THE CAREER SUPPORT NETWORK

Workforce Programming through a New Lens

Rickie Brawer, PhD, MPH, MCHES
James Plumb, MD, MPH
Stephen Kern, Ph.D., OTR/L, FAOTA
Department of Family and Community Medicine
Center for Urban Health
Jefferson School of Health Professions
Thomas Jefferson University and Hospitals
THE CAREER SUPPORT NETWORK (CSN)

Historical Perspective:
What led us to the CSN?

Work Support That Works When YOU Need It
NEIGHBORHOOD CENTERS: The Beginning

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

Work Support That Works When YOU Need It
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.
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

Work Support That Works When YOU Need It
GREEN JOB READINESS PARTNERSHIP:
Key Program Components (Phase I)

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

Work Support That Works When YOU Need It
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
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
**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)
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
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.
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.
Work Support That Works When YOU Need It
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

Work Support That Works When YOU Need It
RWJF Local Funding Partnerships


- 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

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.
Career Support Network

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
Career Support Network

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)?
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
Career Support Network

CSN Team
- Career Counselor
- Peer Counselor
- Neighborhood Centers Network
- Health Education Team
- Occupational Therapist
- Thomas Jefferson University Hospital

PARTICIPANT & FAMILY
- Peer Group & Individual Counseling
- Family Health Counseling & Referrals
- Neighborhood-based food, clothing, housing, utility, youth & children programming
- Chronic Disease Testing, Education, Counseling & Referrals
- Job Readiness – Group & Individual Support
- Individual Career Counseling & Job Placement
- Job Retention Supports for up to 2 years

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 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

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

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
**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
Research Assistant enters data within 2 weeks of screening completion

PRE-HEALTH SCREENINGS/SURVEY

5 HEALTH SEMINAR & ACTION PLANS

HISTORY OF CHRONIC ILLNESS

NO HISTORY OF CHRONIC ILLNESS

ABNORMAL screening

NORMAL Screening

HEALTH COACH Counseling

P.C.P.

NO P.C.P.

INSURANCE

NO INSURANCE

CONTINUE TO SEE

REFER TO MA, FHC, HC, ST. ELIZABETH’S

1-800-JEFF-NOW or other Health system referrals

HEALTH COACH Counseling

P.C.P.

NO P.C.P.

INSURANCE

NO INSURANCE

1-800-JEFF-NOW

CONTINUE TO SEE

REFER TO MA, FHC, HC, ST. ELIZABETH’S

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.

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

Health Coach notifies PCP or Dr. Plumb of abnormal results

INSURANCE NO INSURANCE

CONTINUE TO SEE REFER TO MA, FHC, HC, ST. ELIZABETH’S

1-800-JEFF-NOW or other Health system referrals

INSURANCE

NO INSURANCE

1-800-JEFF-NOW

REFER TO MA, FHC, HC, ST. ELIZABETH’S

REFER TO MA, FHC, HC, ST. ELIZABETH’S
## Preliminary Data through January 2012

<table>
<thead>
<tr>
<th>Demographics</th>
<th>N=31</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>18-54</td>
<td>NA</td>
</tr>
<tr>
<td>Mean Age</td>
<td>30.6</td>
<td>NA</td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Male</td>
<td>26</td>
<td>84</td>
</tr>
<tr>
<td>Race:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Black</td>
<td>26</td>
<td>84</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>
### Demographics

<table>
<thead>
<tr>
<th>Marital Status: Household</th>
<th>N=31</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>25</td>
<td>86.6</td>
</tr>
<tr>
<td>Married</td>
<td>4</td>
<td>12.9</td>
</tr>
<tr>
<td>Divorced/ Separated</td>
<td>2</td>
<td>6.5</td>
</tr>
<tr>
<td>Children in Household (N=27)</td>
<td>10</td>
<td>37.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education:</th>
<th>N=31</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;HS</td>
<td>1</td>
<td>3.2</td>
</tr>
<tr>
<td>HS Grad/GED</td>
<td>12</td>
<td>38.7</td>
</tr>
<tr>
<td>Vocational/Trade</td>
<td>15</td>
<td>48.3</td>
</tr>
<tr>
<td>College +</td>
<td>4</td>
<td>12.9</td>
</tr>
</tbody>
</table>
## Health Status

<table>
<thead>
<tr>
<th>Indicator</th>
<th>N=31</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>20</td>
<td>64.5</td>
</tr>
<tr>
<td>No primary care provider</td>
<td>20</td>
<td>64.5</td>
</tr>
<tr>
<td>ER visit past year (n=29)</td>
<td>14</td>
<td>48.2</td>
</tr>
<tr>
<td>Take medication for serious illness</td>
<td>6</td>
<td>19.0</td>
</tr>
</tbody>
</table>

