

# JOINED-UP

## Job Opportunity Investment Network Education On Diabetes In Urban Populations

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# Employment in Philadelphia

- Less than half of working-age adults in the city are currently employed
- 40% of those who have jobs earn poverty wages.
- Philadelphia ranks in the bottom 10% of U.S. cities in terms of both post-secondary educational attainment and labor force participation.
- This crisis is particularly severe for the vulnerable adults living in South Philadelphia. South Philadelphia's unemployment rate is 35% with 77,868 unemployed adults.
  - 32.7% AA/ 67.9% Latinos employed full-time



# Background

- Work Development Programs help vulnerable, adults succeed in realizing long-term careers by helping them overcome barriers to employment.
- The current workforce system funds training and placement services to get individuals *into* jobs, but does not pay for the empowerment and counseling services to ensure newly-employed individuals *keep and advance* in their jobs.



# Background

- 50% of low-skilled adults with physical and/or behavioral health problems, do not keep their jobs within one year of being employed. The most frequent reasons for losing their jobs are physical and behavioral health problems.
- According to the Partnership for Prevention, reducing just one health risk can increase productivity by 9% and reduce absenteeism by 2%. Absence management leads to a healthier workforce and maximizes a company's productivity and profit.



# Background

- Diabetics - total loss in income due to health-related work impairment has been estimated to be an incremental \$57.8 billion dollars/year
  - Lost productive time at work
  - Poor glucose control = increased absenteeism, decreased earnings, disability, decreased productivity



# Background

- Diabetes burden in Philadelphia neighborhoods served by this project:
  - 16.7% of AA and 9.7% Latinos report diabetes
  - 69.4% AA and 60% Latinos overweight or obese therefore at greater risk for diabetes or complications from diabetes
  - 30% have high blood pressure
  - Over half smoke cigarettes
  - Almost 30% have diagnosed clinical depression or mental health conditions
  - 50% report high levels of stress



# Mt Sinai - Diabetes IMPACT Center

- Centers for Disease Control (CDC) designated the Communities IMPACT (Inspired and Motivated to Prevent and Control and Treat) Diabetes Center as a national Center of Excellence in the Elimination of Disparities (CEED).
- The Communities IMPACT Diabetes Center
  - a collaborative that includes community residents, community-based organizations,
  - health care providers and researchers, faith-based institutions, housing and social service
  - agencies, and local policymakers.
- Through a five-year grant, Center is charged with working
  - toward eliminating diabetes disparities among African Americans and Latinos with or at risk for diabetes using community-based participatory approaches.

Provided funding for JOINED-UP



# Grant Partners

- Job Opportunities Investment Network
- Federation of Neighborhood Centers
  - Diversified Community Services
  - United Communities
- Thomas Jefferson University and Hospitals – Family and Community Medicine and Center for Urban Health







# Saving Energy . . . Saving People . . . Saving Cities.

*A Plan for Training the Most Vulnerable from our  
Neighborhoods to Make Philadelphia the  
GREENEST CITY IN THE NATION  
- A Replicable Model for America's Great Cities-*





# Federation of Neighborhood Centers

- **The Federation of Neighborhood Centers (Federation) - established in 1906 to help build strong neighborhoods by strengthening families and civic life**
- **Network of 15 settlement houses and neighborhood centers—community-based anchor institutions that collectively provide services to more than 100,000 low-income families, children and youth per year.**

Community Partner

# Diversified Community Services

- Given 150 year old history, Diversified Community Services (DCS) is an anchor organization in South Philadelphia.
- DCS has evolved into the largest human services agency in Point Breeze. DCS serves over 8,000 children, youth and families in a year through a wide array of services that are easily accessible and close to home.





# Green Jobs

## ■ Partners

- Philadelphia WIB
- Smart Energy Initiative
- Federation of Neighborhood Centers
- Energy Coordinating Agency
- Sustainable Business Network
- Mayor's Office of Sustainability
- United Way of SE PA

## ■ Demand

- Alternative Energy Investment Act
- Act 129 (conservation programs)
- Advanced Energy Portfolio Standard
- Weatherization Assistance Program




# Center for Urban Health: Project Team

- Neva White, DNP, MSN, CRNP, CDE
  - Coordinator of Diabetes Education Program
- David Madison, MEd
  - Diabetes Educator
- Pam Harrod-Smith, MS
  - Project Assistant
- Rickie Brawer, PhD, MPH, MCHES
  - Evaluator
- James Plumb, MD, MPH
  - Medical Director
- Suzanne Rossi
  - Medical Student (MS2)



