

THE CAREER SUPPORT NETWORK

An Interdisciplinary Model Integrating Chronic Disease Prevention and Management Programs, Public Health and Occupational Therapy into a Workforce Development Program for Low Skilled, Low Resourced Individuals

Rickie Brawer, PhD, MPH, MCHES

James Plumb, MD, MPH

Department of Family and Community Medicine
Center for Urban Health

Stephen B. Kern, PhD, OTR/L, FAOTA

Robert Walsh MS, OTR/L

Department of Occupational Therapy, Jefferson School of Health Professions

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THE CAREER SUPPORT NETWORK (CSN)

***Historical Perspective:
What led us to the CSN?***

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NEIGHBORHOOD CENTERS: *The Beginning*



- Anchors in their neighborhoods
- Long-term relationships with community members
- Provide wrap-around supportive services

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GREEN JOB READINESS PARTNERSHIP (GJRP)

2009: **Living Cities & Job Opportunity Investment Network (JOIN)**

2010: **Pathways Out of Poverty** through **Jobs For the Future**

invested in a partnership to:

Develop and implement a model where community centers become points of engagement for marginalized workers to attach to employment and training.

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GREEN JOB READINESS PARTNERSHIP

WHO WE ARE

A partnership managed by

The Federation of Neighborhood Centers

And including . . .

The Philadelphia Workforce Investment Board

Jobs for the Future

Job Opportunity Investment Network

Sustainable Business Network

Diversified Community Services & United Communities of SE Philadelphia



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GREEN JOB READINESS PARTNERSHIP: *Key Program Components (Phase I)*

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

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WHAT IS THE GREEN JOB READINESS PROGRAM?

Phase I

9 weeks of training & preparation: Monday - Friday 9:00 to 4:30

- Classes in Green Literacy, Math, Workplace Readiness, Hands-on Tool Use
- Preparation for Hard Skills training & transition into the training
- Assistance in removing barriers to work
- Case Management and Career Coaching
- Certificates and Resumes

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GREEN JOB READINESS PARTNERSHIP: *Lessons Learned (Phase I)*

- Physical and mental health problems – significant barriers to employment
- Getting a job a priority – not addressing health problems
- Average length of time to get jobs: 6 months

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HEALTH IMPACT ON WORK

- 50% of low-skilled adults with physical and/or behavioral health problems:
 - Do not keep their jobs within one year of being employed.
 - 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.

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DIABETES' IMPACT ON WORK

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

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DIABETES' BURDEN:

Philadelphia Neighborhoods Served by GJRP

- 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

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**New Partner Joins GJRP:
Thomas Jefferson University and Hospital**

**Job Opportunity Investment Network Education On
Diabetes In Urban Populations
(*JOINED-UP*)**

Funded by Mt. Sinai- Diabetes IMPACT Center

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JOINED-UP

Goals

- 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

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JOINED-UP Training Program

- Introductory healthy lifestyle educational program (*Required*)
- 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
- 6 Program 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

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JOINED-UP

Profile of Participants

- 79%- male; Average age - 32
- 70% - no health insurance; 45% - no 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)

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JOINED-UP

Results (N=41)

- **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”**
 - 73% enrollees achieved at least one Personal Action Plan goal
 - 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% stopped smoking; 73% reduced smoking
 - 34% use stress management techniques more often
 - 24% lost weight
 - 34% decreased alcohol use

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JOINED-UP

Impact on Families

44% completing the post test reported having children living in their households.

As a result of taking part in this program:

- 72% reported their children are more physically active and eat more servings of fresh fruits/vegetables daily;
- 66% reduced salt in their family's diet and reduced consumptions of soda and other sugar beverages;
- 61% reduced dietary fat in their children's diet and reduced screen time to no more than 2 hours daily.

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JOINED-UP

What Did We Learn?

Integrating a diabetes prevention and management program into a workforce development program is feasible and effective

Requiring health component as part of a workforce development program is key to recruiting participants, particularly men, into health promotion/disease management program

Directly linking the management of one's health to attaining and retaining a job, enhances the motivation of clients to better manage their chronic health conditions

Providing healthy lifestyle education in a trusted community center helps build trust between the health educators and other members of the healthcare team

Providing wrap-around centralized services (i.e. job training, transportation, child care, emergency assistance, housing assistance, etc.) in conjunction with providing disease self management helps keep the clients engaged

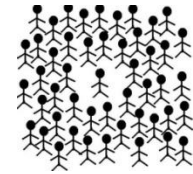
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Traditional Workforce Programming*



Job Retention Tracked at 1/3/6 month intervals by Case Manager

Program Eligibility maintained via participation reporting in up to 4 separate systems by Case Manager

Job Readiness Training – group classes



Individual Case Manager (client ratio as much as 120:1)

Limited transportation assistance – managed by Case Manager



Program Participant

Job Development (cafeteria-style, 90% entry-level – client ratio as much as 250:1)



Clinical Counselor (client ratio as much as 400:1)

*based on current Philadelphia TANF programming

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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.

CAREER SUPPORT NETWORK

Innovative Partnership Model



Jefferson™
University Hospitals



Thomas
Jefferson
University



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RWJF Local Funding Partnerships

- 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.

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Goal

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 systemic gaps in the workforce development system

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Proposed Outcomes

Move vulnerable adults from short-term, dead-end jobs into long-term careers that pay family-sustaining wages

- Increase the number of vulnerable adults who will be employed in jobs with sustainable wages for a minimum of one year
- 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
- Reduce the recidivism rate

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Key Questions

- **Does the inclusion of a CSN in a workforce development program improve participant health and employment success prior to and during employment?**
- What is the value of the CSN from the perspective of program participants, program staff, employers and training programs?
- What is the impact of the CSN on participants' physical and behavioral health?
- What is the value of the community center in facilitating health improvement/maintenance among CSN program?
- How do we effectively integrate a behavioral /physical health component into a workforce development program (pre employment through employment)?

