

**READY, WILLING, AND ABLE: AN UPDATE FOR
CLINICIANS ON EVIDENCE-BASED
STRATEGIES TO STRENGTHEN MENTAL
HEALTH AND BEHAVIORAL CAPACITY FOR
PUBLIC HEALTH PREPAREDNESS**

**Clinician Outreach and
Communication Activity (COCA)
Conference Call
August 16, 2011**



Objectives

At the conclusion of this session, the participant will be able to accomplish the following:

- ❑ Describe key influences affecting the willingness of healthcare providers to respond to public health emergencies
- ❑ Describe how a threat-and efficacy-based model can inform approaches to boosting health providers willingness to respond to public health emergencies
- ❑ Identify the five components of the Johns Hopkins Model of Psychological First Aid Training for Paraprofessional Disaster Volunteers
- ❑ Describe three major ideas proposed by representatives of local health departments to sustain project-initiated, disaster preparedness relationships with faith-based organizations

Continuing Education Disclaimer

In compliance with continuing education requirements, all presenters must disclose any financial or other associations with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters as well as any use of unlabeled product or products under investigational use. CDC, our planners, and the presenters for this presentation do not have financial or other associations with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters. This presentation does not involve the unlabeled use of a product or products under investigational use. There was no commercial support for this activity

Accrediting Statements

CME: The Centers for Disease Control and Prevention is accredited by the Accreditation Council for Continuing Medical Education (ACCME®) to provide continuing medical education for physicians. The Centers for Disease Control and Prevention designates this electronic conference/web-on-demand educational activity for a maximum of 1 *AMA PRA Category 1 Credit™*. Physicians should only claim credit commensurate with the extent of their participation in the activity. Non-physicians will receive a certificate of participation.

CNE: The Centers for Disease Control and Prevention is accredited as a provider of Continuing Nursing Education by the American Nurses Credentialing Center's Commission on Accreditation. This activity provides 1 contact hour.

CEU: The CDC has been approved as an Authorized Provider by the International Association for Continuing Education and Training (IACET), 1760 Old Meadow Road, Suite 500, McLean, VA 22102. The CDC is authorized by IACET to offer 1 ANSI/IACET CEU for this program.

CECH: Sponsored by the *Centers for Disease Control and Prevention*, a designated provider of continuing education contact hours (CECH) in health education by the National Commission for Health Education Credentialing, Inc. This program is designed for Certified Health Education Specialists (CHES) to receive up to 1 Category I CECH in health education. CDC provider number GA0082.

CPE: The Centers for Disease Control and Prevention is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. This program is a designated event for pharmacists to receive 1 Contact Hour in pharmacy education. The Universal Activity Number is 0387-0000-11-069-L01-P and enduring 0387-0000-11-069-H01-P. Course Category: This activity has been designated as knowledge based.

TODAY'S MODERATOR



Mary R. Leinhos, PhD, MS

Health Scientist

Extramural Research Program

Office of Public Health Preparedness and Response - CDC

TODAY'S PRESENTER



Jonathan M. Links, PhD

Professor

Deputy Chair of Environmental Health Sciences
Director, Preparedness and Response Learning Center
PI - Emergency Preparedness and Response Research Center
Johns Hopkins Bloomberg School of Public Health

TODAY'S PRESENTER

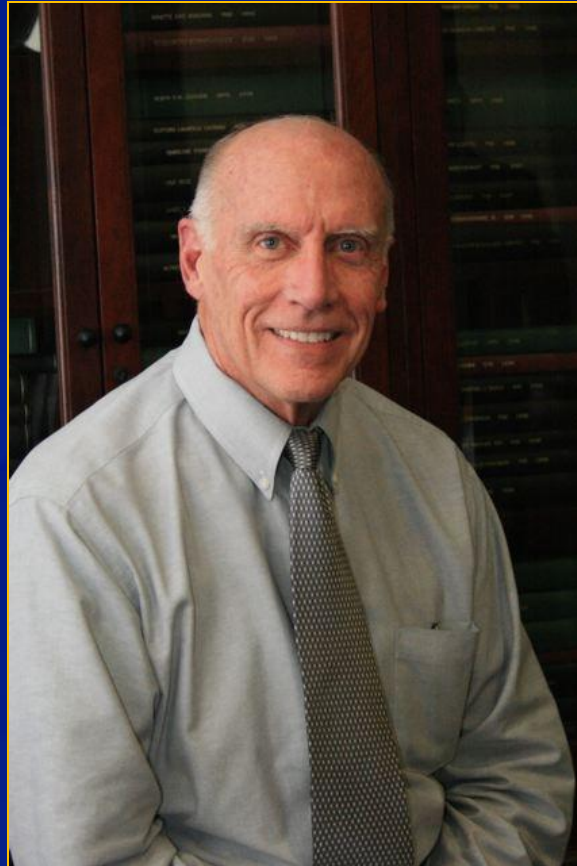


Daniel J. Barnett, MD, MPH

Assistant Professor

Department of Environmental Health Sciences
Johns Hopkins Bloomberg School of Public Health

TODAY'S PRESENTER

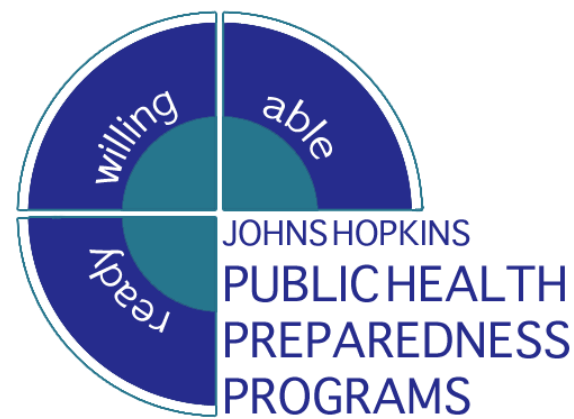


O. Lee McCabe, PhD

Associate Scientist

Department of Mental Health

Johns Hopkins Bloomberg School of Public Health



Ready, Willing, and Able:
A Briefing for Clinicians on Evidence-based Strategies to
Strengthen Mental Health and Behavioral Capacity for Public
Health Preparedness

Johns Hopkins Preparedness and Emergency Response Research Center

Jonathan M. Links, Ph.D.
Daniel J. Barnett, M.D., M.P.H
O. Lee McCabe, Ph.D.

