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## ➤ CHRONIC DISEASE: Yale New Haven Hospital- Department of Community Health

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### *Diabetes 360°*

#### **Overview of Project:**

Students working on this project will have the opportunity to develop skills in planning and conducting an assessment of a particular health issue and the programs addressing that issue in a specific region. In addition, students will need to develop skills in interviewing staff of provider organizations. There will also be an opportunity to strengthen data analysis skills. Students are invited to help in crafting a 360° continuum of care best practice model for diabetes care. The skills developed in conducting the assessment will be transferable to other contexts where an assessment of public health programs and gaps in service is needed.

#### **About Yale New Haven Hospital:**

Yale-New Haven Hospital is a 944- bed tertiary referral medical center, which includes the 202 bed Yale New Haven Children's Hospital and the 72-bed Yale-New Haven Psychiatric Hospital. We provide services for over 51,000 inpatients and over half a million outpatient visits a year, relying on the skills of 6,978 employees, including 1,700 registered nurses 2,600 university and community physicians and more than 500 resident physicians practicing more than 100 medical specialties. Yale New Haven Health System (YNHHS), through Yale New Haven Hospital, Bridgeport and Greenwich delivery Networks, provides comprehensive, cost-effective, advanced patient care characterized by safety, and clinical and service quality. YNHHS, in affiliation with the Yale University School of Medicine and other universities and colleges, educates health professionals and advances clinical care. Our mission of patient care, teaching, research and community service is reflected in all that we do for those to whom we provide care.

#### **About the project:**

Small group discussions and larger forums have identified a number of diabetes initiatives in place in the greater New Haven area. However, it has also become apparent that many of these programs are disconnected from one another causing those in need of care, education, support and lifestyle modification to fall short. YNH is interested in looking at the diabetes challenge in a 360° continuum of care model that includes all stakeholders, service sites and research programs to truly affect change upon the neighborhoods in New Haven and create a national standard of citywide care coordination which would include Type I and Type II diabetics and their families.

New Haven has a combined estimated 70% African American and Latino population. African American adults in Connecticut are significantly more likely than White (14.0% vs. 6.4 %,  $p \leq .05$ ) and Hispanic adults (14.0% vs. 7.1%,  $p \leq .05$ ) to report that they have been diagnosed with diabetes. Estimated diabetes prevalence rates for Hispanic and White adults are not significantly different. It is important to note that the African American and Hispanic populations are younger than the White population in Connecticut, and that these unadjusted prevalence estimates do not take into account the different age structures of these three populations. "Age-adjusted" diabetes prevalence estimates adjust for the age differences in these populations and these estimates indicate that both African American and Hispanic adults have significantly higher age-adjusted diabetes prevalence rates

compared with White adults in Connecticut. Age-adjusted diabetes prevalence estimates (2006-2008) are as follows: Black or African American adults - 15.9%; Hispanic adults - 10.5%; White adults - 5.5% ( $p \leq .05$  for both comparisons of Black or African American vs. White, and Hispanic vs. White). Historically, New Haven has done an inadequate job in identifying minorities with diabetes. As a result, a larger number of admissions are at earlier ages with consequently more devastating results (lower limb amputation, kidney disease and related illnesses). Once diagnosed, minorities with diabetes in greater New Haven still appear to lack continuity of care either by choice or due to a lack of education and/or access to care.

**Methodology:**

Currently there are three or more programs in New Haven involving research or prevention studies that affect those living with Type 2 diabetes. It is unclear what the long term outcomes will be for these activities or whether a collaborative, long-term plan to sustain success is in place. Students will be asked to meet with community based organizations, health service delivery sites and health leadership in New Haven that provide direct or indirect care to Type 2 diabetes patients in an effort to evaluate this concern. Data models will be developed that provide information on the progress of various programs that are currently being funded in the greater New Haven area and how they are impacting their targeted communities. Additionally, interaction with community based organizations involved in diabetes prevention programs will focus on review and making recommendations regarding similarities and differences of current diabetes initiatives, while paying close attention to the initial goals and actual outcomes of each initiative. Finally, students will develop empirical data that will provide a basis by which to seek federal grant funding for a citywide collaborative of all major stakeholders, with the goal of creating a holistic, lifestyle focused diabetes prevention and treatment program that is evidence based and sustainable.

