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PRESENTATION ABSTRACT

Thriving to make workplace health promotion a success: Riverside County's Thrive Across America challenge.

Presented November 19, 2014 at the American Public Health Association Annual Meeting, New Orleans, LA.

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Introduction. Research supports the notion that well-designed workplace health promotion can improve employee health and well-being as well as reduce chronic disease. Employee health is a unique opportunity for health promotion efforts as employees are a captive audience, spending their most productive hours in the workplace. This study aims to explore the effects of a countywide effort to support a healthy

workplace through fostering engagement in physical activity.

Methods. Over 17,000 county employees across more than 40 departments and agencies were invited to participate in the Thrive Across America challenge, an online program that encourages physical activity. Participants were asked to log their minutes of physical activity daily. Pre- and post participation data on exercise frequency as well as participant stage of behavioral change also was gathered. The initial goal was to obtain participation of at least 2,000 employees. *(continued page 2)*

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Results. Surpassing original goals and expectations, 3,846 registered for the challenge. Of those, 65% participated on one of 325 teams. Before the challenge, 16.8% of participants reported being physically active more than 5 days each week. At the end of the challenge, that percentage increased to 44%. The percent of participants that reported spending, on average, 30 minutes or more exercising increased from 57% to 74.5%. Additionally, 67% of participants experienced an increase in their physical activity over their course of the challenge.

Summary. Workplace health promotion can be an important tool in enhancing employee health and increasing productivity. Efforts that include peer encouragement and managerial support can be particularly effective. ❖

PRESENTATION ABSTRACT

Linking federal preparedness funding programs to improve community-based response.

Presented April 15, 2014 at the Preparedness, Emergency Response and Recovery Consortium's Annual Conference and May 7, 2014 at the Iowa Healthcare Coalition Summit.

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Background. The events of September 11, 2001 and the subsequent anthrax attacks on the east coast highlighted that the public health and medical infrastructure in the United States was less than adequate to support a large scale response to terrorism, an infectious disease outbreak or a natural disaster. In 2002, Congress significantly increased appropriations to the Centers for Disease Control and Prevention (CDC) to enhance public health core functions, with a focus on emergency preparedness and response to an act of bioterrorism. That same year, the National Bioterrorism Hospital Preparedness Program was established under Health and Human Services (HHS). In 2004, the CDC implemented the Cities Readiness Initiative (CRI) Program, which focused on planning for mass distribution of medications under an anthrax attack scenario. In 2005, CRI was expanded and a phased

appropriation for pandemic influenza planning was initiated. CRI continued to expand in 2006 and the federal Pandemic and All-Hazards Preparedness Act (PHAPA) established the Assistant Secretary for Preparedness and Response (ASPR) in HHS. Over the next several years, the focus of the grants shifted from bioterrorism preparedness to all-hazards preparedness and response. Federal, state and local government recognized the need for capabilities based planning and response, and in 2011 capabilities for the Public Health Emergency Preparedness (PHEP) grant and the Hospital Preparedness Program (HPP) were released.

Although programs changed and grant requirements expanded over the course of a decade, funding levels peaked for both the PHEP and HPP programs in Riverside County in 2004. Since then, funding decreases in these programs have ranged from 25% to 50%. With significant decreases in funding came challenges to the sustainability of the advancements made in public health and medical preparedness and response capabilities over the years. In order to continue to remain at a heightened level of preparedness and ready to respond to any emergency, the Riverside County Department of Public Health (DOPH) employed three strategies to maximize the integration of funding streams and to leverage existing grant dollars.

Strategy 1: Integrate all Public Health and Medical Emergency Management Funding Streams under One Branch. DOPH created a branch in 2002 in anticipation of federal funding to support local public health emergency preparedness and response activities. The department recognized early on that the most efficient way to improve public health and medical emergency preparedness and response capabilities was to house all of the funding, program staff and activities under this one Branch. As grant funding for public health or medical projects became available through the State Homeland Security Grant Program or the Urban Area Securities Initiative, it was the Public Health Emergency Preparedness and Response (PHEPR) branch that applied for and received funding. This structure allowed for enhanced coordination between funding streams and allowed grants to be leveraged to accomplish priority preparedness projects.

