

EPH 542b: Practice-Based Community Health Research 2017

PROJECT PROSPECTUS

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MEASURING IMPACT IN COMMUNITY PROGRAMS

Organization: Common Ground High School

Project Title: *Evaluating and Growing Health Impact at Common Ground High School, Urban Farm, and Environmental Education Center*

Overview of Project

Students working on this project will have the opportunity to work with Common Ground to continue to develop their whole-organization approach to health impact assessment. This will be accomplished by conducting a statistical analysis of 2 years of quantitative survey data collected by previous teams of Yale Public Health students, creating user-friendly data analysis systems to allow for further data analysis by Common Ground students and staff, holding focus groups of Common Ground stakeholders using previously developed protocols, and disseminating results and recommendations through a report to be presented to Common Ground stakeholders for changes in practice and policy.

About Common Ground High School

Common Ground, founded in 1992, is a center for environmental learning and leadership located on 20 acres of city park land at the base of New Haven's West Rock Ridge State Park. Their mission is to cultivate habits of healthy living and sustainable environmental practice within a diverse community of children, young people, and adults. They achieve this mission through three tightly coupled efforts:

- The nation's longest-running environmental charter high school, creating the next generation of successful college students and powerful environmental leaders;
- A community environmental education center, engaging children and adults in programs that connect them to the natural world and the sources of their food; and
- An urban farm, modeling sustainable agriculture and sharing 7,000+ pounds of produce per year with the local community.

Common Ground's programs have engaged more than 15,000 members of the Greater New Haven community. The Common Ground community is genuinely diverse: from birth to old age, across a wide economic spectrum, of every racial and ethnic background, from every New Haven neighborhood and many surrounding towns. The intensity and nature of individuals' engagement varies widely, as well. Some connect through Common Ground's onsite farm stand, the mobile farm market, a single school field trip, or a onetime community festival or workshop. Others participate in 9 week after school programs, 16 weeks of summer camp, or a summer farm internship. The 180 students of Common Ground High School, by comparison, participate for at least 180 days each year for four years. High School students who are members of Common Ground's Green Jobs Corps, and who participate in afterschool and summer programs, have an even more intensive experience. Many students and community members

sustain their engagement over time, climbing – they hope – a ladder of learning and leadership opportunities on their campus.

Existing data (quantitative and qualitative) give some sense of the impacts of these experiences on health behaviors and on other outcomes. After participating in Common Ground’s summer camps, 56% of parents say their children are more likely to try new, healthy foods at home. Last year, New Haven’s mobile market visited 24 sites, connecting at least 1,000 city residents with nearly \$12,000 worth of produce – more than 75% purchased with benefits from food assistance programs like the Senior Farmers Market Nutrition Program. Common Ground High School students have, over the last six years, made some of the state’s largest test score gains. More than a third of recent Common Ground graduates say they are interested in pursuing a field related to health or the environment in college.

About the Project

Common Ground’s mission – to cultivate habits of healthy living and sustainable environmental practices within a diverse community of children, young people, and adults – puts improving community health behaviors and outcomes at the center of our organization’s work. Given this mission, a shared commitment to improve health has the potential to pull together and drive the three major parts of Common Ground’s work: a charter high school, community environmental education center, and urban farm. While more than 15,000 children and adults join in Common Ground’s program in any given year, the 200 students of Common Ground High School are by far the most deeply involved in our work. Because these students are immersed in this unique educational setting – including an urban farm, access to West Rock Ridge State Park, unique course-based experiences that emphasize health and health leadership, etc. – we would hypothesize that these young people’s health identity, agency, understanding, behaviors, and outcomes would change significantly over their four years at Common Ground. High School students who are members of our Green Jobs Corps, and who participate in our after-school and summer programs, have an even more intensive experience, so might experience even more significant positive health impacts

Existing data (quantitative and qualitative) give some sense of the impacts of these experiences – on health behaviors, and on other outcomes. More than a third of recent Common Ground graduates say they are interested in pursuing a field related to health or the environment in college. An initial round of survey data collected by YSPH students give some indications of our health impact. For instance, 72% percent of our high school students agreed or strongly agreed that they are more aware of what they eat, and 69% said they are more likely to spend time outdoors, as a result of being students at Common Ground. Moreover, Students who consistently participate in Common Ground’s school lunch program eat significantly more fruits and vegetables than those Common Ground students who do not eat school lunch regularly. Students in Green Jobs Corps also tend to get more exercise and outdoor activity, and students in the Food & The Environment Class – a team taught course unique to Common Ground – eat more fruits and vegetables than their peers.

Common Ground does not have sufficiently powerful ways to quantify and qualify their impact on health behaviors and outcomes of stakeholders and participants. Over the last two years, students in the Practice-based Community Health Research course have helped Common Ground make strides in this direction: first by developing focus group protocols and survey instruments to understand the health impact of our charter high school, and then by developing parallel instruments for the programs of Common Ground's environmental education center and urban farm. Common Ground is poised to make a big step forward in this direction, as they collect a second year of quantitative and qualitative data on the health of our 200 high school students. But they do not have the capacity of make meaning of these data, or to figure out a path forward based on the results of these evaluative tools. This is where Common Ground needs the help of another group of Public Health students.