The opportunity to assist in crafting a best practice model is at the forefront of this project selection. If successful, New Haven could become a national diabetes disease standard bearer. The students will ultimately be involved in providing rationale and data that lead to a pathway of sustainability by working alongside community based organizations and health care professionals that are passionate about establishing a ongoing, fully vetted process of changing attitudes and saving lives. Obesity, preventative care, monitoring and challenging the current machinery that is creating this debilitating disease to manifest itself disproportionately in communities of color is cause for alarm and action.

**Special skills of desired students (3-4 students requested):**

Strong interpersonal skills; ability to perform quantitative analysis; critical thinking and familiarity with Excel, Access and Powerpoint.

**Resources available to students at agency:**

Students will be introduced to key service site stakeholders in the community and have access to IT personnel at the hospital to acquire information from qualified data sources. Workspace will be assigned as needed that has wireless capability; telephone access and clerical support (when available).



## **CHRONIC DISEASE: Community Renewal Teams**

### *Investigating the Level of Need for Developmentally and Culturally Relevant Nutrition and Physical Activity Programs among Children Enrolled in CRT's Early Care and Education Programs*

#### **Overview of project:**

Students working on this project will gain skills in data analysis, increased knowledge of issues involved in nutrition and physical activity for young children, increased awareness of parent/child issues around physical activity and nutrition, skills in conducting focus groups and interviews, and some knowledge of the health care challenges faced by a community based organization providing a range of services. Data analysis, focus group and interview skills developed in this project could be applied in a variety of settings.

#### **About Community Renewal Teams:**

CRT is the largest community action agency in Connecticut and the oldest continuously operating community action agency in the United States. After 45 years, the organization continues to uphold its founding purpose of counteracting poverty and providing poor communities with the education and resources essential for attaining self-sufficiency. The mission of the organization is "Preparing our community to meet life's challenges," and fulfills the mission by providing a multitude of services including family and community strengthening programs.

CRT currently manages an annual budget of over \$66 million dollars and employs more than 650 people. The greatest number of programs and services are concentrated in Hartford and Middlesex Counties; however, the agency provides some type of service to individuals living in 65 of Connecticut's 169 towns. In 2008, CRT served 91,856 individuals from racially and culturally diverse backgrounds, ranging in age from six weeks through the elderly who were at or below the federal poverty level. CRT serves members of high-risk communities on a daily basis and provides life-sustaining services such as Early Care and Education (Head Start, School Readiness, Childcare, Infant & Toddler); Behavioral Health Services; Emergency Shelters, Residential and Housing Assistance; Energy Assistance and Weatherization; Elderly Nutrition (congregate and meals on wheels); Senior Programming; Supportive Housing; Employment Training and Placement Services; Community Justice Programs; Asset Development/Economic Literacy Programs and Neighborhood and Suburban Outreach multi-services. Given the variety and number of programs CRT collaborates in numerous ways with many different nonprofits, local governments, civic organizations, schools, hospitals, etc.

#### **About the project:**

Obesity is a critical health concern for children. Obese children are at risk for a multitude of physical health conditions during their youth and adulthood including Type 2 diabetes, asthma, sleep apnea, high blood pressure, and high cholesterol. Children and youth who are obese or overweight may also be exposed to social stigmatization based on their weight. These children may encounter name calling and derogatory remarks, physical bullying, and social isolation, e.g. being ignored or avoided or excluded from peer activities (Puhl, n.d.). Childhood obesity is even more problematic because the physical inactivity and poor dietary habits related to obesity in childhood, as well as the low self-

esteem, may persist into adolescence and adulthood hindering physical health, academic performance, and social functioning.

Data from National Health and Nutrition Examination Surveys (1976-1980 and 2003-2006) show that the prevalence of obesity has increased: for children aged 2-5 years, prevalence increased from 5.0% to 12.4%. Among low income children the prevalence of obesity is greater. The Pediatric Nutrition Surveillance System (PedNSS), the only national source of compiled obesity surveillance data obtained at the state and local levels for low income children from birth to age 5 (CDC, 2009), indicated a steady increase in obesity during 1998-2003, from 12.4% in 1998 to 14.5% in 2003. Since 2003, the percentage among this population has remained relatively stable with a reported 14.9 % in 2008 and 14.6% in 2008 (CDC, 2009). In 2008, over 60,964 children were included in the PedNSS data. Although specific town data was not made readily available, given the income guidelines for PedNSS ( $\leq 185\%$  of poverty level), many of the children probably resided in Hartford, considering 37.8% of all families with children under 18 years of age in Hartford fall below the federal poverty level and the rate of childhood poverty is 44.0% (U.S. Census, 2007).