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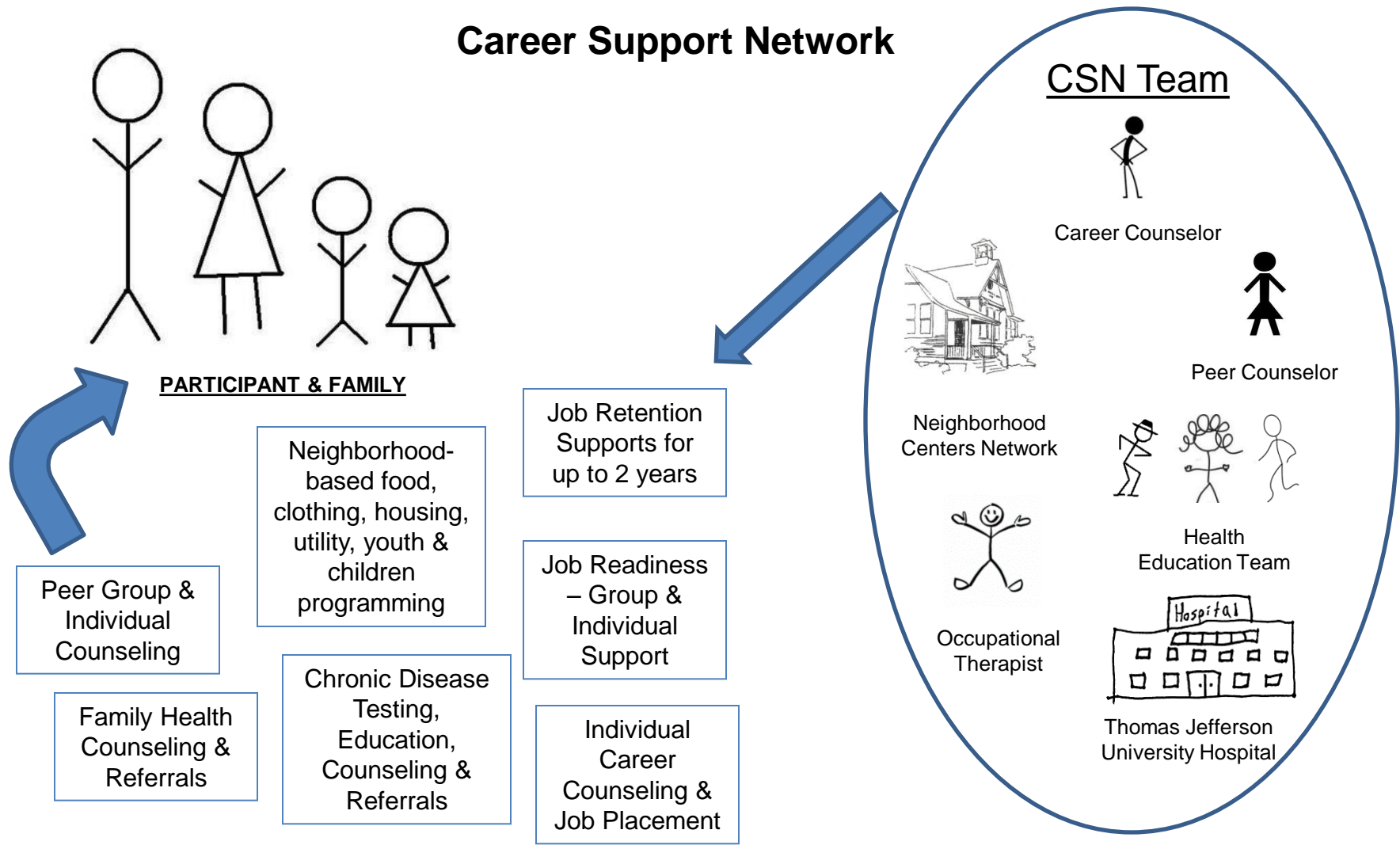
Interdisciplinary CSN Team

- Physician (1)
- PhD, Masters Public Health (1)
- Masters Public Health (1)
- DNP, RN, Certified Diabetes Educator (1)
- Masters prepared Health Educators (2)
- Occupational Therapists (2)
- Physical Therapist (1)
- Peer Counselor

Getting Started

- Creating pre-post evaluation instruments
- Recruitment, hiring and training OT
- Completing/executing contracts with TJU and TJUH
- Completion of TJU IRB
- Integration of R2R (Roots to Re-entry)
- Recruitment and hiring of Research Assistant
- Integration into RISE activities (Mayor's Reentry Program for Ex-offenders)
- Completion of PDPH IRB

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Work Support That Works When YOU Need It



Recruitment:
N=207 eligible
Green Jobs
EARN
Roots to Reentry

Informed
Consent
N=207

CSN
Non-participants = 37

CSN Participants = 170

Career Support Network Flow Chart
 •Current components
 •Expanded Component Based on Pilot Program
 •New components

Career Sense
 Dixon House/Houston Center – community center training sites
CSN Team meets weekly to discuss program issues
 •Career Sense Training
 •Chronic Disease prevention and management focus (diabetes, hypertension, asthma, behavioral health) that includes assessment, 9 weeks of healthy lifestyle education and individual counseling/coaching by the Chronic Disease Management Health Educator and Healthy Lifestyle Educator
 •Peer-Peer Support/ Coaching/ Mentoring
 •Referrals to Medical Director, primary care providers, behavioral health as appropriate, community resources