Methodology

- 1) Analyze previously collected high school survey data collected from 2015-2016, and link these data to data provided by Common Ground (e.g., attendance, GPA, race, free/reduced price lunch status) focused on a range of aspects of health including diet, physical activity, outdoor experience, connection to green spaces, etc. Conduct analysis to seek an understanding in answering some of the following questions:
 - a. How do students' health attitudes, behaviors, efficacy, etc., change over time – with a particular focus on choosing healthy food, outdoor experiences, physical activity, and health leadership/advocacy?
 - b. How does participation in specific experiences – health-focuses courses, Green Jobs Corps, health-focused after-school programs, etc. – impact students' answers to health-related questions?
 - c. How do health behaviors, attitudes, etc. – and changes in these health indicators -- relate to student demographics (race, free/reduced lunch status, gender, grade) and academic success (GPA, attendance/chronic absenteeism, successful transition to the next grade)
 - d. What are the implications of these results for how Common Ground supports and could support student health?
- 2) Documenting data analysis processes in ways that can be replicated by Common Ground staff in the future by creating a simple data analysis manual/protocol and excel workbooks ready to accept future rounds of survey data will position us to be increasingly self-sufficient moving forward.
- 3) Conducting 3 focus groups – one each of Common Ground students, alumni, and families – using pre-existing protocols, and coding these surveys using systems already developed by previous YSPH students. Code results, and compare these results to those of earlier focus groups for a more complete understanding of Common Ground's program impact. Facilitate focus groups of participants recruited by Common Ground staff.
- 4) Develop a written report to present findings for key Common Ground stakeholders (health committee members and students), and facilitate discussion about findings and implications evaluation results. Common Ground will provide space and participants.

Special Skills of Students (3-5 requested)

- 1) An ideal team will be interested in, and have some experience with, both quantitative and qualitative evaluation work.
- 2) Students with an interest in the intersection of health, public education, urban agriculture, and community education programs may find this to be a particularly interesting project. Students will have the opportunity to interact with high school students and a variety of staff through this project.

Resources Available to Students at Agency

A clear, responsive point person for all project-related work; a team of Common Ground staff who are invested in the project's success; all the work completed by two previous years of YSPH students, shared in a common Google Drive folder; advice and support from our partners at CARE; existing data and evaluation tools in a format that meets student and program participant privacy and confidentiality standards; access to Common Ground's site, including meeting space, network/internet access, and opportunities to observe programs; use of a dedicated SurveyMonkey account, paid for and administered by Common Ground; other resources as needed.

MEASURING IMPACT IN COMMUNITY PROGRAMS

Organization: AIDS Connecticut

Project Title: *Assessing the Results of Community Distribution of Naloxone*

Overview of Project

Students working on this project will have the opportunity to work with AIDS Connecticut to evaluate the Connecticut community naloxone distribution program for opiate overdose prevention. Measures of perceived successes, challenges, and potential improvements to their program will be conducted through assessing client and staff experiences with outreach and naloxone training sessions, level of preparedness to administer naloxone, measures of kit utilization, and attitudes regarding service access. Further steps may include investigating and understanding the attitudes or perceptions of stakeholders including law enforcement, pharmacists, and legislators regarding level of support for naloxone distribution initiatives and any misconceptions that may provide opportunities for education and targeted outreach. AIDS Connecticut believes the results of this project will lay the groundwork for future research and program development to help Connecticut turn the tide on the opiate overdose epidemic.

About AIDS Connecticut

In 2013, the Connecticut AIDS Resource Coalition (CARC) and AIDS Project Hartford (APH) merged to form AIDS Connecticut (ACT). Based in Hartford, ACT is a statewide coalition of organizations that provide services to people living with HIV/AIDS in Connecticut.

CARC - Incorporated in 1989, the founding members' aim was to work with and mutually support organizations wishing to create AIDS housing by sharing resources, skills, and information. In the fall of 2005, the agency broadened its mission to embrace all aspects of housing and services to persons living with HIV/AIDS in Connecticut.

APH - The agency was founded by a committed group of volunteers in 1985 as a grassroots response to the growing AIDS crisis. During the past two decades, we have evolved from an organization fighting to help people face an imminent death into one focused on helping people live a longer life with hope and dignity.

The mission of AIDS Connecticut (ACT) is to, in partnership with its member agencies, improve the lives of people impacted by HIV through care and supportive services, housing, advocacy and prevention. ACT offers a wide array of well-developed and linked prevention, treatment and care programs, including counseling, testing and referral, several evidence based group and individual prevention interventions, Syringe Exchange services in Hartford, Drug Treatment Advocacy, and an extensive medical case management program. The Deputy Director oversees ACT's programs as well as its public policy work.

In the spring of 2013, with a number of significant partners, Shawn M. Lang, Deputy Director of AIDS Connecticut (ACT) convened an Opioid Overdose Prevention Workgroup. The workgroup is statewide and has multi-disciplinary, cross-departmental

participation. The workgroup is open and current participating partners include the Connecticut Departments of Mental Health and Addiction Services, Public Health, and Corrections, Children and Families, Consumer Protection, and Social Services; the Connecticut Prevention Network; APT Foundation; AIDS Connecticut; Walgreens; researchers from Yale; Recovery Network of Programs; medical doctors and affected family members. The goals of the group are to raise awareness about and access to naloxone, provide education to prescribers to increase access to and availability of naloxone, and look at other states' policies to continue to make additional positive changes in CT.

About the Project

Deaths related to prescription opioids began rising in the early part of the 21st century. By 2002, death certificates listed opioid analgesic poisoning as a cause of death more commonly than heroin or cocaine. Connecticut is no different. Between 2009 and 2014, there were **nearly 2,000 accidental and unintentional opioid involved deaths that occurred in 152 of Connecticut's 169 cities and towns.** The demographic breakdown is: 70% male, 84% white, mean age of 40 years, 70% pharmaceutical opioid involved, increase in heroin between 2012- 2014. **82% of those overdoses occurred in a residence.** (Dr. Laretta Grau, Yale University – data from the Office of the Chief Medical Examiner)

Naloxone, or Narcan, is the life-saving antidote to an opioid overdose. It is a short acting medication which revives a persons within two to three minutes, and allows a 20 - 90 minute window of opportunity to access medical help. Naloxone has no street value, little to no side effects, and has a lower incidence of adverse reactions than an Epi-pen, antibiotics or Aspirin. Unlike many other medications, Naloxone cannot be abused or misused.