The 2007 Youth Risk Behavior Survey (CDC, 2007), a national survey administered by the CDC every two years in Connecticut among high school aged youth, reported that 54.9% of Connecticut's youth were not physically active for a total of at least 60 minutes per day on five or more of the past seven days and only 21.5% reported eating five servings of fruits and vegetables daily (a recommendation of the American Dietary Association). This means that in a Connecticut classroom of 30 students, nearly 4 students would be overweight and 24 would not have the daily recommendation of fruits and vegetables. Breaking the data down by race/ethnicity, the YRBS found that Black and Hispanic youth reported a much lower percentage of activity (34.4% and 32.3%, respectively) than their White counterparts. Black and Hispanic youth also reported strikingly higher percentages for watching 3 or more hours of TV on an average school day (indicating lower activity levels) compared to Whites - 56.8% and 39.5%, respectively, compared to 23.6%. Regarding fruit and vegetable consumption, only 24.6% of Black and 21.7% of Hispanic youth indicated that they had eaten five servings of fruit or vegetables per day in the past seven days. Although this age group is older than those served by CRT, based on previous research, these habits or practices were more than likely instilled much younger.

According to the 2008-2009 Head Start Program Information Report for Hartford, 1,358 children were initially enrolled in the CRT's Head Start Programming. Forty-four percent lived below 100% of the poverty line, 45% received some type of public assistance, 1.5% were in foster care, 1% were homeless and 10% were over income. Only 5% of the children were White, 51% were Black, 42% were Hispanic, and the remaining children were reported as Asian or Bi/multi-racial. In the East Hartford CRT delegate site, 257 children were enrolled. Seventy-seven percent were below 100% of the poverty line, 16% received some type of public assistance, 3% were over income, and 3% were in foster care. 52% were Hispanic, 30% Black, 13% White, and 5% Asian or Bi/multi-racial. The Bristol delegate site reported an enrollment number of 74 with 90% below 100% of the poverty line, 3% received some type of public assistance, 3% were in foster care, 1% were homeless, and 3% were over income. CRT does have other children enrolled who are not included in this report, but have very similar demographics as reported here.

Due to the demographic make-up of CRT's ECE children and given the high percentage of children living below the poverty line, we strongly suspect that the project's findings to be somewhat more disparate than the YRBS (CDC, 2007) findings.

CRT has no formal physical activity instructor and only one full-time registered dietician responsible for overseeing the daily nutrition needs of 1,423 children ranging in ages from six weeks to 5 years. The need to investigate the nutritional and physical activity practices of the CRT ECE families, the overweight and obesity status of the enrolled children, and time spent on nutrition and physical activity in the ECE classrooms is imperative to future program planning that directly affects the children's immediate and future health and wellness practices. Collecting, analyzing, and reporting on such data will assist the parents, ECE staff, and other CRT staff in understanding the trends and prevalence of nutrition and physical activity deficits and obesity, determining nutrition and activity practices of the families and children at home and in the classroom, and identify developmentally and culturally appropriate components of future programming to specifically meet the needs of CRT's children. CRT would like to offer the ECE children and their families the opportunity to instill nutrition and physical activity practices that will improve their physical and emotional health and well-being. Investigating the level of need among the families is the logical place to begin.

**Methodology:**

To assess the level of need for developmentally and culturally relevant nutrition and physical activity programs among children enrolled in CRT's Early Care and Education programs a quantitative and qualitative study is proposed. The goals of this project include:

1. Determine physical activity practices/programs/curriculum offered throughout the day/month/year at the CRT ECE program.
2. Determine predictors and barriers to implementing a sufficient physical activity programs at the CRT ECE (via interviews with staff, etc).
3. Determine CRT ECE nutrition and physical activity practices program preferences (via focus groups with families and interviews with staff).
4. Identify available NAEYC recommended programs for future CRT ECE physical classes.