Strategy 2: Fund Cross-Discipline Projects to Promote Cooperation and Community Preparedness. The PHEPR branch has worked closely with partners in the first responder community to identify areas for collaboration. In 2006, PHEPR worked with the Riverside County Fire Department/CalFire and the Riverside County Department of Environmental Health to implement the Countywide Hazmat Operations Group (CHOG). PHEPR has been awarded funding from the State Homeland Security Grant Program every year since the inception of CHOG to fund 5 municipal fire departments, the Riverside

Sheriff's Office, the Department of Environmental Health and DOPH. PHEPR has also identified and secured funding to establish pharmaceutical caches for first responders, field treatment site caches, and caches of basic first aid supplies to be used by first responders during a large scale incident. By engaging first responders in public health and medical preparedness activities, networks are established pre-event that will improve efficiencies during a response.

Strategy 3: Utilize the Emergency Management Healthcare Coalition to Create a System-wide Strategic Plan and Identify Funding Streams to Accomplish Goals. The Riverside County DOPH leveraged the existing multi-disciplinary committee established through the Metropolitan Medical Response System (MMRS) in the late 1990's to create what is now known as the Emergency Management Healthcare Coalition. The committee membership was expanded to include all acute care hospitals, representatives from skilled nursing facilities and community-based clinics, surgical centers and other medical providers. The focus on all-hazards planning was emphasized and a strategic plan was developed for the Public Health and Medical Emergency Response System. This strategic plan continues to serve as our roadmap to preparedness; as funding becomes available, we utilize the strategic plan to identify priority projects and determine methods for implementation. This approach also promotes the integration of funding streams so that multiple sources of funding can be leveraged to accomplish an identified goal.

Conclusion. Having an integrated, prepared public health and medical emergency response system increases the likelihood that responses will be effective and that morbidity and mortality will be reduced. The benefits of employing the 3 strategies described above are highlighted during every response. First responders are aware of the capabilities and resources of the PHEPR branch and call them to assist as needed. Several examples of successful response activities involving the public health and medical system can be described in Riverside County. PHEPR has successfully coordinated the evacuation of skilled nursing during power outages, medical support has been provided to general population shelters, public health concerns have been mitigated during flooding incidents, and over 1,800 staff and students were tested for tuberculosis after a high school exposure occurred in the desert. All of these examples utilized the resources, staff, plans and relationships that have been built over the past twelve years despite decreases in grant funding. Leveraging funding opportunities and creating an integrated, multi-

disciplinary approach to public health and medical preparedness has better served the residents of Riverside County. ❖

POSTER PRESENTATION

From paternalism to partnership: the evolution of a family-centered, episodic service delivery model in the California Children's Services Medical Therapy Program.

Presented September 11, 2014 at the American Academy of Cerebral Palsy and Developmental Medicine Conference, San Diego, CA.

*Susan Lennan, BS, OTR/L *Kaitlin Smith, OTD, OTR/L*

Introduction. The California Children's Services (CCS) Medical Therapy Program is available to California residents from birth to 21 years of age who are diagnosed with a qualifying physically disabling condition, with cerebral palsy being the most common. 1,650 children are currently being served at nine Riverside County Medical Therapy Units (MTUs). Services are free.

Five years ago physical and occupational therapy services provided by Riverside County CCS Medical Therapy Program focused on providing frequent and long-term direct therapy services to a small segment of the total population of clients. As a result, due to large caseloads, clients receiving monitoring services were often marginalized. Many times families were not engaged in the process of selecting therapy goals, nor did they observe or participate in their child's therapy sessions. As a result, families often did not have the tools or sense of empowerment they felt they needed to meet the challenges of managing their child's special health care condition.

*Our next issue
will be published July 1.*

In 2008 we began an extensive exploration of alternative therapy service delivery models in an effort to understand current best practice/evidence informed practice models to better meet the needs of our clients who have chronic, physically handicapping conditions. Our journey of implementation began in April 2009 with the goal of providing effective, equitable therapy services to all our clients.

