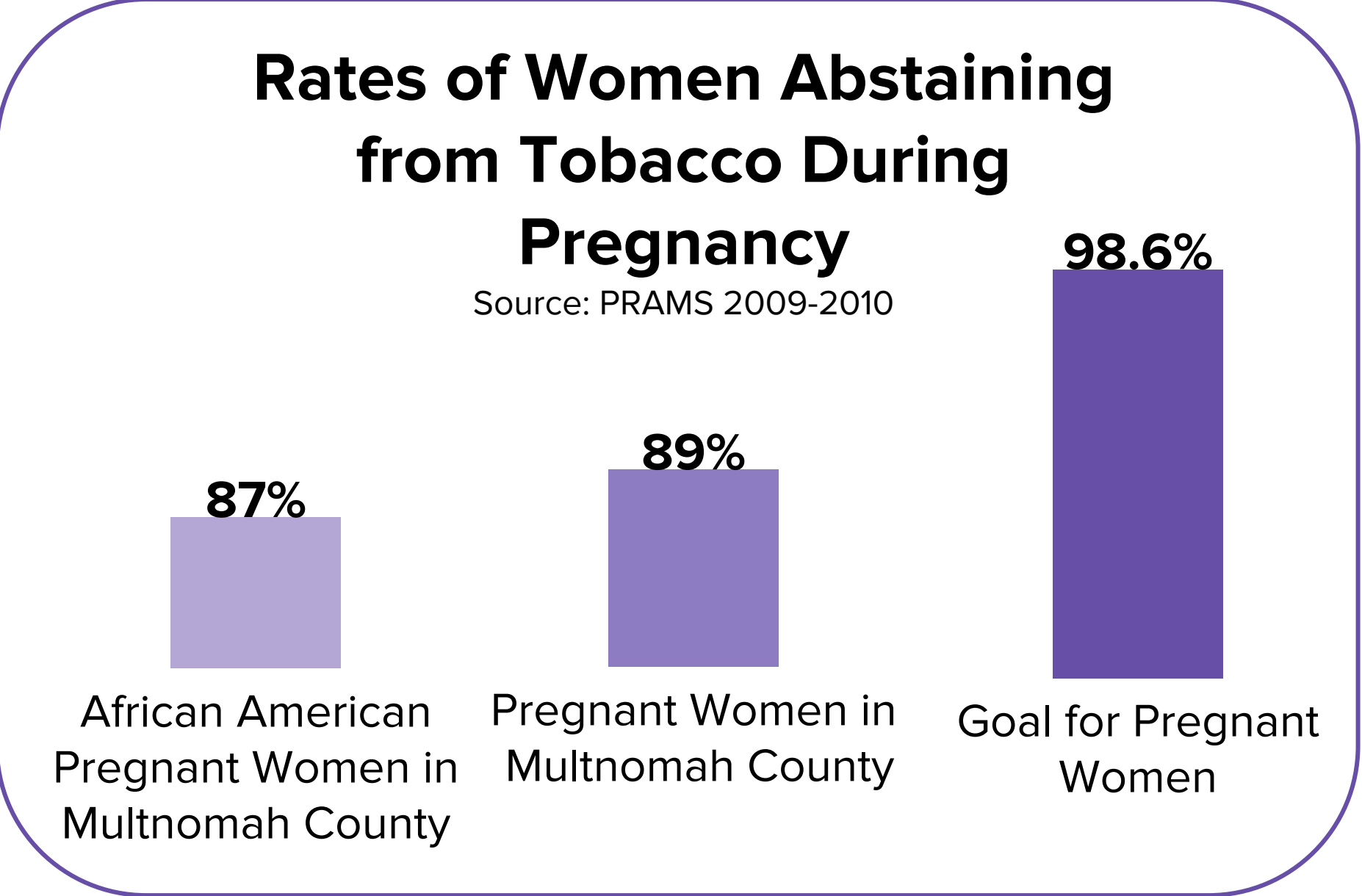
Reducing the racial health disparities in Multnomah County through Policy, Systems, and Environmental changes

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### SCRIPT (Smoking Cessation and Reduction in Pregnancy Treatment)

Multnomah County Health Department’s REACH program implemented an evidence based tobacco screening and cessation intervention as part of standard vitals screening for pregnant women in clinics serving a high percentage of African-American pregnant women.

**Our long term goal** is to make tobacco screening and counseling an integral part of clinical practice to reduce health disparities in communities of color.