The qualitative methodologies selected for this project are the focus group, which is ideal for exploring the nutrition and activity practices of the families, and the semi-structured, face-to-face interview, ideal for determining the time spent on nutrition education in the classroom. The focus groups will elicit responses from parents of the children enrolled at the CRT ECE Centers and directly address food frequencies during at-home meals and snack times, daily minutes of physical activity after-school and on the weekend by family members, and daily minutes of television and computer time by family members. The interviews will elicit responses from the teachers of the classroom regarding the amount of time, content, and activities that focus on nutrition and physical activity.

The quantitative methodologies selected for this project are survey administration, record review, and mining existing medium and large data sets. Surveys will be used during focus groups with parents to further record food frequencies during at-home meals and snack times. Reviewing records will include a review of classroom lesson plans to document the number of minutes dedicated to nutrition, gross motor skill activity, and indoor/outdoor

physical activities. Existing CRT data sets to be analyzed will include height and weight data of the children, nutrition survey data, and student achievement data focusing on physical activity. Some data has been collected over time, making it feasible for multiple time-point analysis. All data will be scrubbed of identifying information.

**Special skills of desired students (3 students requested):**

- Strong data entry and analysis skills
- Experience using large data sets
- Survey construction and administration
- Focus group moderation
- Knowledge of the link between nutrition, physical activity, and obesity among children

**Resources available to students at agency:**

Students will have the following available: specific ECE data sources including student outcome data, student measures physical health, and select demographic data; computer, SPSS software, telephones, fax, copier, and scanner. Other resources may be available or secured as the need arises.



## **CHRONIC DISEASE: City Seed**

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### *EBT/Food Stamp Use at Farmers Markets*

#### **Overview of project:**

Students working on this project will gain experience in planning and designing a social marketing campaign to increase awareness and use of EBT/food stamps at farmers markets. In addition to developing the intervention, students will also design an evaluation to determine effectiveness of the marketing campaign. Skills from this project could be applied to work in program evaluation, school health, child health, and social and behavioral health programs.

#### **About City Seed:**

**CitySeed Mission:** To engage the community in growing an equitable, local food system that promotes economic development, community development and sustainable agriculture.

**CitySeed Vision:** To create a sustainable model of local economy, urban community, regional agriculture, environmental stewardship, and well-being through food.

CitySeed is a community-based non-profit organization with a mission to do two things: increase access to local, healthy food and promote farm viability. What began as four neighbors launching a producer-only farmers' market in New Haven has grown into an organization that works statewide to build a local, equitable food system through innovative, responsive programs and policy work. In New Haven, CitySeed coordinates a network of four neighborhood farmers' markets, all of which accept EBT/Food Stamps and WIC Farmers' Market Nutrition Program Coupons. In 2008, vendor sales at City Farmers' Markets contributed over \$1.75 million to job creation and the local economy.

Building on the farmers' markets, CitySeed has created innovative programs with the intent of making local, healthy food available to everyone. In 2006, CitySeed created the Community Supported Market (CSM) to deliver shares of fresh produce from the Fair Haven market to work sites. CitySeed has since extended the CSM to community sites to include the delivery of subsidized shares to senior centers and health clinics, delivering over 1,105 subsidized shares in 2008 alone. In 2007, CitySeed partnered with the CT Children's Museum to create an educational curriculum designed to grow healthy eaters and readers that has reached over 1,000 New Haven pre-schoolers and their families in the past 2 years. In the spring of this year, CitySeed and the Buy CT Grown Advisory Team launched [www.BuyCTGrown.com](http://www.BuyCTGrown.com), a comprehensive, online directory of local food and farms.

CitySeed's advocacy also led to the establishment of the New Haven Food Policy Council and the Working Group on School Food, which are currently focused on promoting healthy, fresh food in New Haven's public schools. CitySeed staffs the Food Policy Council and the Working Group and is actively working to bring together administrators, parents and community members to increase fresh, healthy food and decrease processed foods in schools.

#### **About the project:**

This initiative will take place within the City of New Haven, an urban location with an estimated population of 124,001 people as of 2006. Although Connecticut is one of the wealthiest states in the US, New Haven is one of the nation's poorest cities. According to a

2005 report by the Connecticut Food Policy Council, the University of Connecticut, and the Hartford Food System, New Haven ranked 161 out of 169 towns in the category of wealth, and 163 out of 169 towns in the category of overall food security. According to the 2005-2007 American Community Survey, 20.2% of New Haven's family population lives below the poverty level. (<http://factfinder.census.gov/>)

The New Haven community has many great programs and organizations that can connect more regularly in order to address the common goal of fighting childhood obesity. Currently, WIC outreach programs and diabetes and obesity programs located within health locations (such as Yale New Haven Hospital's pediatric obesity prevention program) have long been allies with community based organizations helping to curb disease, illness and unhealthy behaviors. In fact, the diabetes prevention program at the Fair Haven Community Health Center bought fresh produce from CitySeed's Community Supported Market program and brought clients to the market to better make the connection between healthy eating and disease prevention.