Issues Identified. Therapy services were not client or family centered. Although high quality physical and occupational therapy services were provided to each client, there was minimal client and family involvement in problem identification, goal-setting, generating treatment recommendations, implementing interventions, and assessing outcomes. Families were not expected to attend therapy appointments with their children and had unrealistic expectations of the therapy's ability to ameliorate clients' disabilities. They tended to become distressed when the frequency of therapy services was reduced, and often expressed that they felt the therapy staff had "given up" on their children. They felt that they did not have the skills necessary to carry over therapeutic activities in the home as they were "not therapists." During transition planning meetings with the Medical Social Worker families often expressed that they felt ill-equipped to meet their children's special health care needs after their CCS eligibility ended at age 21.

In addition, it was identified that clients had inequitable access to therapy services. A program-wide overemphasis on direct treatment services resulted in 20% of the clients receiving 80% of the treatment services. These clients commonly received twice weekly treatment sessions for a period of three to five years. Slow functional progress was typically demonstrated, despite long-term direct therapy services. The remaining clients received inconsistent access to services in the form of periodic monitoring. Until 2006, these clients typically did not have formal re-evaluations and often did not have an updated home program. Following the transition to monitoring services, clients tended to continue to receive this level of services for the remainder of their involvement in the CCS Medical Therapy Program.

Methods. Our therapy staff aimed to provide exceptional services that were client and family centered in order to empower clients and their caregivers to actively participate in the therapy process. We continually strove to provide the right therapy at the right time.

Families were respected as the experts about their children.¹ Families and clients were involved in identifying problems,^{2,3,4,5} goal-setting,³ and measuring progress using the Canadian Occupational Performance Measure (COPM).

A parent or caregiver was required to attend every therapy appointment with the client. Clients and family members were empowered to practice skills in a supportive

environment, with the therapy staff acting as coaches and mentors, and providing immediate feedback. Open lines of communication were maintained² as therapy staff, clients, and family members discussed progress, modified home program and treatment activities, and adjusted expectations in response to change.

Episodes of direct treatment services followed by periods of monitoring were provided as families partnered with therapists to identify the client's need/readiness for different levels of intervention to reach identified goals. Considerations included ability of client to participate, presence or absence of critical period, level of clinical skills required, and amount of family support available.⁶

Clients and/or their families were viewed as crucial partners in the journey towards empowerment and independence.⁷

Results. California Children's Services Medical Therapy Program utilizes the Functional Improvement Scale (FISC) gross motor and Activity of Daily Living (ADL) assessments to document clients' functional change in mobility and self-care skills at each evaluation. FISC data indicate that on average clients experienced greater functional gains following implementation of the new model of service delivery. Gross motor score change for active clients was +21.8 for the 2006-June 2009 period (prior to implementation) versus +23.57 for July 2009 through July 2014 (after), and for monitored clients +6.6 versus +8.78 in the same periods. ADL score change for active clients was +17.21 versus +19.43 in the same periods, and for monitored clients was +9.19 versus +11.22 in the same periods.

Survey results indicated that families experienced a high level of satisfaction with the services that they received, with 99% of survey respondents reporting they were satisfied or very satisfied with the care their children received.

The Measure of Processes of Care (MPOC), a means to assess family-centered behaviors of health care providers, was also administered. The results reveal staff felt they made sure parents had a chance to say what was important to them, treated children and their families as people rather than as a "case" and helped parents feel like a partner in their child's care. Results of MPOC-20 assessments completed by nearly 100 families reveal they felt staff, likewise, treated them as an equal rather than just the parent of a patient, helped them to feel competent as a parent, and planned together so they were all working in the same direction.

Conclusion. Going forward, we intend to continue to explore strategies to provide services in a manner that supports and empowers each client and their family, and identify sensitive, widely recognized, reliable and valid outcome measures to more effectively capture outcome data for our individual clients and to explore the efficacy of our

therapy services delivery model.

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POSTER PRESENTATION

Supporting mothers in life's emotions (S.M.I.L.E.) program: a perinatal mood and anxiety disorders support program.