August 16, 2011

The findings and conclusions in this presentation are those of the author and do not necessarily represent the views of the Centers for Disease Control and Prevention

The Challenge

Experience in the United States and other countries has shown repeatedly that, following disasters, the surge of demand for health services to treat psychological symptoms is much greater than for services to treat physical injuries.

North, Nixon, Shariat, Malonee, McMillen, et al., 1999; Galea, Ahern, Resnick, Kilpatrick, Bucuvalas, et al., 2002; Schlenger, Caddell, Ebert, Jordan, Rourke, et al., 2002; Shalev & Solomon, 1996; Bowler, Murai, & True, 2001; Ursano, Norwood, Fullerton, Holloway, & Hall, 2003; Watts, 1999

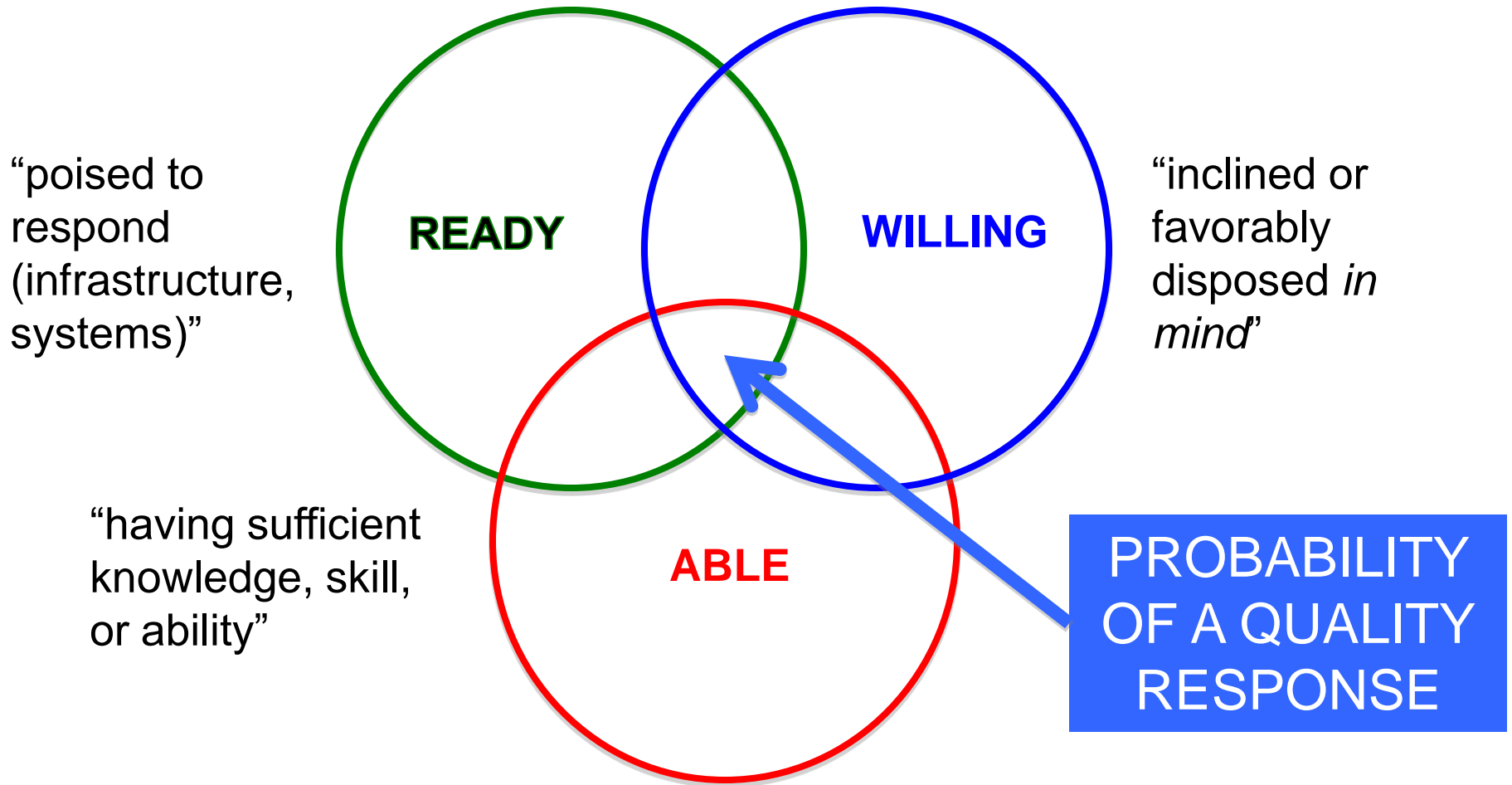
One Possible Intervention: Psychological First Aid