Hard Skills Training / Internship or Job Seeking
 •Job readiness, job search and interview preparation
 •Peer Support/Coaching/Mentoring provided by Peer counselor
 •CDSM support as needed
 •Peer Counselor/OT on-going contact with participants; referrals to community resources, behavioral health resources and Medical Director as needed; completion of individually tailored plan of action
 •OT and Peer Counselor lead monthly CDSM; Peer Counselor with support from OT leads bi-weekly support group sessions on work related self-management skills
 •Follow-up Health Screening and Assessment

Work Sense (Employment)
 •Work Sense Peer-Peer Support/Coaching/Mentoring
 •CDSM support as needed
 •OT weekly contact with participants for first 6 months of employment and as needed thereafter; on-going contact with workplace supervisors; referrals to community resources, behavioral health resources and Medical Director as needed
 •OT and Peer Counselor lead monthly CDSM
 •Peer Counselor with support from OT leads bi-weekly support group sessions on work related self-management skills
 •Follow-up Health Screening and Assessment

Outcomes
 Improved physical and behavioral health
 Reduced absenteeism
 Reduced criminal recidivism
 Improved job retention

Occupational Therapy Assessments

- **Allen Cognitive Level Screen – 5** - quick measure of global cognitive processing capacities, learning potential, and performance abilities that detects unrecognized or suspected problems related to functional cognition
- **Canadian Occupational Performance Measure (COPM)** - measures change in a client's self perception of performance in daily occupations over time; supports the notion that clients are responsible for their own health
- **Worker Role Interview** – a semi structured interview that assesses psychosocial & environmental factors that impact return to work or maintenance of work role
- **Assessment of Work Performance** – measures motor, process, and communication/interaction skills

Occupational Therapy Intervention

- OT and client collaboratively identify measurable goals to work on
- Intervention is a combination of
 - Group sessions – focused topic with 4 components
 - Didactic (Instruction)
 - Activity (“Doing”)
 - Peer (interpersonal/communication)
 - Homework/Reflection (self-efficacy, habit training)
 - Individual Sessions

Occupational Therapy Groups

- **Healthy Living**
 - Stress Management
 - Habit Formation/Training
 - Health Promoting vs. Non-Health Promoting Occupations
 - Action Planning
- **Time & Self-Management**
 - Time Management
 - Roles & Responsibilities
 - Role Balance
- **Putting Your Best Foot Forward**
 - Assertive Communication
 - Body Language
 - Conflict Management
- **Work & Ergonomics**
 - Assessing the match between work skills & job requirements
 - Body Mechanics

Advisory Group formed consisting of job readiness staff and Jefferson staff:

- Review protocols
- Develop promotional materials (flyer)
- Review curriculum (Literacy Staff and CUH educators)

Promote to work readiness enrollees via flyer and Career Advisors promotion in work readiness classes

Cohort 1: Introduction of program:
•Informed Consent conducted by PI

Participants

Session 1: Baseline Screening and Pretest for research participants
BP, cholesterol, glucose, Hemoglobin A1c, height, weight, BMI provided for research participants only

***Session 2 – 5: Educational Sessions**
All research participants must participate

Session 6: Post Program Screening and Posttest Survey
research participants only

Non- Research Participants

Session 2 – 5: Educational Sessions
All enrollees must participate for GJRP

Celebration/ Graduation

CSN FLOW CHART

CSN Process Evaluation

Process Evaluation 1:

- Discussion Group with participants about program and satisfaction
- Key informant interviews with staff about process and satisfaction

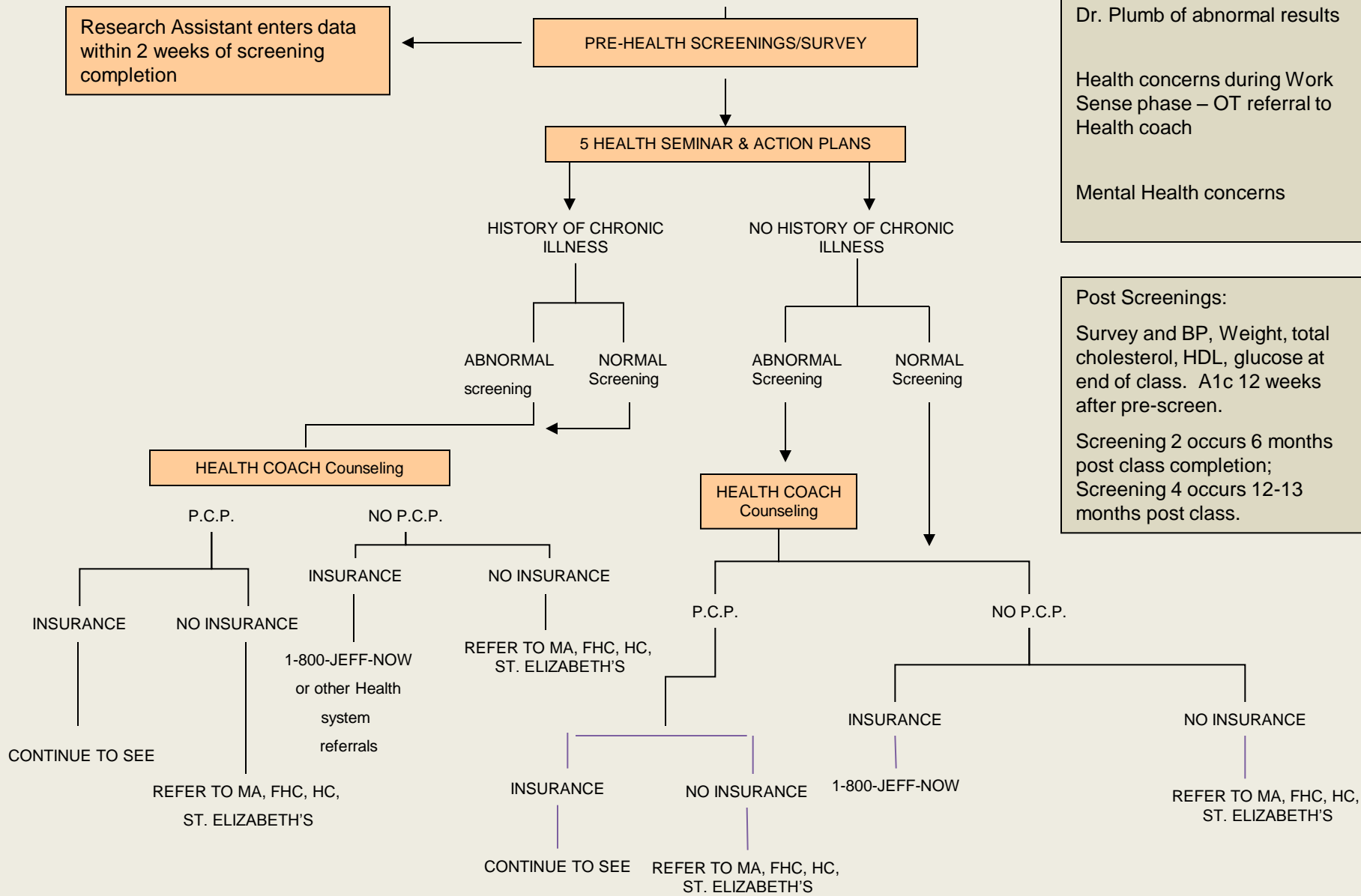
Revise Program process based on findings and repeat program for new cohorts