# The Goals of JOINED-UP were to:

- Assess the feasibility of integrating a diabetes prevention and control program into a community-based workforce training program
- Increase healthy lifestyle behaviors related to preventing diabetes in overweight/obese individuals participating in the workforce training program
- Improve diabetes self-management among diabetics participating in the workforce training program



# Job Opportunity Investment Network (JOIN) - Training Program

## ■ Four cycles of:

- 1-2 weeks baseline assessments
- 7-8 weeks of training
- 1 week of post-training assessments

## ■ Required components:

- Work Readiness Soft Skills Training
- Individualized Case Management
- Contextualized Literacy Training
- Physical Training

***JOINED-UP program - Health assessments - Diabetes prevention and control integrated into job training for low skilled – low resourced workers – group sessions, personalized action plans and motivational interviewing***





# JOINED-UP Training Program

- Required to attend introductory healthy lifestyle educational program
- Questionnaire to ascertain current knowledge, attitudes and health behaviors, particularly as they pertain to diabetes prevention
- Baseline assessment:
  - Height, weight, BMI, glucose, blood pressure, health history, TC, HDL, HgbA1c
- JOINED-UP program: 6 sessions
  - Individualized counseling session (Personal action plan) - Diabetics: AADE7 Impact curriculum: healthy eating, physical activity, monitoring, problem solving, reducing risks, health coping.
  - Four interactive, skill-building group sessions
  - Reassessment of the baseline measures, surveys



# *Healthy Lifestyle* workshops

- Designed to encourage sharing of real life experiences through discussions
- During the initial class, participants develop characteristics for an individual who is then also given a name, *Thelma* or *Wille Make-it*.
- "*Thelma*" serves as a case for discussion during workshops By referring to "*Thelma's*" issues and concerns and asking - "*What would Thelma do?*" - participants safely discussed personal issues without disclosing their own private information.




# Individual Counseling

- Reviewed screening and survey results
- Discussed personal health concerns
- Developed personal action plans
  - Motivational interviewing techniques were used to guide this discussion that encouraged small changes over time.
  - Assisted in obtaining PCP



# Recruitment

- 84 enrolled in JOIN; 9 dismissed
- 75 eligible for Health component; 50 enrolled
  - Concerns about privacy
  - Of the 25 not enrolled, 16 dropped out of JOIN and 9 attended the JOINED-UP program but did not take part in the study
  - 9 of 50 left prior to post test due to finding work
  - Pre/post data on 41 participants



# Cohort I-III (N=50)

- Average age 32
- 79% - male
- 70% - no health insurance
- 64% have children in home
- 5% did not graduate from HS; 52% HS/GED; 10% vocational school; 33% some college
- 45% did not have a PCP
- 56% were at risk of diabetes or already diagnosed – 44% had pre-diabetic readings (HbA1c 5.7-6.4) and 12.5% were known diabetics.
- 38% smoke
- 53% - obese, 18% - overweight
- 51% had pre-hypertensive blood pressure or high BP readings (30% hypertension)
- 15% had elevated cholesterol (>220)
- Attendance rate -92% at all sessions



# Diabetics

- Among the 3 diabetics who participated in the program, 2 had hypertension, 1 had high cholesterol, 1 smoked, all were overweight or obese and none had ever participated in a DSME class before or instruction on meal planning.



# Impact on Families

- 18 of 41 (44%) completing the post test reported having children living in their households.
- As a result of taking part in this program
  - 13 of 18 (72%) reported their children are more physically active and eat more servings of fresh fruits/vegetables daily;
  - 12 of 18 (66%) reduced salt in their family's diet and reduced consumptions of soda and other sugar beverages;
  - 11 of 18 (61%) reduced dietary fat in their children's diet and reduced screen time to no more than 2 hours daily.
- These results imply that providing healthy lifestyle education as part of a workforce development program can be an important factor in improving the health of children and families.



# Personal Action Plans

- Completed by 95% of enrollees
- 30 of 41 enrollees achieved at least one goal (73%)
- 13 of 41 enrollees who completed the program accomplished 2 or more goals (32%)





# Personal Action Plans

- The majority of action plans focused on increasing physical activity; increasing/improving diet through eating more fruits and vegetables, losing weight through reducing soda/increasing water intake, reducing fried foods, reduced snacking and increased physical activity; and learning to manage stress.