CitySeed coordinates a network of four neighborhood farmers' markets in New Haven, all of which accept EBT/Food Stamps and WIC Farmers' Market Nutrition Program Coupons. Both USDA and USA Today have recognized CitySeed for increasing access to local, healthy food for community members who are nutritionally at-risk. And in 2008, farmers at CitySeed's Farmers' Markets redeemed over \$78,000 in WIC coupons and EBT/Food Stamps from local families in need, ensuring the markets are accessible to the entire community.

CitySeed currently works closely with the WIC offices of New Haven to provide outreach and education about using food assistance benefits for fresh fruits and vegetables at farmers' markets, and has seen an increase in redemption with this outreach and promotion. While many WIC coupons are being redeemed, few EBT benefits are being used at the farmers' markets (less than \$10,000 of the total listed above was EBT redemption). Considering the number of residents in New Haven with access to EBT/Food Stamps and the high rate of WIC redemption we know there is a larger group of people who could be accessing fresh, healthy, local food if they (a) knew our farmers' markets accepted EBT and (b) knew our vendors represent a variety of price points and fresh, healthy, local food can be affordable.

### **Methodology**

Electronic Benefit Transfer (EBT) is the system through which Supplemental Nutrition Assistance Benefits (SNAP, formerly known as Food Stamps) are accessed. SNAP recipients receive an EBT card, which functions like a debit card. They receive their monthly allocation of SNAP benefits to their EBT card, which they can spend as needed throughout the month. At the farmers' markets in New Haven, SNAP recipients receive wooden market coins in exchange for a swipe on an EBT wireless terminal. Farmers then take the wooden market coins as cash. They are then reimbursed by CitySeed, the original recipient of the EBT payment. The US Department of Agriculture's Food and Nutrition Service Department is responsible for EBT/SNAP disbursements. Their website will likely be the best source for data on disbursement, receipt, and use of EBT/SNAP (Food Stamps).

Students will research how individuals receive food stamp benefits, and what education, outreach, and resources are included with disbursement of such benefits, including what food items can be purchased and where. Students will then create an outreach/marketing campaign that promotes the use of EBT/Food Stamps at Farmers' Markets as a way to use

food benefits for fresh fruits and vegetables. The outreach/marketing campaign should be created in such a way as to be easily evaluated. CitySeed will implement the proposed outreach/marketing plan and will conduct an evaluation to measure the effectiveness of the plan.

This project will require research of the EBT system and the design of an outreach plan with an evaluation component. The implementation and evaluation of the plan will be conducted by CitySeed during the 2010 growing season.

**Special skills of desired students (3-5 students requested):**

Students will have strong written and verbal communication skills, and will be able to work independently and as a part of a team. Students will possess a willingness to work with and around food, to work in the community and to think critically about food access and food justice.

**Resources available to students at agency:**

Students will have access to a workspace at the CitySeed office, which will include telephone, printing/copying, and fax. Ideally, students will have their own transportation.



## **UNDERSERVED POPULATIONS: Leeway Community Services**

### *Community AIDS Service Provider Strategic Planning Project*

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#### **Overview of project:**

Students working on this project will conduct a needs assessment through surveys and interviews. Students will develop skills in survey design, administration, and data coding and analysis. Students will also develop familiarity with the methods of SWOT analysis, examining strengths, weaknesses, opportunities and threats to the organization and clients. These skills will be readily transferable to needs assessments and evaluations and will provide a greater understanding of assessment methodologies.

#### **About Leeway:**

Leeway, known nationally as a “leader in AIDS care,” is committed to being a center of excellence in providing inpatient rehabilitative and palliative care and creating new community treatment options so that those with AIDS can live as independently as possible. Our 40-bed facility provides both short and long term care for the management of medical or psychiatric conditions, initiation or stabilization or of anti-retroviral therapy, completion of treatment for acute medical illness following hospitalization and palliative, end of life care.