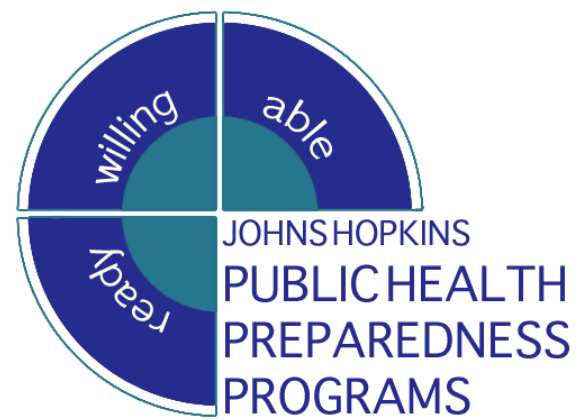
“In the past decade, there has been a growing movement in the world to develop a concept similar to physical first aid for coping with stressful and traumatic events in life. This strategy has been known by a number of names but is most commonly referred to as psychological first aid (PFA).”

Institute of Medicine 2003

*But who will **ready, willing, and able** to deliver PFA?
And to provide other needed services?*

“Ready, Willing, and Able”

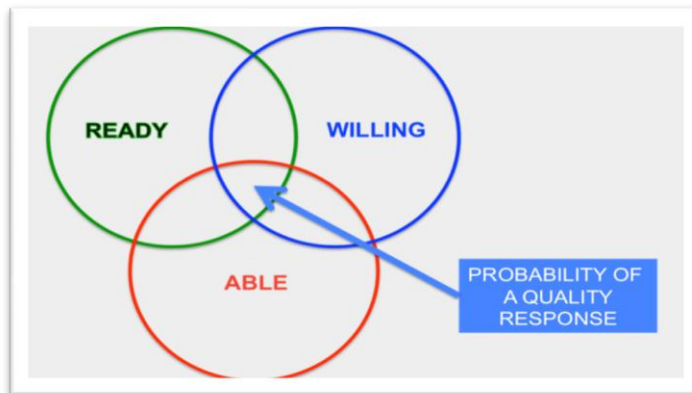




Willingness-to-Respond in Public Health Emergencies

Willingness vs. Ability

- “Willingness” to respond
 - State of being inclined or favorably predisposed *in mind*, individually or collectively, toward specific responses
 - Numerous personal and contextual factors may contribute
 - Beliefs, understandings, and role perceptions
 - *Scenario-specific*
- Preparedness training focus nationally to date = *ability*
- But, willingness & ability are conceptually AND functionally distinct!



Source: McCabe OL, Barnett DJ, Taylor HG, Links JM. Ready, Willing, and Able: a framework for improving the public health emergency preparedness system. *Disaster Medicine and Public Health Preparedness* 2010;4:161-168.

2005 Pilot Study in Md Health Departments

- Only 54% indicated they would likely report to work during influenza pandemic
- Only 33% considered themselves knowledgeable about public health impact of pandemic flu
- Perception of the importance of one's role in the agency's overall response was the single most influential factor associated with willingness to report
 - *Those who perceived their response roles as important to agency were **9.5 X** more willing to respond than those who perceived their roles as marginal.*

Source: Balicer RD, Omer SB, Barnett DJ, Everly GS, Jr. *Local public health workers' perceptions toward responding to an influenza pandemic*. BMC Public Health 2006; 6:99

Hospital-based Willingness: A Clinical Surge Capacity Concern

- Pandemic influenza
 - 32% of surveyed hospital workers were unwilling to respond to an influenza pandemic “regardless” of severity
 - Response rates were consistent across departments
 - One-third lower among nurses compared with physicians
- Radiological dispersal device (“dirty bomb”)
 - One-half of hospital workers unwilling to respond regardless of severity

Assessing LHD Workforce's Response Willingness: Overview

- 8 Clusters of local health departments (LHDs) nationwide identified for participation
 - 4 Urban (FL, IN, OR/WA, WI)
 - 4 Rural (ID, MN, MO, VA)
 - Each cluster randomly divided into control vs. intervention LHDs
- Johns Hopkins ~ Public Health Infrastructure Response Survey Tool (JH~PHIRST)
 - Online agency-wide survey of perceptions of **threat** and **efficacy** and related attitudes/beliefs regarding response willingness
 - 4 scenarios across all-hazards spectrum
 - Weather-related
 - Radiological ('dirty') bomb
 - Pandemic influenza
 - Inhalational anthrax

Assessing LHD Workforce's Response Willingness: Overview

- Johns Hopkins ~ Public Health Infrastructure Response Survey Tool (JH~PHIRST) delivery timeline
 - All LHDs in a cluster are scheduled to receive baseline JH~PHIRST and three resurveys
 - Resurveys for a given cluster administered:
 - 1 week post-intervention
 - 6 months post-intervention
 - 2 years post-intervention

JH~PHIRST Baseline (LHDs): Willingness Varies by Scenario / Context

Willingness-to-Respond by Scenario/Context
(8 LHD clusters)

	Weather-Related	Pandemic Influenza	Radiological ('dirty') Bomb	Anthrax Bioterrorism
If required	93%	91%	74%	80%
If not required	83%	80%	62%	69%
Regardless of severity	77%	79%	53%	65%

JH~PHIRST Baseline Findings: Greater Willingness in Rural LHDs

Willingness-to-Respond: Regardless of severity

	Weather-Related	Pandemic Influenza	Radiological ('dirty') Bomb	Anthrax Bioterrorism
Rural	81%	87%	59%	70%
Urban	75%	76%	51%	63%