Community distribution of naloxone is relatively new in Connecticut, and AIDS Connecticut was the first community based organization to begin such a program with our syringe services clients and, to date, there has been no evaluation as to the barriers and facilitators, or the value of such a program for clients in terms of harm reduction and overdose prevention.

This project would provide valuable information to assist AIDS Connecticut in not only shaping their policies and procedures, but will also help to shape future programs and public policy.

Methodology

1. Perform a descriptive analysis of available statewide data on naloxone use and overdose in Connecticut.
2. Conduct a comprehensive analysis of national naloxone community distribution programs and available data.
3. Conduct 20 client and 5 staff member key informant interviews to collect qualitative data on programmatic performance.

For analysis of statewide data on naloxone use and overdose, internal program data is available for student access. Reversal reports contain quantitative data that have yet to be examined, including if people call 911 for overdose, how long naloxone takes to work, what negative consequences occurred from administering, etc. Access to other data, such as opiate-related overdose deaths and aggregate data from the Department of

Public Health is available to students. Students will examine comparative samples for programs in Massachusetts or Rhode Island. Information from programs in neighboring states will be provided regarding methods of community distribution, experiences, and results. Statewide distribution data and overdose responses reported by community programs will be provided through the Department of Public Health.

Qualitative analysis is proposed for this project to obtain additional data, which is not addressed through currently available quantitative data. 20 key informant client interviews and 5 staff who work in the mobile van will be conducted. Recruitment of clients will occur in collaboration with SSP staff, who will identify and refer clients who have been trained through the overdose program and who carry overdose kits. Interviews with clients will be fairly brief and focused, taking into consideration time constraints of the client population. Staff interviews will be more in-depth. Examples of domains to be assessed include experiences with staff outreach, retention of education from training, forms of naloxone being utilized and trends in preferences from injecting communities, overdose incidents and preparedness surrounding naloxone administering, and returning to services regarding naloxone access.

Special Skills of Students (3 requested)

- 1.Strong verbal and written skills.
- 2.Critical thinking and ability to analyze the information.
- 3.Experience or willingness in working with diverse clientele.

Resources Available to Students at Agency

Students will have continued communication with a primary preceptor who has extensive experience as a community PI on multiple CIRA Community Research Partnership Projects and other additional staff support. ACT has “floating desks” that have computers and phones, as well as copiers. Key staff will be available for support and as a resource to the students. Two points of staff contact for project work will be available to students at all times, who are very responsive to emails and message communications. Funding in the budget will be available for client stipends in the form of gift cards (\$15 for 20 clients) for use with the conduct of client qualitative interviews.

VULNERABLE POPULATIONS: COMMUNITY HEALTH OUTCOMES

Organization: New London Homeless Hospitality Center (NLHHC)

Project Title: *Improving Health Outcomes through Supportive Housing*

Overview of Project

Students will have the opportunity to work with the New London Homeless Hospitality Center to improve the health of people experiencing homelessness by building the evidence base for health-related case manager support for the homeless population. NLHHC believes that this project will help them position themselves to demonstrate a direct impact on key health indicators regarding diabetes, and will allow this organization to be in a position to maximize the number of people reached by their programs as well. Methods used include literature reviews, the conduct of key informant interviews, identification and descriptions of possible diabetes interventions and diabetes care partners for NLHHC, and creation of dissemination training materials.

About New London Homeless Hospitality Center

The New London Homeless Hospitality Center's mission is to offer hospitality to its single homeless adult neighbors and to provide a bridge for them to permanent housing.

Hospitality—The center is not just a place to sleep or shower or sit. The center seeks to be a place where people feel welcome, where they feel safe, where they feel that someone cares, where they feel respected and where who they are as an individual matters. The daytime hospitality center also serves as the primary “front door” for individuals seeking access to services through the New London county coordinated access process.

Emergency Shelter—Another expression of the center's mission is to offer short-term emergency shelter that helps people regroup and set a course to permanent housing. The goal is to partner with others and to organize shelter services in such a way as to meet the full regional demand for shelter services. The center does not view itself as offering a particular number of shelter beds (although capacity limitations are very real) but rather as a group seeking to work with its partners to find ways to provide every adult experiencing homelessness in the region with access to emergency shelter when they need it. A specialized respite section of the shelter provides emergency shelter specially designed to address the needs of individuals who are both homeless and facing serious health challenges.

Bridge to permanent housing—What every homeless person needs is a permanent home. As the center offers hospitality, the staff is always thinking of how they can help a person build a bridge back to permanent housing. They seek to act as partners and advocates for our guests as they take the lead in finding ways to return to housing. The primary tool in this area of their mission is rapid rehousing.

Offer affordable and/or supportive housing—Where possible, the center's staff manages a variety of high quality affordable housing options that address the needs

of their guests who face the greatest barriers to finding safe and affordable housing. In some cases this housing is financed with public rental subsidies, especially rental assistance program (RAP) vouchers. The Veterans Administration finances one of these housing options. In other cases NLHHC has had the opportunity to purchase multi-family buildings, which the center can then rent out at very reasonable, all-inclusive, weekly rates.