Presented November 19, 2014 at the American Public Health Association Annual Meeting, New Orleans, LA.

Amy Larsen, RN, PHN, MSN, IBCLC

Background. Perinatal mood and anxiety disorders

(PMADs) affect 10 to 20 percent of childbearing women and families of every race, culture, age, and income level. PMADs are not related to education, race, religion, sex of infant or mode of delivery but are related to risk factors such as a personal or family history of mental illness, depression or anxiety during pregnancy, PMDD or PMS, adolescence, decreased social support, current or historical stressful life events, multiple births, marital or relationship stress, complications with pregnancy, birth or breastfeeding, NICU admission, infertility treatments, thyroid imbalances or diabetes of any type. Treatment and support of PMADs help prevent family unit breakdown and decreases in maternal-infant bonding and attachment, and in severe cases can prevent suicide or infanticide.

Methods. In the pilot program, eleven pregnant and postpartum women were enrolled in a ten-week support group with pre- and post-program Edinburgh Postnatal Depression Scale (EPDS) and NCAST Feeding Scale testing. In 2011, due to its success, the pilot program was expanded to weekly support group services countywide with pre- and post-program EPDS and Mills Depression and Anxiety Symptom-Feeling Checklist (Mills) testing. 150 women were enrolled in 2011 and 152 women were enrolled in 2012.

In 2013, the program name changed to S.M.I.L.E. and the support regimen was revised to bi-monthly support groups and home listening visits, and quarterly family evening meetings. 263 women were enrolled. Of the women enrolled for the 2013-14 year, 65% stated they had a history of physical, emotional, and/or sexual abuse and 61% had a family history of mental illness and/or substance use.

Pre- and post-program scores for EPDS and Mills in the support group (SG, n=91) and home visitation (HV, n=44) programs were similar: EPDS testing demonstrated a 30% decrease for SG and 31% decrease for HV, with Mills demonstrating a 39% decrease for SG and 42% decrease for HV. Decreasing the support regimen from weekly to bi-monthly did not negatively affect EPDS and Mills post test scores. 97% of the enrollees for the 2013-14 year strongly agreed or agreed that if they were going to seek help for postpartum depression again they would return to this program. In the family evening meetings for the 2013-14 year, 89% strongly agreed or agreed that they could recognize the signs and symptoms of perinatal mood and anxiety disorders, and 89% strongly agreed or agreed that they had learned whom to call for additional support.

Conclusions. S.M.I.L.E. is an innovative program that has decreased depression and anxiety symptoms and is a promising development of evidence-based PMAD support programs. We intend to continue QA/QI on compliance with post-test evaluations; this increased 42% this year, but improvement is still needed. We also plan to develop QA/QI measures to improve follow up on mothers who never attend a support program after intake assessment, develop a men's support group, and continue family evening meetings. ❖

Information for Disease Reporters

All case reporting forms and information for the County of Riverside Department of Public Health are available from our website at www.rivcoph.org.

Communicable Disease Reporting

Please refer to our on-line list of reportable conditions, including those to be reported immediately by telephone, within one day of identification and within seven calendar days. All forms are available from <http://www.rivco-diseasecontrol.org/>

Telephone Reporting: For STD reporting, please call 951 358 7820. For all other conditions, or after hours or urgent reports, call 951 358 5107, 24 hours a day.

Fax Reporting: Please use the appropriate form for the condition. STD reports should be faxed to 951 358 6007. All other reports should be faxed to 951 358 5102. Please note that HIV/AIDS reports may *not* be faxed and must be securely sent by mail. Please see our website for specific instructions.

Non-Communicable Disease Reporting

Certain non-communicable diseases are reportable under state and local statute. These conditions include, but are not limited to, pesticide exposure and DMV reportable conditions such as disorders characterized by lapses of consciousness. Please refer to our on-line list of reportable conditions for more information.

Animal Bites

Animal bites must be reported to both the Department of Public Health and the Department of Animal Services. For more information, please call 951 358 7387 during business hours.

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Riverside County
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