# Personal Action Plans

- Philadelphia Health Center and make an appt to see physician (establish a medical home). Plan to have an appt within the next two weeks. Increased fruit and vegetables in daily diet
- Decreased the amount of potato chips in the home
- Continue to abstain from smoking. Enroll in next smoking cessation class at Health Center 10
- Has increased distance in biking and walking more
- Snacking more fruits and nuts and less candy
- Increased walking 3 blocks to center and 2 blocks back  
Increased water intake
- Eating more fruit and vegetables. Preparing at least two meals at home



# Impact

## As a result of taking program (n=41):

- 26% obtained a PCP
- 61% increased physical activity
- 76% increased fruits/vegetables in diet
- 61% decreased salt; 63% reduced fat
- 61% now read labels
- 13% (2 of 15 smokers) stopped smoking; 73% (11 of 15 smokers) reduced smoking
- 34% use stress management techniques more often
- 24% lost weight
- 34% decreased alcohol use
- 76% felt that their state of health improved “a lot”
- 68% felt that their ability to control health improved “a lot”
- 53% felt that their quality of life improved “a lot”



# Weight loss

- 10 enrollees (24%) lost 4 or more pounds (99 pounds total); 13 maintained their weight within 2 pounds; and 13 gained 4 pounds or more (128 pounds gained).
- Program participants shared that they were less active during the training program and were eating out more often. In addition, healthy food is not readily available near the JOIN program. Future programs should consider the inclusion of regular opportunities for physical activity and building relationships with vendors who can provide healthier food choices.



# Diabetics

- All diabetics achieved two or more of the personal action plan goals, improved glucose monitoring (testing daily and recording blood sugars), and are exercising more often
- 1 has obtained and seen a PCP and is taking medications as prescribed
- 2 have improved their diets (eating more fruits and vegetables, decreased fat in diet, reduced alcohol, and purchasing less convenience food)
- The diabetic who smokes reported “cutting back” on cigarettes



# Diabetics

- All reported that their knowledge about diabetes and A1c improved a lot (all questions answered correctly), quality of life improved a lot and their ability to control their diabetes improved a lot.
- Participants valued the individual counseling and nutrition education most. They felt that more time was needed for DSME and that assistance in accessing diabetes supplies would be helpful.



# Focus Group Suggestions

1. Most participants did not have previous experience with a health education program. Information from family, friends, TV, library, family doctor.
2. Screenings well received, many don't have insurance to get those tests done. Want to learn more about insurance options, continue presenting healthcare information. More follow-up information on the screenings (i.e. What do I do to bring up my HDL, etc?)
3. This class taught how to read packages, learned about other people's health status.
4. Enjoyed the character in the sessions, request handouts, wanted more in-depth education, more sessions, longer time to talk about character.



# Suggestions, continued

5. Felt the lunch choices and sedentary style of the program interfered with ability to follow health advice. Would like to do some physical activity during the training
6. Improvements: Give brochures, go more in-depth on topics like smoking and nutrition. More visuals.
7. More follow-up/teaching for the Action Plans during the training.
8. Bring a scale to more consistently check weight and progress or leave one in the corner.
9. HbA1c: would like to be retested; willing to come to community center for retesting





# Sustainability:

## RWJF Local Funding Partnerships – JOIN + RWJ

- Common Places. Common Causes. Uncommon Connections.
- Working together so better health can take root in our communities.
- Robert Wood Johnson Foundation Local Funding Partnerships (LFP) leverages the power of partnership to address community health needs through matching grants programs for innovative projects.



# Career Support Network

- The project will increase the number of vulnerable adults who obtain and retain sustainable, competitive employment, with *a focus on retaining jobs*, through strategically addressing this systemic gap in the workforce development system.



# Objectives

- **Move vulnerable adults from short-term, dead-end jobs into long-term careers that pay family-sustaining wages**
  - **Reduce the recidivism rate**
  - **Increase the financial stability of vulnerable adults, as measured by their savings and stable housing rates**
  - **Increase the number of vulnerable adults with physical health conditions such as diabetes, hypertension, and obesity who demonstrate improved disease management and self-efficacy**
  - **Increase the number of vulnerable adults with mental and behavioral health conditions such as depression, anxiety, and addiction who demonstrate improved coping skills and understanding of their conditions**