The center seeks to offer this hospitality and bridge to permanent housing to all single adults facing homelessness in the region. The founding vision, however, puts a special emphasis on serving the very most in need—individuals suffering from substance abuse/mental illness, people coming out of prison, those currently living outdoors, those who have been homeless a long time and those who are vulnerable due to age or illness. The center is also committed to achieving cost effective results on behalf of its guests and funders. Its commitment is to a restless focus on outcome and on improving what we do based on our own and national experience.

About the Project

The health care world is coming to increasingly understand the impact of social determinants of health. Maybe most centrally, policy makers are beginning to see that achieving high quality health outcomes is difficult for individuals without stable housing. Housing instability is also a major contributor to health inequality as people experiencing homelessness face additional challenges in accessing traditional health care resources.

One manifestation of this growing awareness of the link between housing and health is a proposed expansion of Medicaid covered services to include housing stability supports. Some states have already expanded their Medicaid covered services to include housing relate supports. CMS has issued an informational bulletin (June 26, 2015) on allowable coverage for housing services.

These trends are bringing supportive housing providers like the New London Homeless Hospitality Center more fully into the dialogue about health. They are in the very early stages of this conversation but they believe that they are in a unique position to impact housing stability and specific health outcomes. NLHHC's goal is to advocate for a broad/robust role for supportive housing providers in the effort to improve health outcomes. NLHHC believes adding specialized community health workers from another agency could represent a duplication of effort. They would like to better understand how the organization could leverage engagement with our participants in a way that allows them to impact key health outcomes.

Demonstrating concrete outcomes related to key health indicators will be critical to claiming a place for housing providers in the healthcare arena. Priorities of health care funders must be identified and the ability to demonstrate results in these areas must be developed. Reducing readmissions and emergency room use are important priorities for the health care system. Controlling overall spending for very high utilizers is also a key concern especially for Medicaid managers at the Department of Social

Services. NLHHC has efforts underway—especially through their respite unit and housing program for high utilizers—on these measures.

Research indicates that investment in preventing these individuals from moving into the high utilizer category provides a greater “return” on investment than many other population health efforts. NLHHC would like to position housing staff (in partnership with VNA nurses) to deliver interventions for this rising risk population, and ask that Yale School of Public Health students assist in developing several protocols that could guide this intervention.

Methodology

1. Student team will review literature to identify supportive interventions focused on diabetes management that can be or have been implemented by case managers;
2. Student team will conduct key informant interviews (5-10) with representatives of organizations working in diabetes management programs to support knowledge generated from literature review
3. Student team will partner with client volunteers to identify interventions most appropriate for the NLHHC setting and adapt training materials from identified interventions for use with NLHHC case managers, and will seek feedback from case manager volunteers regarding training materials developed

Special Skills of Students (2-3 requested)

Knowledge of population health resources. Ability to translate outcome measures into workable and fairly standardized interventions.

Resources Available to Students at Agency

Students will have access to the Executive Director of this organization as a preceptor, with over 30 years of experience managing effective programs for the not-for-profit sector. NLHHC partners closely with the local VNA and staff from that agency would be accessible for consultation. The local hospital (L+M Hospital) is now part of the Yale New Haven system and there are multiple resources available on diabetes management through Yale. NLHHC would also seek to involve the Community Health Center in supplying input to the project team.

VULNERABLE POPULATIONS: COMMUNITY HEALTH OUTCOMES

Organization: Planned Parenthood of Southern New England

Project Title: LGBTQ Health Care Analysis for Connecticut and Rhode Island

Overview of Project

Students will have the opportunity to work with Planned Parenthood of Southern New England (PPSNE) in conducting an analysis of the LGBTQ community's needs surrounding reproductive and sexual health services, and perceptions of PPSNE as a sexual health care provider by this community. Students will work to develop a report and presentation to address descriptive information about the LGBTQ community reproductive health needs, current organizations that meet these health needs, any unmet needs described by LGBTQ community, perceptions of PPSNE services and recommendations on ways to increase engagement with LGBTQ community in services. PPSNE is in the process of revising its Strategic Plan and developing the annual plan for the next fiscal year, and hopes that the outcomes of this project will inform their work going forward.

About Planned Parenthood of Southern New England

PPSNE is the largest provider of reproductive health services in Southern New England. PPSNE has a budget of nearly \$30 million dollars and a staff of about 200. PPSNE operates 18 health centers in Connecticut (17) and Rhode Island (1) and served served 68,000 women and men with 111,000 visits last year. Our community educators annually reach more than 6,000 teens, young adults and parents across Connecticut and Rhode Island.

The mission of Planned Parenthood of Southern New England is to protect the fundamental right of all individuals to manage their own fertility and sexual health and to ensure access to the services, education, and information to realize that right. PPSNE's clinical services include primary gynecology care, family planning services and supplies, Pap tests, STD and HIV colposcopy/cryosurgery and pregnancy termination. 90% of visits to PPSNE are for gynecology care, including STD testing and treatment. In the last two years, PPSNE has been implementing primary care services in selected health centers. This includes diagnosis and treatment for upper respiratory infections, skin conditions, school/ work physicals, flu shots. PPSNE is looking to offer comprehensive primary care in our Hartford North center. In June PPSNE initiated the HIV prevention protocols PrEP and PEP.

Most of PPSNE patients are under the age of 30, and 11% are men. About 45 percent of PPSNE patients are people of color (African-American/Black, Latino, Asian, more than one race). About 40 percent of our patients are covered by Medicaid (including the CT Medicaid Family Planning Expansion plan), 30 percent are covered by commercial insurance and 30 percent are uninsured and are charged according to a sliding fee scale that is based on income and family size.