Celebration/ Graduation

Enter Data into database and analysis

Dissemination of Results Reports to funder





Health Coach notifies PCP or Dr. Plumb of abnormal results

Health concerns during Work Sense phase – OT referral to Health coach

Mental Health concerns

Post Screenings:

Survey and BP, Weight, total cholesterol, HDL, glucose at end of class. A1c 12 weeks after pre-screen.

Screening 2 occurs 6 months post class completion;

Screening 4 occurs 12-13 months post class.

Demographics (N=50)

Age:

- Range 18-50
- Mean 30.8
- Median 27

Age Group	#	%
<20	4	8
20-29	26	52
30-39	9	18
40-49	8	16
>50	3	6

Gender:

100% male

Race/Ethnicity

Race/Ethnicity	#	%
Hispanic/Latino	11	22
Non Hispanic Black	33	66
Non Hispanic White	5	10
Other	1	2

Demographics: Education

Highest Grade Level Completed	#	%
8th Grade or Less	1	2
9th - 12th Grade, no diploma	15	30
HS Diploma/GED	32	64
Some College, no degree	2	4

32% do not have a high school diploma

Demographics: Household

Marital Status	#	%
Common Law	1	2
Divorced	2	4
Domestic Partner	4	8
Married	9	18
Separated	4	8
Single	30	60

- 60% are single
- 28% are married or living as married
- 12% are divorced or separated

# Children	#	%
0	19	41.3
1	9	19.6
2	9	19.6
3	6	13.0
4	2	4.4
5	1	2.2

- 58% have one or more children (n=46)

Health Care Utilization in Past Year

- 37.5% (18) had not seen a PCP in the past year
- 24% (11) had been hospitalized in the past year
- 39% (18) had used the ED in the past year
- 38.3% (18) reported having seen a mental health provider in their lifetime.
 - 9 of the 18 had seen a mental health provider in the past year

Health Status: Self Reported Health Conditions

Condition	#	%
Heart Trouble	2	4%
High Blood Pressure All report taking medications	8	16%
Diabetes None take medications	2	4%
Overweight /Obesity	7	14%
Asthma	5	10%
Disabled	4	8%

21.7% of those at baseline reported their health as fair or poor

Mental Health Screening Results

- GAD7 (anxiety)
 - Baseline: 16 of 46 (34.8% vs 18% nationally) men had moderate or severe anxiety
 - Anxiety Change (of 36 with pre and post scores)
 - 18 no change in anxiety level
 - 10 decreased anxiety level
 - 8 increased anxiety level
- Depression
 - Baseline: 22 of 46 (47.8% vs 9.1% nationally) screened as depressed
 - Depression change (of 36 with pre and post scores)
 - 23 no change
 - 5 depressed to not depressed
 - 6 not depressed to depressed

Health Status

One man had a total cholesterol-HDL risk ratio indicating above normal risk for heart disease

At baseline, 50 % of the men had a blood pressure reading considered above normal

32 men were rescreened at the end of the program.

- 4 (12.5%) had blood pressure levels that got worse (ideal level to prehypertension)
- 7 (21.9%) had levels that improved (prehypertension to ideal)

A1c levels at baseline, indicated 12 (37.5%) men were at increased risk for diabetes.

Indicator	#	%
Total Cholesterol (N=33)		
• Ideal	30	90.9
• Above normal	3	9.1
HDL (n=33)		
• Ideal	15	45.5
• Low	18	54.5
Blood Pressure (n=48)		
• Ideal	24	50.0
• Prehypertension	21	43.8
• Hypertension	3	6.2
A1c (n=32)		
• Ideal	20	62.5
• At risk of diabetes	12	37.5
• Diabetes	0	0

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A1c (n=32)		
• Ideal	20	62.5
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• Diabetes	0	0

Health Status: Screening Results

At Baseline (n=48):

Mean BMI = 27.4

Range = 21-46

70.8% had a BMI indicating overweight/obese status :

- Ideal 14 (29.2%)
- **Overweight 25 (52.1%)**
- Obese 9 (18.7%)

Weight Change (n=31)	#	%
• Gained weight*	11	35.9
• Lost weight**	7	22.6
• No change	13	41.9
BMI Change (n=31)	#	%
• No change	27	87.1
• Overweight to obese	3	9.7
• Overweight to ideal	1	3.2