Leeway has extended its role within the continuum of AIDS care by developing supportive housing and housing-related supportive programming. By creating community housing and support services, we hope to see less “cycling through” of persons living with AIDS who are medically frail and prone to repeated bouts of illness. Currently, Leeway provides housing case management services to 14 individuals and families in scattered site apartments in the greater New Haven area. Two other stand-alone supportive housing projects for which Leeway is the sponsor/developer are under construction in Hamden and New Haven, slated to open in 2010. These programs will bring the total number of Leeway supported supportive housing units to 41.

#### **About the project:**

Leeway last conducted a major strategic planning exercise in 2005, with a minor update in 2007. The 2005 plan envisioned and articulated the expansion of the organization into community-based residences and service roles, as well as the development of a new Medicaid community-based reimbursement program to fund these options. These new initiatives are coming to fruition now. As the organization now prepares for its next strategic planning exercise, a client needs assessment and a SWOT analysis are essential prerequisites.

#### **Methodology:**

YSPH students will perform a needs analysis of current, past and potential clients of the organization to ascertain possible future program initiatives for Leeway. Additionally, if time permits, students would perform an analysis of the organization’s strengths and weaknesses, as well as environmental threats and opportunities (SWOT).

The needs assessment will be conducted using an instrument and implementation design that is to be developed during the fall 2009 semester by a team in the YSPH program evaluation course. Interviews, in person or by phone, will gather data for the needs assessment. Analysis of the data and reporting of results will be a deliverable for the

students. The SWOT analysis will require research of various community agencies' services/programs, interviews with agency staff and interviews of Leeway personnel. Analysis of the data and reporting of results will be a deliverable for the students.

**Special skills of desired students (4 students requested):**

Intellectual curiosity, interest in community non-profit agency development work, familiarity with data collection using a needs assessment and conducting a SWOT analysis are preferred capabilities of the students.

**Resources available to students at agency:**

Access to organization staff, computer and telephone will be available, access to clients and mileage reimbursement.



## **UNDERSERVED POPULATIONS: Connecticut AIDS Resource Coalition**

### *An Analysis of HIV Prevention Strategies in Selected CT Cities: Hartford, New Haven, and Willimantic*

#### **Overview of project:**

Students involved in this project will develop skills in mapping and analysis of needs and services provided in a marginalized population. Communication skills, problem analysis and identifying policy implications will also be important for this project.

#### **About the Connecticut AIDS Resource Coalition:**

In October 1987, under the leadership of the Rev. Thaddeus Bennett, then Executive Director of AIDS Ministries, four organizations came together to talk about how to address the growing problem of housing for people with AIDS. They created a collaborative to assist programs in building strong supportive housing models for people with HIV/AIDS. Connecticut's AIDS housing programs were created in response to a clear crisis: people who were sick and dying had no place to live due to discrimination and loss of income during illness.

The CT AIDS Residence Coalition incorporated in 1989. Its founding members included Center City Churches, the CT AIDS Residence Program (now Liberty Community Services), the Stewart B. McKinney Foundation, Leeway and St. Luke's Community Services (now St. Luke's LifeWorks). The aim of the group was to work with and mutually support organizations wishing to create AIDS housing by sharing resources, skills, and information. Together we would advocate collectively for funding on a local and national level.

In the Fall of 2005, the agency changed its name to the Connecticut AIDS Resource Coalition to reflect its broadened mission to embrace all aspects of housing and services to persons living with HIV/AIDS in Connecticut and the fact that CARC is the only statewide AIDS coalition.

Our current mission is: CARC, through its member agencies, strives to ensure quality housing and supportive services for people living with HIV/AIDS in Connecticut and to promote effective HIV/ AIDS awareness and prevention education. We focus on public policy and advocacy on the state and federal levels; quality assurance and technical assistance with our members; training and workshops for front line staff; outreach to and with faith communities; administration of Ryan White housing and client assistance funds; campus organizing and consumer empowerment.

#### **About the project:**

Every three years, the CT HIV Planning Consortium (CHPC) develops a Comprehensive Statewide Plan for HIV Care and Prevention which outlines the epidemiological profile of the state, identifies priority populations to be reached, identifies gaps and outlines a comprehensive plan. The plan, in effect, directs the CT Department of Public Health (DPH) with direction as to where to prioritize the allocation of state and federal dollars for HIV care and prevention. As part of the plan, DPH provides a "service matrix" which shows what programs are being funded and for what services.