About the Project

A significant proportion of PPSNE patients are men (up to 15 percent in some health centers), while the organization is still seen as a women's health organization. Similarly, while PPSNE provides more than 100,000 tests for sexually transmitted diseases and 17,000 HIV tests, the agency is better known as a provider of abortions and contraceptives. PPSNE is always looking to ensure its services are attractive to all young women and men who need them. Focusing on the needs of the LGBTQ community meshes with their internal initiative, Creating an Effective and Inclusive Organization (CEIO), and is integral to achieving our mission of ensuring access for all individuals to services that enable them to manage their sexual health.

In recent months, there have been developments—internal and external—that have led to additional focus on the LGBTQ community: In June, PPSNE initiated PrEP services, the HIV prevention protocol, in several centers, with plans to roll it to all 18 PPSNE health centers in the coming months (based on demand and resources). This year, PPSNE also plans to expand its services to transgender individuals. Currently, one PPSNE clinician offers hormonal therapy to women and men seeking gender reassignment primarily at our New Haven center on a part-time basis. They are looking to train clinicians in other PPSNE centers to provide this service.

PPSNE would like to know more about the need or market for services. PPSNE was encouraged to implement PrEP by the Connecticut Department of Public Health and occasional patient inquiry, but needs to consider questions such as: Is there a need for another PrEP provider? Is the demand greater in some areas compared to others? As far as transgender services, how great is the need? Are there underserved communities where PPSNE should focus on for transgender care? To ensure the success of PrEP and transgender services, as well as to better serve young adults in general, it is important to assess how PPSNE health centers and services are viewed by the LGBTQ community. Do women and men in the LGBTQ community view PPSNE as a place where they would want to receive reproductive health services—such as annual STD testing? Would organizations that serve the LGBTQ community refer clients to PPSNE?

In addition, there are changes in the external environment that make it important for PPSNE to pay more attention to the LGBTQ community. These include:

- Growing demand for services from individuals and LGBT organizations
- The LGBT community is organized, vocal, and influential
- Heightened awareness of transgender issues through television and media
- Policymakers and Healthcare industry have begun to take notice of shifting needs of LGBTQ individuals.

Students will develop a report and presentation to addresses the following:

- An estimate of the size of the LBGTQ community that needs annual reproductive health care services
- Description and location (towns/cities) of organizations currently meeting needs of LBGTQ community in Connecticut and Rhode Island
- Description and location (towns/cities) of the unmet reproductive health needs of LBGTQ community

- Description of how LGBTQ organizations, individuals currently perceive PPSNE
- What LGBTQ individuals are looking for in a reproductive health provider
- Recommendations on what PPSNE can do to better attract LGBTQ individuals—marketing, internal changes.

Methodology

1. Needs assessment: Summary of what is known about the currently identified needs of the LGBTQ community in Connecticut for reproductive health services. Is there any way to estimate the size of the community—hundreds or thousands of individuals?
2. Asset mapping: Identify current providers, towns/cities where located, serving LGBTQ community. Detailed GIS mapping is not required, but it is desired for the team to identify towns or areas where there are gaps between resources and need that PPSNE could fill.
3. Key informant interviews: This would include staff at organizations identified above, as well as representatives from public health community. PPSNE’s Public Affairs team has worked with LGBTQ communities on legislative issues and will be able to provide contact names. This may also include interviews with staff that provide transgender and PrEP services.
4. Focus groups: PPSNE may be able to help in recruiting from among organizations that PPSNE’s public affairs team partners with as well as from current and former patients (approach must be compliant with HIPAA and PPSNE’s patient confidentiality policies and may need Yale IRB approval). PPSNE can also reach out to potential focus group participants through its social media outlets, such as Facebook, twitter. Possibly including an online survey that might reach those are most hidden and/or disenfranchised. Key informant interviews might provide some insight here.

Special Skills of Students (4 requested)

MS Excel, survey question preparation (possibly even online surveying), focus group management, presentation preparation

Resources Available to Students at Agency

Meeting rooms, telephones, temporary use of computer, printer (at PPSNE office).

Data sources: PPSNE does have some data on patients that have used our transgender and PrEP services—but the numbers are fairly small. We can provide some demographic data (age, gender, race/ethnicity, poverty level, insurance status, zip code) in a HIPAA compliant format. This would need to be approved by Yale IRB and PPSNE’s HIPAA privacy and security officers.

VULNERABLE POPULATIONS: Aging Populations

Organization: Jewish Senior Services

Project Title: *An Interfaith Response to Elder Abuse and Neglect in Connecticut*

Overview of Project

Students will have the opportunity to work with Jewish Senior Services to determine clergy and faith-based organizations' baseline knowledge, awareness, and understanding of elder abuse and identify any barriers that these groups may face when encountering and/or suspecting elder abuse and/or neglect. Project results will be used to spread awareness and knowledge of elder abuse to clergy as mandated reporters, will broaden new avenues for elder abuse prevention, intervention and response, and finally will create strong community partnerships between faith-based organizations and aging services in Connecticut.

About Jewish Senior Services

The Center for Elder Abuse Prevention, located within the Institute on Aging of Jewish Senior Services, advocates for the prevention of elder abuse at the local, state and federal levels. The program also coordinates victim services and facilitates shelter for those experiencing abuse and provides outreach and education on elder abuse to professionals, seniors and caregivers who reside in community-based settings.