* Weight gain = 3 to 40 pounds

**Weight loss = 5 to 13 pounds

Only 7 of the men self-reported being overweight or obese

Health Behaviors

23 (46%) smoked at baseline (n=50)

- of smokers, 54.5% smoked 10 or more cigarettes per day

Smoking change pre-post (n=34)

- 6 reduced smoking
 - 2 quit (5.9%)
 - 4 (11.8%) reduced the number of cigarettes smoked by at least 2 per day
- 10 increased smoking
 - 2 (5.9%) increased the number of cigarettes smoked
 - 8 (23.5%) initiated smoking

Health Behaviors

- 36.7% exercise 5 or more times weekly for at least 30 minutes
- 42.9% eat fruit/vegetables daily or almost daily
- 34.8% eat salty snacks daily or almost daily
- 22.4% drink soda daily or almost daily
- **28% trying to lose weight**
- **86% trying to increase physical activity**
- **84% trying to eat more healthy**

Contextualized Learning

- Concept
- Results
 - Baseline for English – 4-10.5 (66% read at 7th grade level or below)
 - Baseline for Math – 2.7-11.6 (66% levels below 7th grade)
 - In a nine week period – scores went up at least two grades overall.

Summary

- Overall, given their young age and high rates of smoking, overweight, obesity, pre-hypertension, pre-diabetes, lack of physical activity and poor diet, and stress, anxiety and depression levels, this population is at great risk of developing chronic diseases if lifestyles remain unchanged.
- Overall, participants reported improved health status and the program appears to be helping participants make behavior changes that are slowly impacting blood pressure, cholesterol and glucose levels.
- Mental health status also seems to be improving among program participants, particularly perceived stress levels.

Summary

- Almost all participants (97.8%) rated the importance of health to success at work as either very important or extremely important.
- However, despite the desire to make positive lifestyle changes, these individuals face obstacles to behavior change such as low income, and lack of health insurance/access to health care.
- In addition, the life priority of “finding employment” often outweighs the desire for reducing health risks.

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- In addition, the life priority of “finding employment” often outweighs the desire for reducing health risks.

Case Studies

- DF is a 26 year old uninsured male, a graduate of the Roots to Reentry Program, referred by the CSN Occupational Therapist to the CSN Medical Director for evaluation of joint pain, fatigue, abdominal pain and chronic headaches. The CSN Medical Director saw DF at the Saint Elizabeth's Wellness Center, a community based primary care and health promotion Center located in Lower North Philadelphia that sees primarily uninsured and/or formerly homeless men and women.
- The Wellness Center is a collaborative effort between Project HOME and the Department of Family and Community Medicine at Thomas Jefferson University. An initial evaluation found traumatic arthritis of the wrist, reflux esophagitis, tension headaches and depression.
- He was given samples of medication for the arthritis and esophagitis; and referred to the Saint Elizabeth's Wellness Behavioral Health Collaborative, funded by the Philadelphia Department of Behavioral Health, for further evaluation and management of depression, and an Emergency Medical Assistance application was completed. He returned three weeks later with marked reduction in symptoms and temporary Medical Assistance. He is receiving on-going Behavioral Health Counseling and medical management.

Case Studies

- DM is a 46 year old uninsured male, a graduate of the Roots to Reentry Program, referred by the CSN Occupational therapist to the CSN Medical Director for evaluation of leg swelling of three weeks duration.
- He had been seen in an emergency room two weeks earlier and given a one week course of antibiotics. He did not follow-up with a provider because he had no health insurance.
- On initial examination, he was found to have marked swelling and redness of the entire right leg, fever and tachycardia. He was referred to a hospital in his neighborhood for admission and treatment of cellulitis and probable septicemia.
- This individual delayed care because he lacked insurance and the ability to purchase needed medication.
- Had the OT and Medical Director not intervened, this individual may have delayed care further and faced life threatening complications.

Case Studies

- Mr. R is a 19 year old male with no significant personal medical history, however his mother has had high blood pressure for years. His initial health assessment screening revealed a pre-hypertensive blood pressure. He explained that he had no knowledge of his blood pressure ever being high. He also stated that he smokes about 14 cigarettes a day, exercises little, and eats an “okay diet” (not really monitoring his sodium intake). He also stated that he has health insurance and a primary care provider. He was counseled on his risk of high blood pressure and advised to make an appointment with his primary care provider for immediate follow up. In addition he received counseling on nutrition, physical activity, and smoking cessation.

Case Studies

- In his second session, Mr. R. explained that he had made an appointment to see his primary care provider in the coming weeks. His blood pressure was checked and it remained slightly elevated. He explained that he has cut down on salt and is eating more fruit and vegetables. We discussed the risks associated with smoking and high blood pressure. He indicated he is smoking less. He was also advised on resources available to help him quit smoking.
- In our third session, Mr. R explained that he saw his primary care doctor and was prescribed medication for high blood pressure. He also explained that he did not like taking the medication because it made him very sleepy. We discussed the mechanism and action of the medication and the rationale for his signs and symptoms. We again reviewed the risks associated with not taking his medication. He was screened and his blood pressure was significantly lower. He shared that he intends to continue to take the prescribed medication, reduce his smoking, and continue his workout plan and healthy eating.

Personal and Family Benefits

- Another individual stated that Joined because he "needed a job, but he got so much more - help with transportation, resume writing, multiple trade school referrals, and he can call for help/support". Other participants wanted to improve their job skills and gain work experience – *"I wasn't working and am interested in construction – I wanted to gain information and accomplish something"*. In addition, several participants specifically noted wanting to improve their health - *"I like to work with my hands and wanted to improve my health because of my genetics and health history"*. One person shared that he wants to be able to be placed into a good job where he has experience (carpentry or solar panels). He is continuing with the CSN program because he would like to work with a larger corporation. He also shared that his current company pays under the table, and that there are no pay raises. Other participants said they are continuing with the program for peer support and to continue to look for employment, particularly full time employment.
- *(I)want to better my situation - I needed help and got it...to look for a job. Since I'm not working full time (I am) using the time to job search. This is why I stay involved.*
- He is continuing the program to *"see his classmates"*, *(he) likes the events*, and he staying involved in the program *even though he graduated.*
- stays involved for the *"help he gets from CSN staff with resumes"* etc.