Leading Modifiers of Response Willingness: JHPERRC Findings

- Most influential modifiers of willingness to respond among healthcare providers include:
 - **Self-efficacy**
 - **Perceived importance of one's role in overall agency response (response efficacy)**
 - **Perceived safety**
 - **Psychological support** during and after events
- In general, the threat/efficacy “profile” of a healthcare provider who is most willing to respond across public health emergency scenarios is **high threat / high efficacy (“concerned and confident”)**

Curricular Intervention

- **Johns Hopkins ~ Public Health Infrastructure Training (PHIT)**
 - Designed to address the attitudinal and behavioral gaps in willingness-to-respond
 - Objective: Extend levels of threat awareness, self- and response-efficacy
 - Goal: Increased system capacity with higher numbers of workers who are willing to respond to all hazards
 - Train-the-trainer format
 - Seven hours of content delivered over a 6-month period
 - Combines a variety of learning modalities in three phases of training
 - Face-to-face lecture and discussion; online learning; independent activities; case scenarios; tabletop exercises; role-playing; knowledge assessments; peer critiques

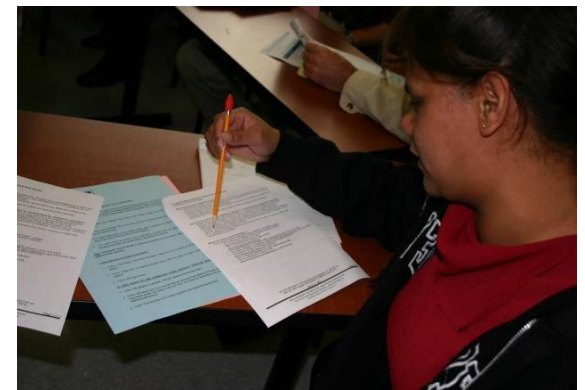
PHIT Curriculum: TOC

- Phase 1: Facilitator-Led Discussion (2 hours)
 - Part 1: Overview of Scenarios and Public Health's Role
 - Part 2: Emergency Scenario Contingency Planning
- Phase 2: Independent Learning Activities (3 hours)
- Phase 3: Group Experiential Learning (2 hours)
 - Part 1: Tabletop Exercise
 - Part 2: Role-Playing Exercise
 - Part 3: Hotwash

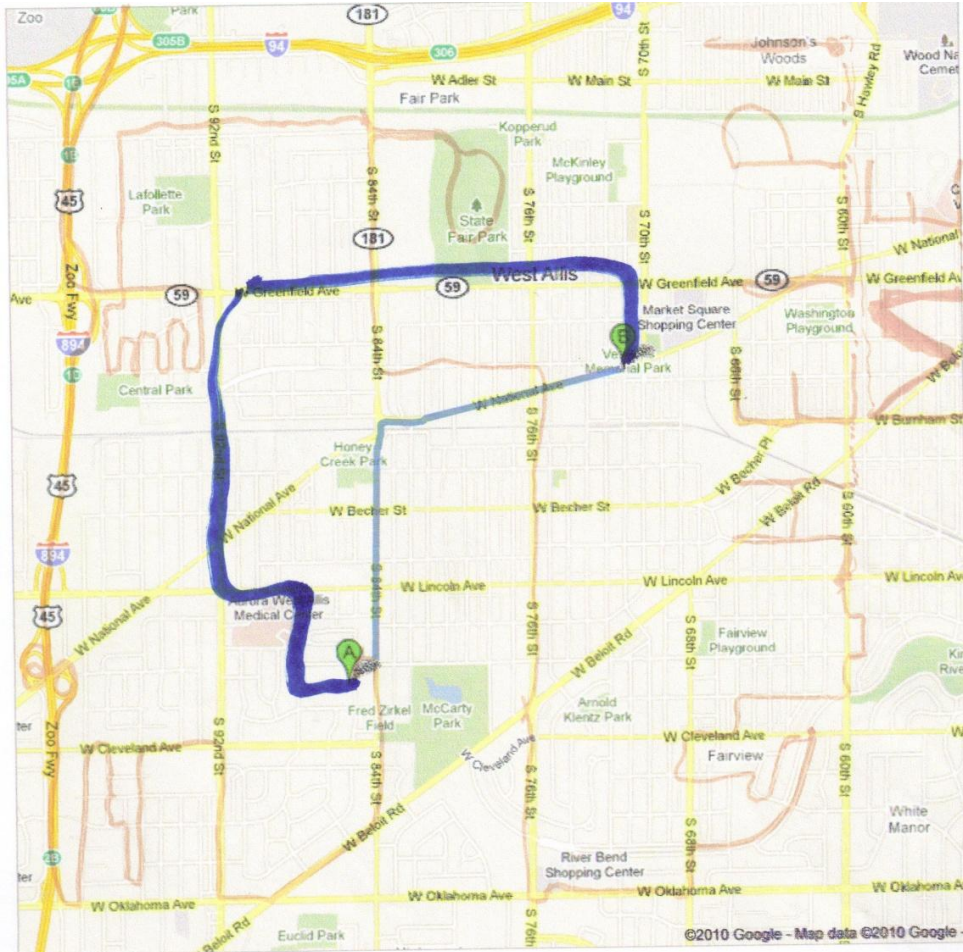
While the content and phases are mostly fixed, local contextual examples are encouraged & formats for training delivery are flexible and scalable to meet the unique needs of health departments

PHIT Implementation: Local Examples

- Interaction
- Participation
- Enthusiasm
- Communication
- Games
- Discussions



PHIT Implementation: Local Examples



“Success Stories” to Date

- Feedback from Butler County (MO) HD Administrator
 - Relevance/utility of PHIT in connection with agency’s response to MO flooding (April 2011)
- Feedback from PHP Summit Town Hall session (February 2011)
- Frederick County Health Department Training (December 2010)
 - "Factors That Influence Willingness to Respond and What the Health Department Can Do About It"
 - FCHD Newsletter re: “Ready, Willing, and Able” (January 2011)