Jewish Senior Services of Fairfield has been providing health and housing services for elders for over 40 years. As the needs of seniors have changed, the array of services and settings offered by Jewish Senior Services has expanded accordingly. Jewish Senior Services offers seniors and their families services and public health advocacy including Geriatric Assessments and Care Management; assistance at home including Medical Home Care, Physical Therapy, Housekeeping, and Social Support; Adult Day Care Program; Membership-Based long-term care protection; 360-bed long-term skilled care; short-term Rehabilitation, and academic affiliations.

About the Project

Many older Americans are active members of their faith communities, where nearly half of all religious services attendance is made up of those who are 65 years of age or older (Rudnick, 2009; Rudnick & Teaster, 2013). Understandably, there are now 40 million people in the U.S. over 65, and more than 6 million over 85. In less than ten years, there will be 1 billion people over age 60. As the population ages the risk of mistreatment increases.

Even as this population segment grows, there is little research on or advocacy for the prevention of elder abuse, particularly amongst clergy and other faith-based communities. Still, in times of suffering, one study reported that older women are more likely to be faith-involved and to turn to their faith leaders for help when facing abuse (Podnieks & Wilson, 2003). Researchers also reported "that clergy are one of the most likely groups of caregivers to encounter cases of elder abuse, but unfortunately they rarely refer or report these cases to agencies that can help (Podnieks, 2001)." Thus many

victims of elder abuse may, and do, turn to their faith communities for help because, for many older adults, faith is a valuable resource, and important aspect of cultural identity and community, and an essential element in decision making and healing. Like many areas of abuse, awareness and prevention are keys to understanding the magnitude of a problem, reducing its prevalence and remediating its effects. Because older people are often invisible in a culture focused on youth, the problem is exacerbated in this population.

In the United States, very little has been written in peer-reviewed literature on the roles of clergy and faith-based organizations in addressing elder abuse or neglect, yet nearly half of all religious services attendance is made up of those who are 65 years of age or older (Rudnick, 2009); highlighting the significant role clergy can play in the prevention, intervention and treatment of elder abuse. In the state of Connecticut, clergy, of all faiths, are mandated to report if they have reasonable cause to suspect or believe someone of the age of 60 or over (1) has been abuse, neglected, exploited, or abandoned, or is in a condition caused by one of these or (2) is in need of protective services (319dd C.G.S. § 17(b)-451). However, very few, if any, elder abuse reports or referrals are received from clergy (Center for Elder Abuse Prevention, Preliminary Analysis Report of CEAP Data, 2014). Although clergy and faith communities can play an important role in the prevention, intervention and treatment of elder abuse, ***very little is known regarding their awareness, knowledge and intervention preferences to handle, or even their preparedness to respond to the emerging health and social issue of elder abuse.***

Students working on this project will:

- Determine clergy and faith-based organizations, in Connecticut, baseline knowledge, awareness, and understand of elder abuse and their role in the prevention and intervention of this growing health and social issue.
- Identify barriers Connecticut clergy and faith-based organizations face when they encounter known and/or suspected instances of elder abuse and/or neglect.
- Assist clergy and faith-based organizations in bridging knowledge and awareness gaps as well as providing awareness and guidance to available aging services and provider resources, in Connecticut.

Methodology

Elder abuse is an emerging issue of serious concern. Clergy are in a unique position to identify, prevent, and report elder abuse and neglect. Achieving the objectives of this project may include:

1. Develop an Assessment: Assess the perceived level of elder abuse and neglect awareness, knowledge, and intervention preparedness and preferences among Connecticut clergy and faith-based organizations.
2. Develop a Suggested Training Outline or Brochure: Use aggregated data and data analysis to guide and outline a comprehensive elder abuse training curriculum or information brochure highlighting elder abuse types, risk factors and warning

signs, mandated reporting responsibilities, suggested intervention strategies (safety planning), and aging services and providers.

Preliminary steps have been taken by the Center to develop several means for acquiring needed data. A survey has been drafted as well as interview and focus group questions. However, students who express interest in this project are encouraged to review these available materials and offer further input and suggested revisions. The Center will also encourage combining both qualitative and quantitative research approaches as a way of acquiring more insight and understanding of the barriers/knowledge gaps clergy experience in detecting and responding to elder abuse.

The Center has developed partnerships with faith-based organizations such as the Episcopal Diocese of Connecticut, Council of Churches of Greater Bridgeport, Fairfield Clergy Association and Safe Havens: Interfaith Partners Against Domestic Violence. In addition, Jewish Senior Services employs a full-time rabbi who actively participates with the community's faith leaders, of all denominations. Furthermore, students would also be wise to connect with the Yale Divinity School for additional leads. These resources would prove valuable for recruitment of clergy involvement. Ideally, the Center would like to target Fairfield and New Haven County but given time limitation, the Center would encourage students to recruit clergy participants from the Greater Bridgeport area.

Lastly, interested students are encouraged to include an intergenerational approach by involving an elderly adviser who may offer regular feedback to students throughout the course of this project. Many of the Center's faith-based partnerships, including Jewish Senior Services, have volunteer programs for elderly individuals who are actively involved in their congregation and would offer valuable insight and perspectives to students as they embark on this project. Such insight might include what resources they would encourage their faith community to make available to other elderly congregants related to elder abuse, protective services and senior benefit programs, or caregiver resources.

Special Skills of Students (3-4 requested)

Interest and/or experience in public health awareness and innovation; older adult needs; behavior change; social media; elder abuse prevention; research and writing; creativity; enthusiasm.