Interviews

- When asked about how the program has benefitted them personally, in addition to gaining employment, most participants shared they are eating healthier (more fruits/vegetables, less fried food, reduced dietary sodium, drinking less soda or have eliminated soda from their diet), have reduced or quit smoking and are more physically active. Participants also shared that they are working on time management and stress reduction. The following are excerpts from the interviews;
- Because of the program *I got and saw a doctor; I am more self-conscious about health and eating better. I have improved my diet and more physically active and am listening to the doctor's advice*
- *I am more active - lost 20 pounds - runs 2-3 miles daily and works out at least 3 days per week.*
- *I try to "go and talk to someone more often"*
- *I started back at the gym, lost weight, and I am improving time management with his family*
- The program helped her to gain “*control of her mental health issue*”. OT and Peer Counselor helped her to “*keep doctor appointments and take her medications for her mental health condition*”.
- As a result of the program she gained experience and now works for a contractor. She now *takes her medications all of the time and goes to work every day* - this is a change from before.

Interviews

- The program has also impacted the families of participants, particularly their diet.
- *My family is asking questions about health*
- Improving his health has been "*inspirational for his fiancée and her 2 sons. He is role model for her kids. The family is eating healthier*
- *Her family is eating better and her son lost 30 pounds*
- *Her children lost weight and can only have second helpings of vegetables; they are eating healthier snacks; and the kids are "bugging her to eat healthier" ...they "want to be healthier".*
- The program has *brought him and his family closer together (wife and 2 kids) – they are more in contact. He talks to them about his problems. The kids look up to him more and talk to him. He is trying to get his wife to eat healthier and work out.*

Interviews

- In addition to improvements in health, participants discussed the impact of the program on their skills to sustain employment and plans to continue their education. One participant shared how the program has helped him to become *focused and organized – Rob stressed keep it clean – and he thinks about safety more often*. Another participant revealed that the program has encouraged him to *stay away from the wrong people/crowds*. He is *focusing on the bigger picture and is more of a people person now - he didn't talk much before*. He says he has *improved his attitude, eating habits, is not as lazy (more of a go-getter) and can speak his mind now*. The program also helped one participant recognize that his verbal communication was not always respectful and as a result, he has become more aware of how he speaks with supervisors and peers. Another participant shared that she is more confident about her skills and plans to go into real estate. Other participants shared they are considering getting a GED or returning to college to complete their degree.

Interviews

- When asked to rate the program on a scale of 1 to 10 with 1 being poor and 10 being excellent, all participants rated the program as 8 or above and the majority rated the program as “10”. When asked what would cause them to raise their rating, *finding a job in less time* was the response. Clearly, employment is the major desired outcome. They also discussed the value of staff referrals in obtaining employment and identifying other training programs. Computer access for searches related to jobs and training programs was also cited as a major CSN program benefit as was providing transpasses, assistance with childcare and resume assistance.
- Participants describe the program as “worth the time” and the staff as “supportive”, “enthusiastic”, “motivational”, “compassionate” and “awesome”. They valued the hands-on approach, integration of math into job training and one-to one instruction. Skill development and learning about health were particularly valued:

Interviews

- *The program was worth the time...food instruction, open, friendly" and people "got to talk". The career staff were "great-very helpful and supportive with finding jobs", and helped her get her heater fixed. She "liked the hands on approach to job training and integration of math. The health class was fun. You could talk about issues you may not have support for at home. I felt comfortable asking questions".*
- *"I liked everything ...got a lot out of it and put a lot into it". Liked the program because" it reinforced learning", "made it more interesting - broke it down" and "made it personal and relevant".*
- Got help with her reading and this was the most valued aspect. She won an award for reading improvement.
- *Educators make it interesting, relaxed and motivate you to learn.*
- *Stress management was the most useful component. Loved the discussions - hearing other people's point of view. Health screening was informative*
- *Liked screening because you could "see how well you are doing.*
- Liked the health educator's compassion ...*he really listens to your issues and concerns.*
- The health educators helped him find mental health care. The health screenings were helpful because "*he found out he has hypertension and it wasn't a fluke"*
- Liked the health screening and getting labs – She had an elevated A1c - *saw doctor and now she checks her glucose* . Liked the hand outs and instructors. Most valued were knowledge gained from classes, OT suggestions.

Interviews

- The program was *“better than any school he went to - great experience”*. This participant and several others liked the idea of being supported *“after graduation”* from the training programs and *“being followed through to the workplace”*.
- The program *“helped me to find work...I got a new family”* as part of the training. *Networking* is key.
- The relationship with the Peer Counselor...*“I can call her and talk – she can help me find a job.”*
- A participant talked with OT last month and he helped to connect her to resources for her children. She likes that *“the program staff still keep in contact with her - the support. Everyone works together as a team to help her”* and she can *“call for support at any time”*.
- participant valued the support network of the CSN and job placement. He got work through the people he met through CSN - *“people help you achieve - get to a certain place”*. The support he receives from the OT and Peer Counselor after the conclusion of the training program is most valued.