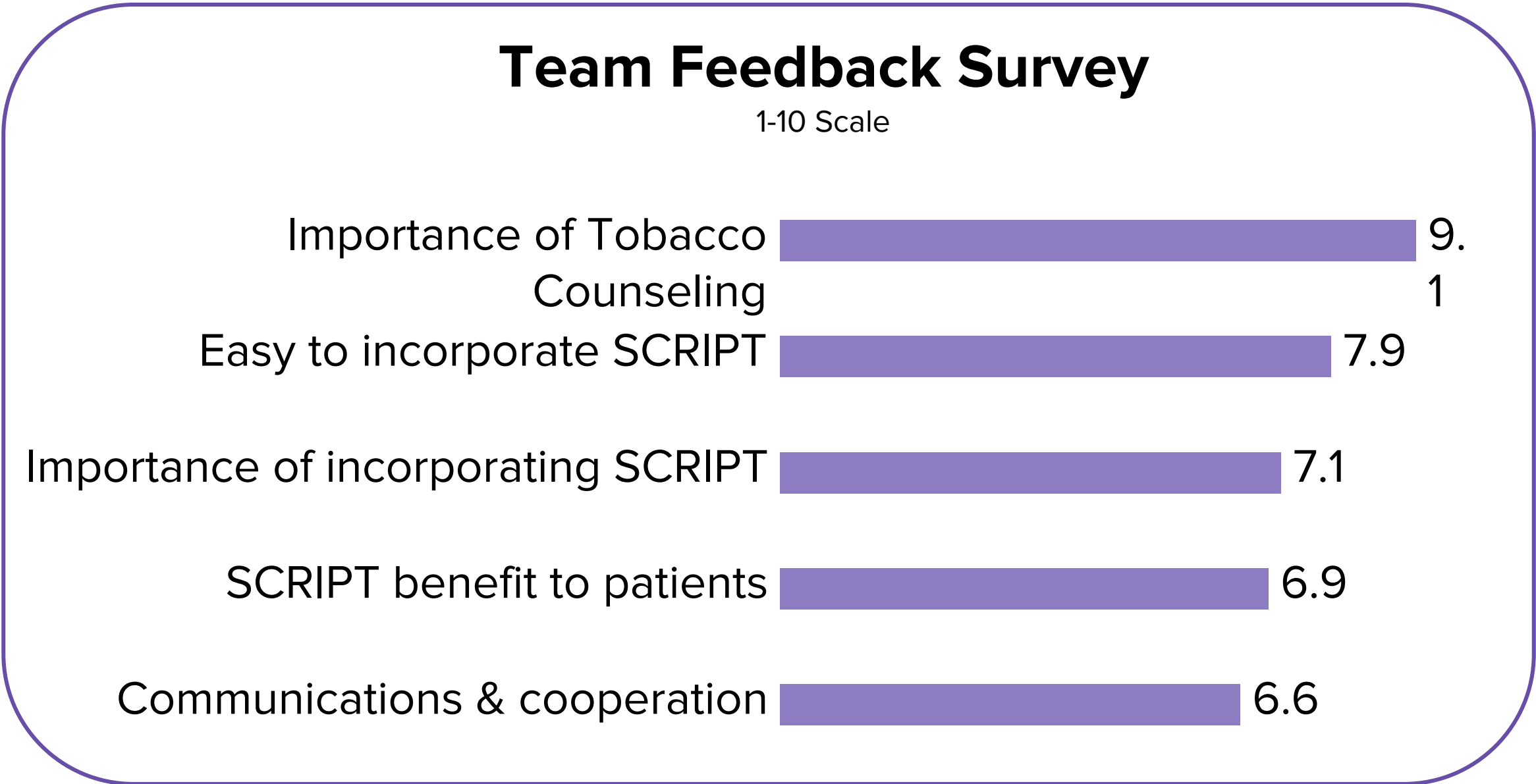
**Of the 58 women screened, 0 tested positive for tobacco exposure.**

**The Smokerlyzer (Carbon Monoxide monitor)**

*This device gives carbon monoxide readings (ppm) to determine an individual’s level of tobacco exposure.*

### Keys to Success

- Identify champion at clinic settings prior to implementation
- Certified Medical Assistants (CMA) can be trained to administer the CO monitor as part of vitals, in only 2-3 minutes during visit.
- Clinic staff ranked the importance of providing tobacco counseling to patients as very high (9 on a 10-point scale).
- Benefits to objective, quantifiable data are clearly evident to patients and staff.
- For patients who test positive for tobacco exposure, CHWs can deliver the cessation counseling intervention.



Our Change Model			
First Steps	Building the System	Pilot Testing	Analysis
<p><b>Goals</b></p> <p>Develop training and Implementation of Clinic Process Workflow</p>	<p><b>Goals</b></p> <p>Adapt Electronic Health Records (EHR) for screening data Purchase and calibrate Smokerlyzer</p>	<p><b>Goals</b></p> <p>Conduct pilot study Collect data to evaluate</p>	<p><b>Goals</b></p> <p>Analyze pilot data Refine interventions</p>
<p><b>Stakeholders</b></p> <p>Community Health Workers (CHW) REACH Staff Physician Lead</p>	<p><b>Stakeholders</b></p> <p>IT Staff REACH Staff Clinic Administrator Physician Lead</p>	<p><b>Stakeholders</b></p> <p>Community Health Workers REACH Staff Physician Lead Patients</p>	<p><b>Stakeholders</b></p> <p>Contacted Evaluator Community Health Workers REACH Staff Physician Lead</p>
<p><b>Lessons Learned</b></p> <p>Document the anticipated process; locations, data collection, screening procedure Create clear roles for clinic staff Practice counseling during trainings</p>	<p><b>Lessons Learned</b></p> <p>Include scheduling, billing and ‘resulting’ all of the data in EHR development Make sure smokerlyzer is used as vitals, not as a lab. Ensure CMA’s are sufficiently trained on smokerlyzer procedure</p>	<p><b>Lessons Learned</b></p> <p>Create a designated lead to check in with all stakeholders on regular basis (CHW CMA, Physician Lead, IT) Create streamlined intake and intervention forms.</p>	<p><b>Lessons Learned</b></p> <p>Include all stakeholders in refining clinic process Use additional intervention models for other relevant patient groups (e.g., Rx for Change, Learning about Healthy Living) Distribute ethnic specific materials for different clientele (e.g., Pathways to Freedom for African Americans)</p>

### Next Steps

- Continue screening and counseling for pregnant women
- Extend the SCRIPT program to women after the birth of their babies
- Expand screening to adolescents at well care visits and incorporate a brief counseling intervention delivered by the physician
- Conduct pilot study within FamilyCare Coordinated Care Organization (CCO) clinics
- Provide technical guidance to two community based addiction treatment centers to adopt tobacco screening and counseling

### A Special Thank You

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