JH~PHIRST Baseline Comparisons to Resurvey: WTR (Severity)

Willingness-to-Respond: Regardless of Severity

	Weather-Related	Pandemic Influenza	Radiological ('dirty') Bomb	Anthrax Bioterrorism
6 clusters - CONTROL*	82% ↓ 78%	83% ↓ 81%	60% ↓ 58%	75% ↓ 64%
6 clusters – INTERVENTION*	79% ↑ 81%	82% ↑ 83%	58% ↑ 72%	69% ↑ 74%

*[BL(6) & FU1(6) – excludes OR/WA & IN for BL and respondents to only 1 survey]

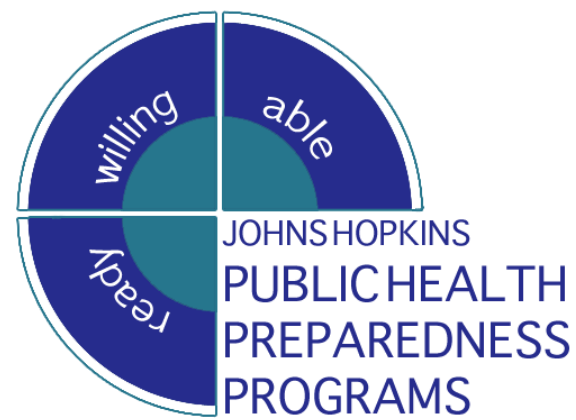
Key:

BL(6) = Baseline (six clusters)

FU 1 (6) = Follow-up Survey # 1 (six clusters)

OR/WA = Oregon/Washington cluster

IN = Indiana cluster



Enhancing Disaster Mental Health Preparedness through Academic/Government/Community Partnerships

Project Overview

- **Actors/Agents:** Faith-based organizations [FBOs], local health departments [LHDs], and academic health centers [AHCs];
- **Activities:** Refining, testing, & validating a portable, dual-intervention curriculum;
- **Aims:** To develop an evidence-based model for enhancing emergency preparedness capacity and competence at multiple levels of the public health system.

Motivational Preparedness Training [MPT]

An intervention, with *Psychological First Aid* training at its core, capable of increasing participants' concern about, and **willingness** and **ability** to respond to (and plan for), the disaster behavioral health needs of their community.

Guided Preparedness Planning [GPP]

An intervention capable of increasing concern about, and the **willingness** and **ability** to support, community planning efforts for disaster mental health preparedness and response.



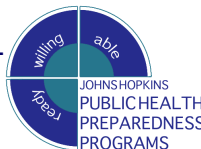
- **Reflective Listening/Rapport-Building**
Re-stating & Para-phrasing; Open- & Closed-Ended Questions
- **Assessment [Screening]**
Functional vs Pathological Orientation
- **Prioritization**
Threats to Physical and Psychological Wellbeing
- **Intervention**
Support; Guidance; Triage; Connection
- **Disposition**
Referral; Liaison; Advocacy

**Everly & Parker, 2007*

Ability to Plan: Skills [n=44]

Skills Variable	Percent Agree		Pre-Post Change %	Statistically Significant?
	Pre-Test	Post-Test		
Self-Efficacy as a Planner	25	84	59	Yes***
Ability to Describe All Hazards Concept	21	82	62	Yes***
Recitation of ICS Titles	16	62	46	Yes*
Differentiating Good vs Inadequate Plans	43	65	22	No
Family Application of Planning Ability	59	98	38	Yes*
Self-Efficacy as a Planning Leader	30	85	55	Yes***

Chi-square statistic w/ 1 degree of freedom [McNemar's Test] *p ≤ 0.05; **p ≤ 0.01; ***p ≤ 0.001



Parallel Interventions Along the Care Continuum



Everly, 2007

Pre-Event Factors

- Children and elderly
- Persons w/physical conditions & disabilities
- Persons w/ Hx of psychiatric Dx & Tx
- Minority status
- Low socio-economic status
- Female gender

Peri-Event Factors

- Dose of exposure
- Dissociation or amnesia
- Physical injuries
- Human-caused event
- Randomness & unpredictability

Post-Event Factors

- Absence of psychosocial support
- Financial problems
- Job loss
- High levels of TV watching [disaster event]