Interviews

- Several participants continue with the program because they like to complete what they start. One of these participants stated that she valued the *“actual training most and the support that she received from everyone....she “needed support”*
- Support from OT and Peer Counselor helped one participant *make and keep appointments with the psychiatrist* and her mental health issues. She was *“surprised that everyone is so helpful”*. She was also referred to DCS for family issues was very helpful and the issue was resolved.
- One participant shared that he was *“down and out and is now making progress - it's positive”*. He is still communicating with the Peer Counselor and values the lifestyle coaching and peer support, particularly *how to handle difficult situations*.
- Another participant shared that he now considers the Peer Counselor *“part of his network”* He has not been in touch with the OT recently because he thought he could *“do it on his own”* but he needs to stop *“being stubborn”* and *“contact them for help”*. The staff was concerned about his not going back to *“old habits”* *...”people, .not just his family cared about his well-being. The calls and running into the OT and Peer Counselor are really valued”*.

Challenges

- Loss of EARN center as referral source
- Multiple IRB submissions
- Training/orientation at Philadelphia Prison System for working with pre-release prisoners
- Service team organization/scheduling
- Coordinating of cohorts at various stages of enrollment

Career Support Network

Questions?

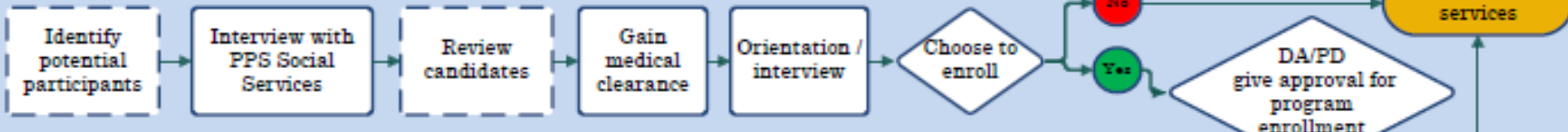
Work Support That Works When YOU Need It