<p>| Rate health overall (n=30)                     |      |     |
| Excellent                                     | 0    | 0   |
| Very good                                     | 8    | 26.6|
| Good                                          | 12   | 40.0|
| Fair                                          | 9    | 30.0|
| Poor                                          | 1    | 3.4 |</p>
<table>
<thead>
<tr>
<th>Indicator</th>
<th>N=29</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blood Pressure</strong>: n=29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;120/80</td>
<td>18</td>
<td>62.1</td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>120/80-139/89</td>
<td>11</td>
<td>37.9</td>
</tr>
<tr>
<td>Pre High BP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥140/90</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>High BP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-report high BP</td>
<td>3</td>
<td>9.7</td>
</tr>
<tr>
<td>Take BP meds</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Cholesterol</strong>: n=29</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;200</td>
<td>26</td>
<td>89.7</td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>201-239</td>
<td>2</td>
<td>6.9</td>
</tr>
<tr>
<td>Borderline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥240</td>
<td>1</td>
<td>3.4</td>
</tr>
<tr>
<td>High</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HDL</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;40 (male)</td>
<td>5</td>
<td>19</td>
</tr>
<tr>
<td>Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;50 (female)</td>
<td>3</td>
<td>60</td>
</tr>
<tr>
<td>Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Low</td>
<td>8</td>
<td>27.6</td>
</tr>
<tr>
<td><strong>Ratio</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤4.5</td>
<td>25</td>
<td>86</td>
</tr>
<tr>
<td>Ideal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-report High Chol</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Take Chol meds</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Indicator</td>
<td>N=29</td>
<td>%</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td><strong>Diabetes: n=29</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>A1c</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;5.7</td>
<td>15</td>
<td>51.7</td>
</tr>
<tr>
<td>5.7-6.4</td>
<td>13</td>
<td>44.8</td>
</tr>
<tr>
<td>≥ 6.5</td>
<td>1</td>
<td>3.5</td>
</tr>
<tr>
<td>Self-report diabetes</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Take Diabetes meds</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Weight: n=29</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>BMI</em> &lt; 25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal Weight</td>
<td>11</td>
<td>38</td>
</tr>
<tr>
<td>25-29</td>
<td>8</td>
<td>27.5</td>
</tr>
<tr>
<td>Overweight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-29</td>
<td>8</td>
<td>27.5</td>
</tr>
<tr>
<td>≥30</td>
<td>10</td>
<td>34.5</td>
</tr>
<tr>
<td>Indicator</td>
<td>N=31</td>
<td>%</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>Perceived Stress (range 0-40); higher scores= more stress</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Total Score = 526</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Score = 16.97</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median Score = 16.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CES-D Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;16</td>
<td>20</td>
<td>64.5</td>
</tr>
<tr>
<td>16+ (indicates depression)</td>
<td>11</td>
<td>35.5</td>
</tr>
<tr>
<td>GAD-7 Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scores range from 0-21; Follow up score ≥10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cut offs:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal</td>
<td>15</td>
<td>48.4</td>
</tr>
<tr>
<td>Mild (5-9)</td>
<td>7</td>
<td>22.6</td>
</tr>
<tr>
<td>Moderate (10-14)</td>
<td>5</td>
<td>16.1</td>
</tr>
<tr>
<td>Severe (15+)</td>
<td>4</td>
<td>12.9</td>
</tr>
</tbody>
</table>
## Health Behaviors

<table>
<thead>
<tr>
<th>Indicator</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoke (n=31)</td>
<td>18</td>
<td>58</td>
</tr>
<tr>
<td>Physical activity &lt;3 x weekly (n=31)</td>
<td>20</td>
<td>64.5</td>
</tr>
<tr>
<td>Fresh fruit/veg 3+ times week (n=31)</td>
<td>21</td>
<td>67.7</td>
</tr>
</tbody>
</table>
## Self-Efficacy

<table>
<thead>
<tr>
<th>Indicator</th>
<th>N=31</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Self Efficacy Measure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never = 1</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Rarely = 2</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Often = 3</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Always - 4</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Scores range from 10-40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Score = 959</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Score = 30.94</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median Score = 32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Mean Score – 3.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median Score = 3.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Health Attitudes

<table>
<thead>
<tr>
<th>Indicator</th>
<th>N=31</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Want to lose weight</td>
<td>13</td>
<td>42</td>
</tr>
<tr>
<td>Want to increase activity</td>
<td>22</td>
<td>71</td>
</tr>
<tr>
<td>Want to eat healthier</td>
<td>25</td>
<td>80.6</td>
</tr>
</tbody>
</table>

**Importance of health status to work success**

(Rate 1-5 with 1=not important to 5 – extremely important)

- Total Score = 122 (n=27)
- Mean = 4.5
- Median = 5

NA NA
## Health Knowledge

<table>
<thead>
<tr>
<th>Indicator</th>
<th>N=31</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Knowledge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total # questions=18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre Range= 9-17 correct</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre Group Mean score =79.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre % scored below 80</td>
<td>16</td>
<td>51.6</td>
</tr>
</tbody>
</table>
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