Resources Available to Students at Agency

Access to Center for Elder Abuse Prevention program contacts, including specific contacts for the Episcopal Diocese of Connecticut, Council of Churches of Greater Bridgeport, Fairfield Clergy Association, Safe Havens: Interfaith Partners Against Domestic Violence, Department of Social Services, Connecticut Elder Justice Coalition, Southwestern Connecticut Agency on Aging, Leading Age peer organizations, Connecticut Legal Services and any other local, state, or national relationships beneficial to this project, strategic insight from leaders providing elder health services across the continuum of care; office space; computer access; telephone, office supplies; engaged, knowledgeable staff.

VULNERABLE POPULATIONS: Aging Populations

Organization: Leeway, Incorporated

Project Title: *Develop a Structure to Support Nursing Home Resident Socialization & Continuum of Care*

Overview of Project

Students will have the opportunity to work with Leeway, Inc. to develop a structure to support nursing home residents who have a primary diagnosis of HIV through socialization and improving continuum of care, by assessing the need for socialization volunteers, and identifying best practices for implementing a volunteer program to support nursing home residents. This project would be a public service for students and an invaluable resource to residents at Leeway, Inc.

About Leeway, Inc.

Leeway, Incorporated was founded in 1995 as Connecticut's first and only free-standing skilled nursing center dedicated to caring for individuals with HIV/AIDS. Leeway continues its tradition of excellence today. Leeway's continuum of care includes 30 skilled nursing beds, 30 Residential Care Beds, 41 units of independent housing and community case management. Leeway is located in New Haven, CT, and provides intensive medical, nursing and behavioral health services in a nurturing and positive environment. Residents also receive treatment for addiction, mental health diagnosis, and a variety of chronic illnesses that accompany HIV/AIDS.

Leeway residents have a primary diagnosis of HIV. However they also have other comorbidities. Over 90% of Leeway's population has some form of mental illness, including a range of anxiety disorders. One of the more prevalent is Mental Illness with Anxiety and depression. They find that the opportunity to have dependable positive social interactions decreases the need for anti-psychotic medications. Leeway would like to develop social networks of community volunteers to work with individual clients. In addition to identifying best practices in similar programs in other places, Leeway also wants to develop the capacity to evaluate the program by adding documentation their standard treatment plan that could capture behavior changes.

Leeway's skilled nursing facility is committed to being a center of excellence in providing inpatient rehabilitative and palliative care so that those with AIDS can live as independently as possible. Leeway's Residential Care Facility, an integral part of the continuum of AIDS care, is committed to being a center of excellence in providing residential, personal and supplement care so that those with HIV/AIDS, Hepatitis C, and/or related conditions can live as independently as possible. This expert care is respectfully provided with compassion and without regard to race, national origin, age, religion, handicap, gender or sexual orientation with a focus on the integration of body, mind, and spirit. Leeway is committed to promoting quality of life and dignity to all those with HIV/AIDS.

About the Project

Methodology

Students working on this project will be participating in the following activities:

- Conduct qualitative interviews (either group or individual interviews) of residents about their experiences. Residents currently have story books provided from previously volunteers, and some narratives have already been collected.
- Complete literature reviews on programs with similar structures and missions to that of Leeway, and analyze which programmatic methodology would work best for Leeway. Conduct literature review to research how social support programs benefit nursing home residents
- Review current Leeway guidelines for volunteers and make recommendations if needed for the new volunteer program
- Collaborate with Med Options and Leeway Nursing Home staff to develop guidelines, an educational training module, and volunteer recruitment for social support program volunteers from Yale University graduate students and the greater New Haven area interested in working with mental health and skilled nursing facility residents

Special Skills of Students (4 requested)

A willingness to work closely with a marginalized population. Experience with diverse cultures. Ability to understand the Spanish language will be helpful but not necessary (translator company is also provided).

Resources Available to Students at Agency

Access to preceptor who is a Yale School of Public health alumni as a resource, access to previously collected data such as electronic medical records.

HEALTH SYSTEMS & HEALTH METRICS

Organization: Southwestern Area Health Education Center

Project Title: *Incorporating Community Health Workers (CHW) into New Models of Health Care Delivery*

Overview of Project

Students will have the opportunity to work with Southwestern AHEC to create a needs assessment of current Community Health Worker (CHWs) utilization in statewide health care delivery systems, and to make recommendations on where improvements could be made for future use of CHWs in clinical care. Data collection will include interviews and possibly focus groups, and collected data will be analyzed and synthesized into recommendations. Results will be incorporated as a component in Southwestern AHEC's State Innovation Model grant, contributing to the building of the infrastructure for CHWs in Connecticut, as well as providing technical assistance in incorporating CHWs into Practice Transformation models.

About Southwestern Area Health Education Center (AHEC)

Southwestern AHEC is a 501(c)3 with the mission of "Opening doors to better health in underserved populations through education, outreach, and careers." Created in 1998, Southwestern AHEC strategically focuses our programs to meet our mission by "Connecting Students to Careers, Professionals to Communities, and Communities to Better Health." Their organization's signature program is Community Health Workers (CHW) which aims to develop recognition and support of the CHW workforce in Connecticut in conjunction with the CHW Association of Connecticut. The Connecticut AHEC Network provides grassroots training and specialized education for CHWs, and technical assistance to employers and supervisors who are working with the CHW workforce. Southwestern AHEC is also building a diverse healthcare workforce by engaging students K- 16 in learning about health careers and the health care field, working to achieve a 90% and above level of immunization in children ages 0-2 years in Bridgeport, and identifying ways to improve overall health by educating providers, consumers and communities about how oral health links to general health.

In 2015-2016, Southwestern AHEC provided services to 2,881 participants in programs. Their success is based on relationships and on working together to highlight their strengths, and the strengths of community partners. Southwestern AHEC believes that their impact is greater when link programs to complement others in the community.