Traumatic event occurred

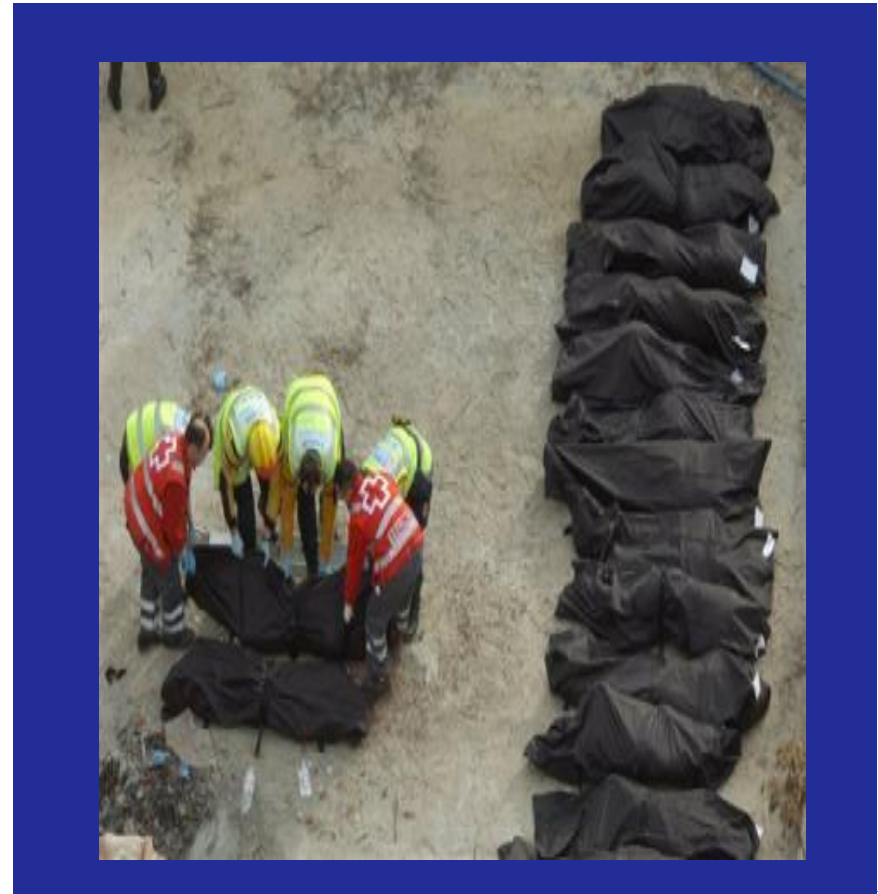
Re-experiences

Avoidance

Unable to function

Month

Arousal



“Is Path Warm?”



Ideation

Withdrawal

Substance

Anger

Abuse

Recklessness

Purposeless

Mood Changes

Anxiety



Trapped

Hopelessness

Courtesy Wilcox, H, 2009 (Orig refs:
American Association of Suicide, 2006;
Berman, 2006)

Skills	Percent Agree		Pre-Post Change %	Statistically Significant?
	Pre-Test	Post-Test		
Rapport Building	55	100	45	Yes
Reflective Listening: Understanding Meanings and Feelings	60	98	38	Yes
Prioritization of Problems	47	98	51	Yes
Differentiating Severe vs Moderate Symptoms	47	96	49	Yes
Diaphragmatic Breathing	57	100	43	Yes
Recognizing MH Referral Needs	53	100	47	Yes
PFA Self-Efficacy	30	98	68	Yes

Immediate Post-Training MRC* Applications to be a Paraprofessional First-Responder	Metric
Number of Submitted Applications	56
Number of Program Completers	178
Percent of Program Completers Applying	31.5%
Number Accepted into Medical Professional Volunteer Corps	56

* Note 1: Refers to Maryland's Medical Reserve Corps (*Medical Professional Volunteer Corps*) and those participants who submitted applications immediately following the PFA training intervention. [Data on number of deferred submissions are not presently available].

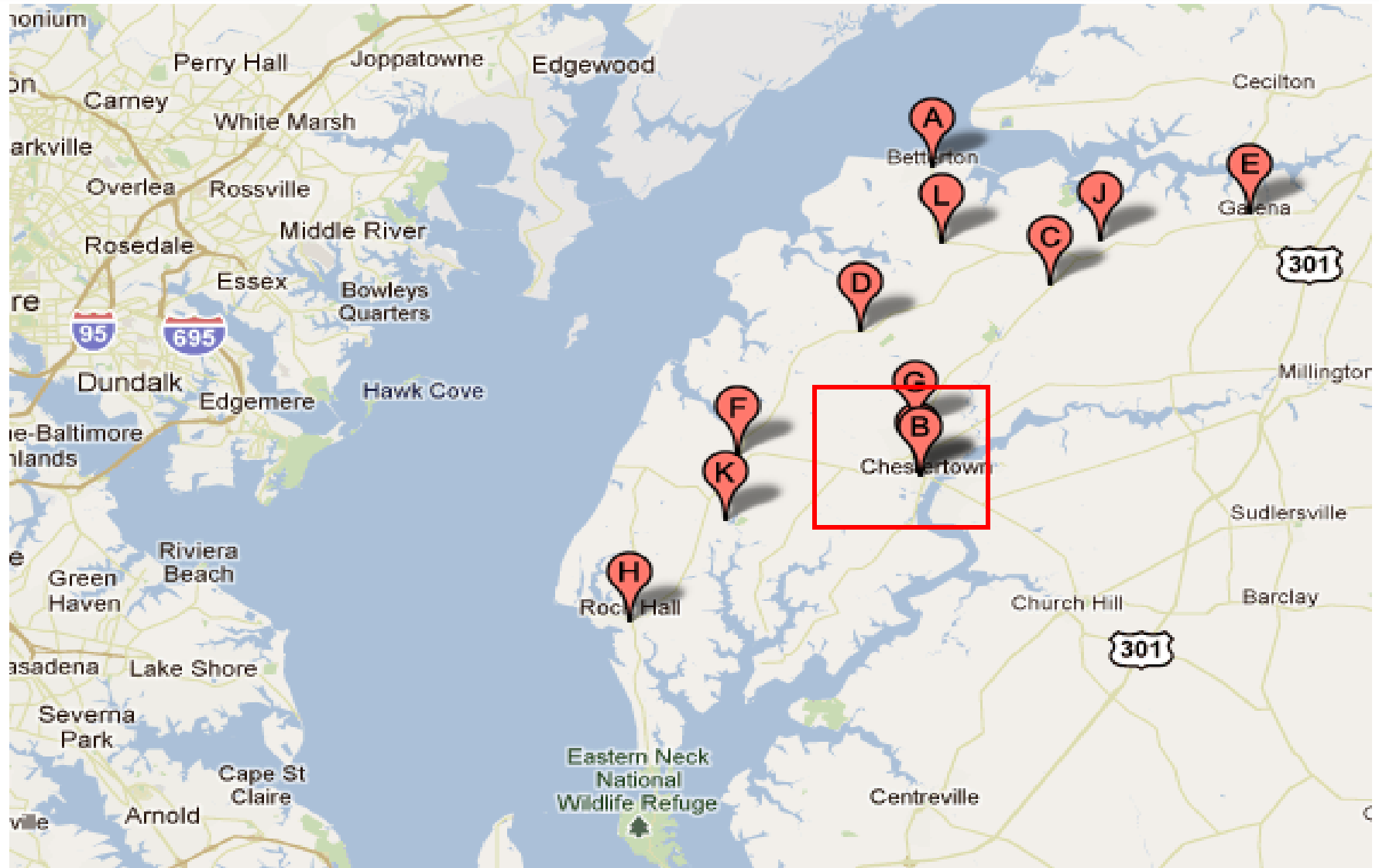
- Background & Planning Assumptions
- Target Community & At-Risk Persons
- Roles & Responsibilities
- SWOT Analysis
- Communications
- Plan Evaluation & Sustainability
- Appendix: Preparedness Tools & Resources