Career Support Network

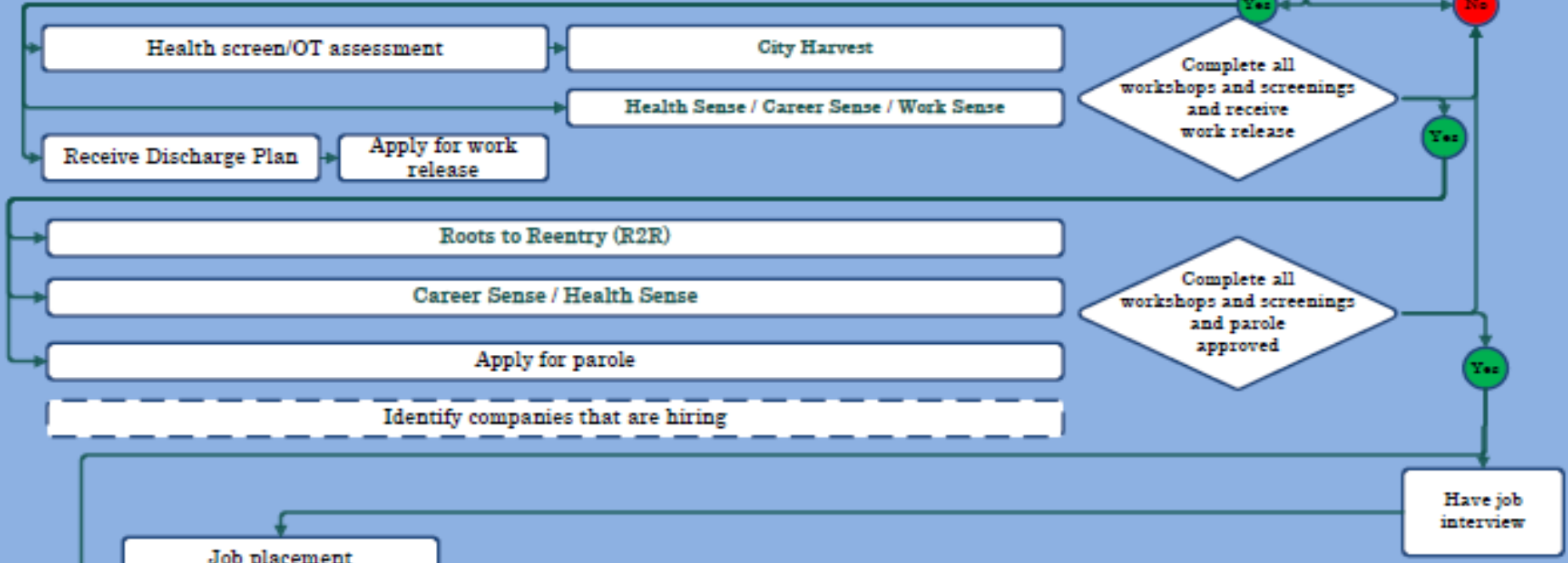


of Philadelphia

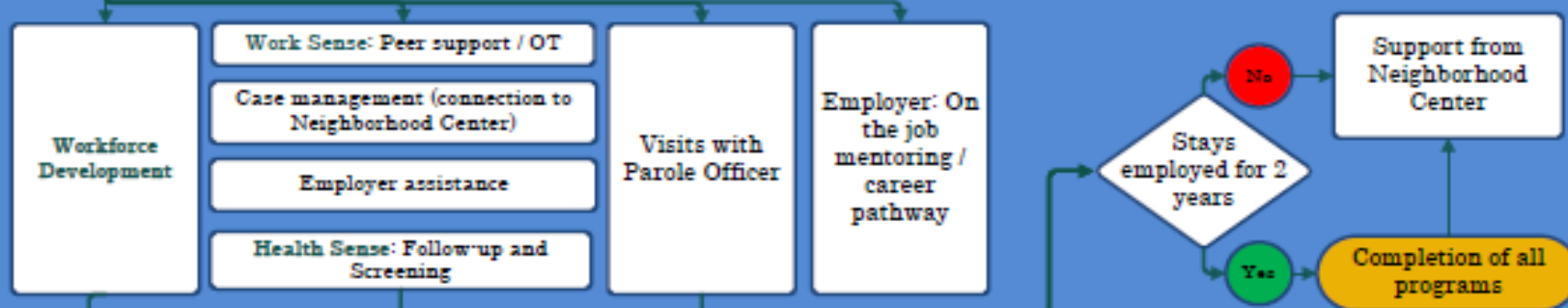
Phase I: Enrollment



Phase II: Job Training



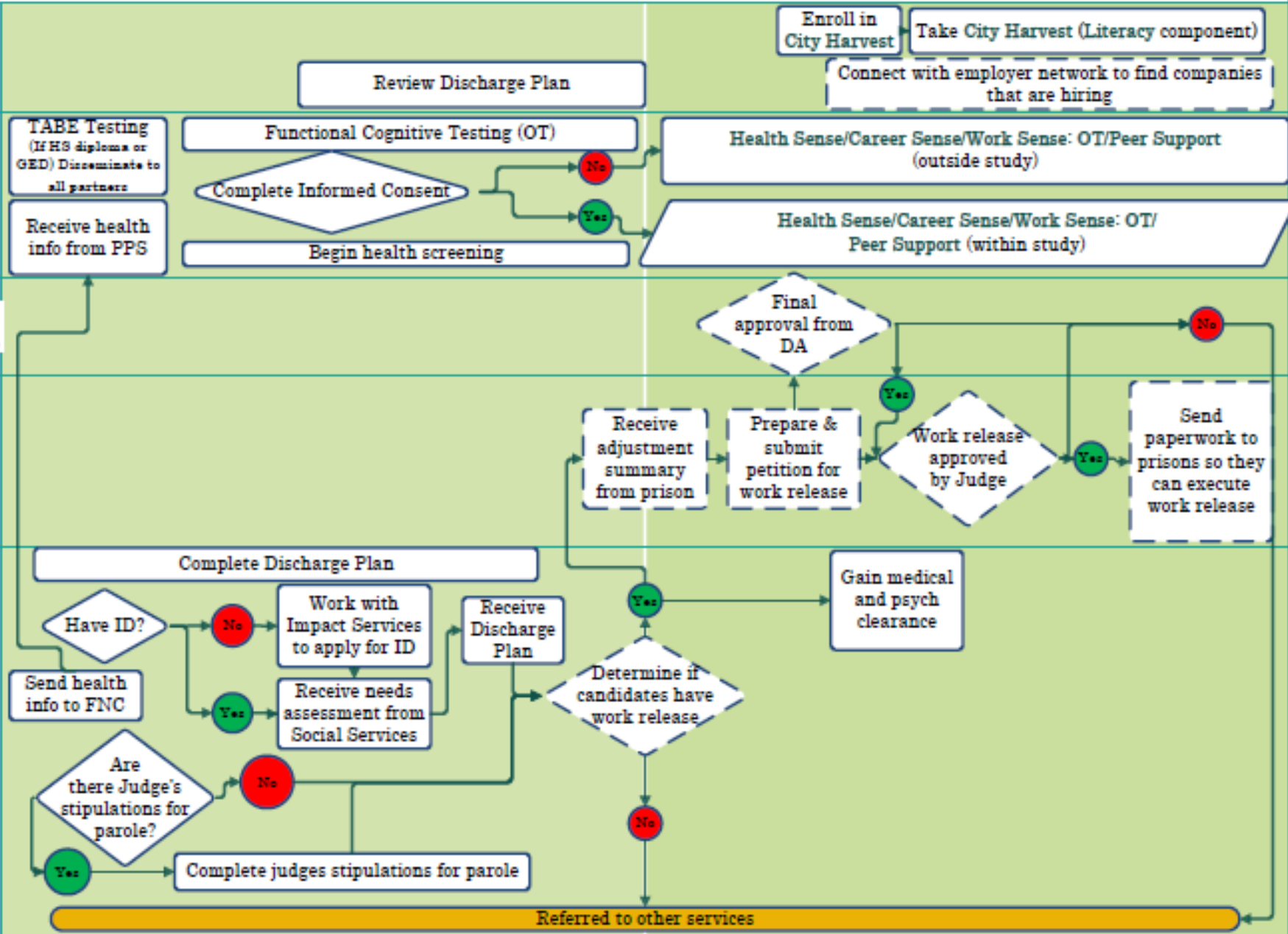
Phase III: Transition & Employment



Phase IIA: Job Training

4 Months Pre-graduation

3 Months Pre-graduation



Phase IIIA: Transition to Employment



Workforce Development

Graduation

PHS hands off employer engagement responsibility



Work Sense: OT (ongoing assessments - COPM, WRI)

Work Sense: Peer Support

Work Sense: Job Development

Office of Parole

Discharged

Parole

Visit their Parole Officer (until Parole complete)

End of Work Release



PHS Employer Network

On the job mentoring (if employed)

Career pathway (if employed)

Vision

- The public will support this network that provides:
 - Access to supports and resources needed to *heal* from past and current traumas
 - Choices for housing, healthcare, education and employment that meet individual interests and needs upon release
 - A connection to a coordinated network of caring individuals and organizations contributing to building individual sense of self-worth and self-efficacy through achieving *successes*
 - Opportunities and resources to discover and explore interests, passions and dreams.

Community Impact Model

- Basic human needs must be met before employment and education needs and should
- Include health explicitly
- Consider other choices such as for housing and healthcare
- There needs to be a balance between support and the returning citizen's
- accountability
- Returning citizens need to be prepared for the education and employment opportunities

Community Impact Model

- Instead of “access to” become “part of”
- Community, family, home environment needs to be considered
- Need to build public support for transforming reentry
- Based on assumption that everyone wants to change – is that a good assumption?
- Support needs to be there when they are ready for change.
- Include sustaining wage or living wage for employment