About the Project

Community Health Workers (CHWs) are being recognized as integral members of Community Clinical Teams in the new models of health care delivery and payment methodology. Yet, health care providers have very little understanding about how CHWs do their work in the community, address social determinants of health, and make an impact. The target audience will include current employers and/or potential SIM grantees who will hire CHWs beginning January 1st, as well as medical practices who are other employers of CHWs.

Several questions need to be answered, including: How are CHWs currently utilized by health care providers statewide? How do health providers see utilizing them in the future? What do they need to know to utilize them effectively? What are the best practices for CHWs to be integrated into community clinical teams?

Students working on this project will distinguish how CHWs are currently being utilized in the health care clinical delivery system in Connecticut to see if CHWs are being utilized in clinical practice, and in what ways they are utilized. If they are not being utilized, students will investigate the reasons for underutilization. This project also aims to identify the steps needed for seamless integration of CHWs into clinical care for Connecticut, as defined in the literature, and in the “Best Practices for Clinical; Integration in Connecticut” report that Southwestern AHEC created for the SIM project.

Methodology

1. Needs Assessment of employers/health care providers through interviews and possible focus groups.
 - a. The data collection can be collected in several ways. As there is not enough time to implement a full survey, gather results and complete the analysis, a pilot survey either in-person or by phone of 10 – 15 identified SIM practice entities is suggested. If possible, the survey will also be administered to a similar number of practice entities that are not part of the State Innovation Model (SIM) project. Several focus groups can be conducted with groups of employers.
2. Create needs assessment tool with guidance from Southwestern AHEC. Tool will be created from previously identified topics for potential use, based on questions from implemented surveys from other nation-wise organizations. Information on these other surveys will be provided by Southwestern AHEC.
 - a. Question validation for assessment tools will be conducted.
 - b. Data collection and analysis will be completed
3. Develop recommendations for future use of CHWs in clinical care in Connecticut.

Special Skills of Students (3-5 requested)

Have an understanding of CHWs and their work. Understanding of social determinants of health; population health; health care delivery paradigm changes with ACA

Resources Available to Students at Agency

Students will have access to previously conducted surveys from other parts of the country, a highly skilled preceptor with experience as a project preceptor, as well as office facilities including computers, telephones, etc.

HEALTH SYSTEMS & HEALTH METRICS

Organization: Yale New Haven Health

Project Title: *Develop and implement evaluation plan and monitoring of community health improvement plan for Yale New Haven Hospital*

Overview of Project

Students will work with Yale New Haven Health to measure its success through developing and implementing improvement plans for a hospital within Yale New Haven Health. This project is an important part of the resources needed by local health improvement coalitions and area hospitals for annual IRS reporting as part of the IRS 990 Schedule H.

About Yale New Haven Health

Yale New Haven Health was formed in 1995 to focus on enhancing the lives of those we serve by providing access to integrated, high-value, patient-centered care in collaboration with others who share our values. Yale New Haven's Health System consists of three Delivery Networks: Bridgeport, Greenwich and Yale New Haven, and a physician foundation, Northeast Medical Group. YNHH has clinical relationships with several hospitals in Connecticut and numerous outpatient locations throughout the state. The vision of Yale New Haven Health is to enhance the lives of the people they serve by providing access to high value, patient-centered care in collaboration with those who share our values. Yale New Haven Health is committed to innovation and excellence in patient care, teaching, research and service to our communities.

About the Project

Help us measure our success! Non-profit hospitals have new requirements related to monitoring and evaluation of community health improvement plans or implementation strategies developed to meet needs identified during their 2016 community health needs assessment. Yale New Haven Hospital requires assistance in developing an evaluation plan and monitoring mechanism for the community health improvement plan developed by the Healthier Greater New Haven Partnership. The Partnership prioritized three focus areas Access to Care, Healthy Lifestyles (prevention and management of chronic disease), and Mental Health & Substance Abuse and has completed the community health improvement plan including action steps and community partners identified for each objective. The evaluation plan and monitoring will include collecting baseline data for measurement as well as the potential to develop and design these plans in both the action steps and overall (micro / macro) in collaboration with community partners.

Methodology

Students working on this project will:

- Develop and design an evaluation plan Yale New Haven Hospital's community health improvement plan overall to be used by the hospital and the Healthier Greater New Haven Partnership for routine reporting and for annual hospital IRS reporting;

- Develop and design an evaluation plan for individual action plans including pilot projects;
- Collect baseline data for measurement and evaluation;
- Identify best practice monitoring of evaluation plans and implement monitoring mechanism.
-

Special Skills of Students (3-4 requested)

Understanding of evaluation and data collection and analysis processes, program evaluation and implementation.

Resources Available to Students at Agency

All resources necessary for individual students to complete tasks associated with the project will be provided including though not limited to work space, data sources, and computer time. Students will have access to a preceptor with 20 years of progressive experience in hospital administration, who has had experience working previously as a co-preceptor for student practicum teams.

Projects	Methodologies				Other Skills and Issues		
	Literature Review	Quantitative Data Analysis	Interviews & Qualitative Analysis	Record or Data Reviews	Measuring Impact	Vulnerable Populations	Health Systems & Health Metrics
Common Ground High School	X	X	X		X		
AIDS Connecticut	X	X	X		X		
New London Homeless Hospitality Center	X		X			X	
Planned Parenthood of Southern New England	X		X	X		X	
Jewish Senior Services	X	X	X	X		X	
Leeway, Incorporated	X		X			X	
Southwestern Area Health Education Center	X	X	X				X
Yale New Haven Hospital	X	X	X				X