Developing an “All Hazards” Plan



SWOT ANALYSIS	Completed	Partially Completed	Not Started
Item			
	3	2-1	0
<p>17. Strengths and Resource Surpluses: Identification of the community's (<u>internal</u>) strengths and resource surpluses that, under various disaster scenarios, is available to those in and (potentially) outside the community.</p>			
<p>18. Internal Weaknesses and Resource Shortages: Identification of the community's (<u>internal</u>) limitations, resource deficits, and needs that will need to be met by external sources in an emergency.</p>			
<p>19. External Opportunities: Identification of available (<u>external</u>) opportunities, resources & agencies that could strengthen the capacity and capability of the community to respond to and recover from an emergency event.</p>			
<p>20. External Threats: Identification of specific (<u>external</u>) obstacles to the community developing a disaster preparedness plan.</p>			
<p>21. Resource Surpluses: Based on community "Strengths," the Plan identifies the human and material resources, assets, etc that can be made available to the 'community-at-large.'</p>			
<p>Section/Column Sub-Totals:</p>			

Geo-distribution of Completed Disaster Plans, Kent County, MD



Recent Advances in GPP: Iowa Cohort

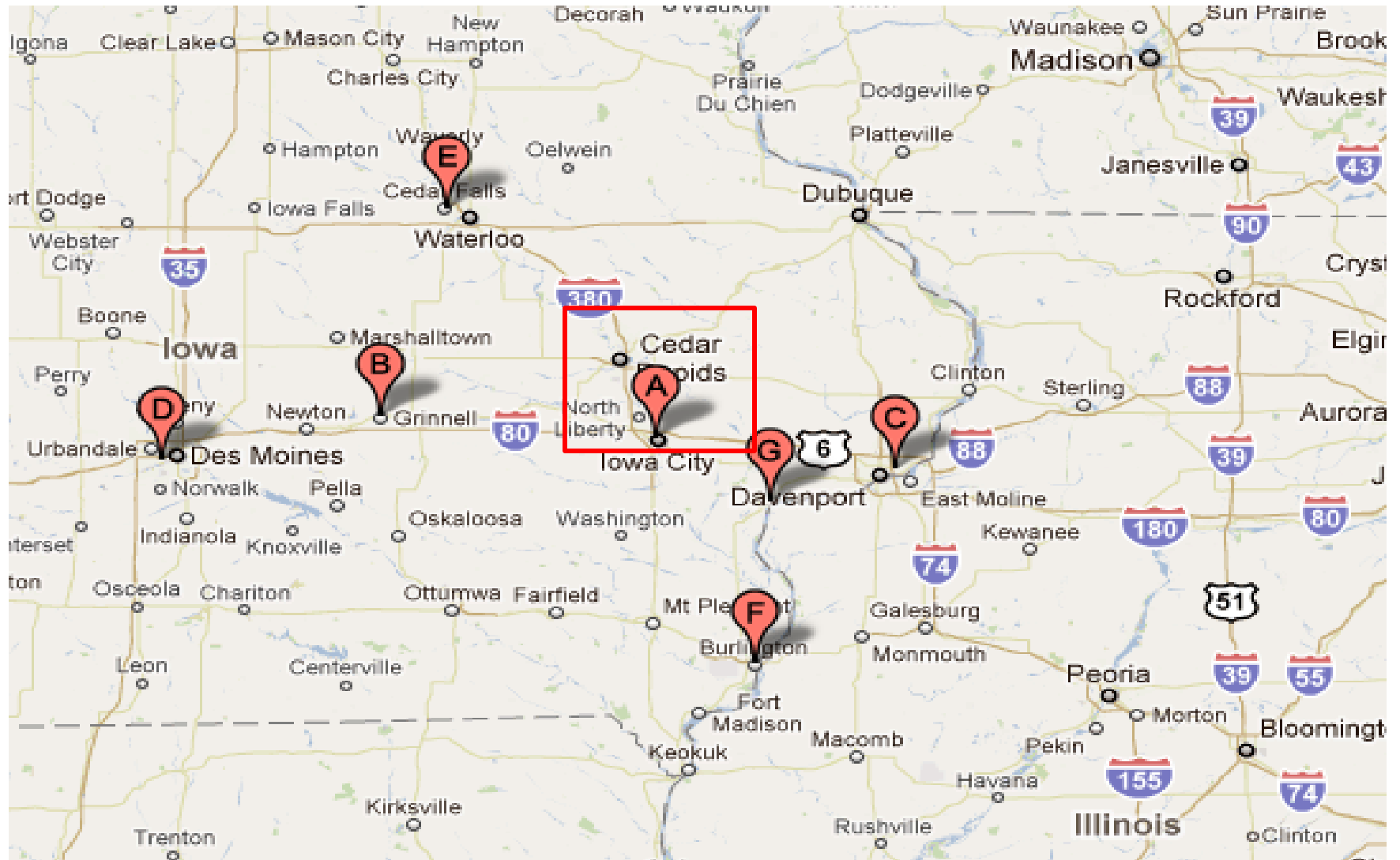
Participation and Plan-Submission Data

Parishes Starting Program	Parishes Completing Program*	Parishes Submitting Plans At End of 1-day Program	Plan Scores**			
			Range	Mean	Med	Mode
7	7	7	74-100	90.6	95.5	100

* Note 1: Submitted plans represent 6 health jurisdictions in Iowa: Black Hawk, Des Moines, Johnson, Muscatine, Poweshiek, and Scott

** Note 2: Scores derived from the *Johns Hopkins Quality Assessment Scale for Disaster Mental Health Plans* [Maximum score: 100 points]

Geo-Distribution of Completed Preparedness Plans, IOWA



Sustainability Ideas of Government Partners

- Conduct **quarterly meetings** with faith leaders to assess ongoing needs, set goals, & provide support.
- Collaborate with FBOs in **exercises and drills** to evaluate and improve their plans.
- Foster the development of relationships between FBOs and **other emergency preparedness agencies**.
- Recruit new FBOs through community health **outreach workers**.
- Strive to have FBO/LHD mutual help agreements codified in **memoranda-of-understanding**.

Conclusions

Findings, to date, indicate that the companion interventions of MPT/PFA and GPP delivered within the framework of a faith-government-academic partnership show promise of being a viable model for enhancing emergency preparedness capacity and capabilities at multiple levels of the US public health system.



Centers for Disease Control and Prevention Atlanta, Georgia

Continuing Education Credit/Contact Hours for COCA Conference Calls

Continuing Education guidelines require that the attendance of all who participate in COCA Conference Calls be properly documented. All Continuing Education credits/contact hours (CME, CNE, CEU, CECH, and ACPE) for COCA Conference Calls are issued online through the CDC Training & Continuing Education Online system
<http://www2a.cdc.gov/TCEOnline/>.

Those who participate in the COCA Conference Calls and who wish to receive CE credit/contact hours and will complete the online evaluation by **Sept 16 2011** will use the course code **EC1648**. Those who wish to receive CE credits/contact hours and will complete the online evaluation between **Sept 17, 2011** and **Aug 16, 2012** will use course code **WD1648**. CE certificates can be printed immediately upon completion of your online evaluation. A cumulative transcript of all CDC/ATSDR CE's obtained through the CDC Training & Continuing Education Online System will be maintained for each user.

Thank you for joining!
Please email us questions at
coca@cdc.gov

Emergency Preparedness and Response

Emergency Preparedness & Response

- Specific Hazards
- Preparedness for All Hazards
- What CDC Is Doing
- What You Can Do
- Blog: Public Health Matters
- What's New
- A - Z Index

Ready, Willing, and Able: An Update for Clinicians on Evidenced-based Strategies to Strengthen Mental Health and Behavioral Capacity for Public Health Preparedness

CE = Continuing Education Credits

Date: Tuesday, August 16, 2011


Time: 2:00 - 3:00 pm (Eastern Time)

Participate by Phone: 888-829-8675

Passcode: 3189025

Register for this Webinar

Presenter(s):

 **Jonathan M. Links, PhD**
Professor
Deputy Chair of Environmental Health Sciences
Director, Preparedness and Emergency Response Learning Center
Principal Investigator, Preparedness and Emergency Response Research Center
Johns Hopkins Bloomberg School of Public Health
Johns Hopkins University

Text size: [S](#) [M](#) [L](#) [XL](#)

[Email page](#)

[Print page](#)


[Bookmark and share](#)


[Subscribe to RSS](#)


Get email updates

[Sign up](#) for COCA email updates.

Contact Us:

 Centers for Disease Control and Prevention
1600 Clifton Rd
Atlanta, GA 30333

 800-CDC-INFO (800-232-4636)
TTY: (888) 232-6348
24 Hours/Every Day

 cdcinfo@cdc.gov

REPORT AN EMERGENCY

<http://emergency.cdc.gov/coca/callinfo.asp>

Join Us on Facebook

CDC launched a Facebook page for Health Partners! “Like” our page today to receive COCA updates, guidance, and situational awareness about preparing for and responding to public health emergencies.



The screenshot shows the Facebook interface for the CDC Health Partners Outreach page. At the top, there is a navigation bar with the Facebook logo, a search bar, and login options for Email and Password. Below the navigation bar, the page header includes a "Sign Up" button and the tagline "Facebook helps you connect and share with the people in your life." The main content area features the CDC Health Partners Outreach profile picture, a "Like" button, and the page's location: "Government Organization · Atlanta, Georgia". The "Wall" section displays several posts, including a post about a webinar on Crisis and Emergency Risk Communication - Radiation, and another about the CDC Emergency Preparedness and Response team. The "About" section on the left provides information about the Health Partners Outreach Team and their collaboration with the CDC Emergency Risk Communication team. The "Likes" section shows 1,187 likes and a "See All" link. The "Check-ins" section shows 2 check-ins.

<http://www.facebook.com/CDCHealthPartnersOutreach>