The problem is that there is no analysis that has been done to determine whether we are, in fact, reaching those priority populations. An additional problem is that the priority populations are based on statewide data and not on a regional or city basis.

We propose targeting two major cities hardest hit by HIV/AIDS (Hartford and New Haven) and one small city (Willimantic), to look at the epi data and overlay prevention services to see if they match up or if there are significant gaps.

CT receives approximately, \$7 m from the Centers for Disease Control (CDC) and the state allocates approximately \$1 m for HIV prevention. Additionally, the state provides \$455,000 for 5 Syringe Exchange Programs (SEPs) in Hartford, New Haven, Bridgeport, Stamford and Danbury.

What we don't know: are we reaching CT's priority populations targeted for HIV prevention?

**Methodology:**

We proposing the following data/information be used in the analysis:

1. Priority populations identified in the Comprehensive Statewide Plan
2. Prevention matrix developed by DPH
3. DPH epidemiological, HIV/AIDS surveillance and SEP data
4. Key informant interviews with selected HIV prevention programs in each area for both qualitative and quantitative data.

After collecting the information, we would like an analysis to determine who is being reached in each area, are they the identified priority populations or not, what some of the challenges/barriers are identified through the informant interviews and a set of recommendations as to what we could do in order to better match data, priority populations and interventions.

**Special skills of desired students (3-5 students requested):**

Comfort with self-directed research; group facilitation skills; comfort with diverse populations; active listening skills; demonstrated writing ability.

**Resources available to students at agency:**

There is space available at CARC, with phone access, copier and WIFI. There is a community computer available in the kitchen, but we occasionally have another intern in-house.



## **UNDERSERVED POPULATIONS: Liberty Community Services**

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### *How to Target Homeless Prevention Efforts*

#### **Overview of project:**

Students involved in this project will have the opportunity to creatively identify approaches to accessing people at greatest risk of becoming homeless, at the forefront of new endeavours to prevent homelessness. Skills in identifying and networking with organizations locally and nationally seeking to address homelessness prevention will also be needed to succeed with this project.

#### **About Liberty Community Services:**

Liberty Community Services provides permanent and transitional housing for people who are homeless due to HIV and mental illness.

#### **About the project:**

One of the newest efforts in ending homelessness is to attempt to prevent homelessness. This is based upon the fact that it is better for the individual and less costly to keep people in housing rather than have them go to emergency shelter and then try to find housing again. But the problem is to try to target intervention efforts to people who will actually become homeless. This project gathers data about prevention programs and about people who become homeless.

Homeless prevention efforts need to be targeted to those who would become homeless except for the provision of the funds. This project looks at programs and also at data to see how people actually come into homelessness.

#### **Methodology:**

1. Review of homeless prevention programs from literature
2. Data on people in New Haven who are facing eviction and where they go after being evicted
3. Interviews with people who are homeless to see exactly how they lost their previous housing

For people who are homeless, the interviewees would be recruited from Liberty's current clients. They would either new people who have applied and been accepted into our housing program or who are in our Day Program. Participation would be voluntary.

For the clients facing eviction, some creative work will be required in order to develop appropriate, effective recruitment strategies. Students could sit in Housing Court and track records as to where the people facing eviction live. That would all be public record. As to how we would find out what happened after eviction, that might be part of the study to see either what public records exist or how an interview would be conducted with essentially the one question, "If you are evicted, where will you go?" I am not sure and the Practicum may leave off at that question and suggest a further study. The research question is "Does eviction predict homelessness?"

Another possibility is to consider a broader approach to data collection, including telephone interviews with key actors (program directors, etc) at homeless prevention programs that are well-established in other cities, interview case workers and agency directors at homelessness support programs around the city.

**Special skills of desired students (3-5 students requested):**

Data collection and interviewing.

**Resources available to students at agency:**

Computer searches, collecting data from housing court, interviews.



## **UNDERSERVED POPULATIONS: Partnership for Strong Communities**

### *Seizing Opportunities for Eliminating Homelessness: Aligning Services Provided through Federally Qualified Health Centers with Affordable Housing*

#### **Overview of Project:**

Students working on this project will develop an understanding of supportive housing as an approach to improving health and well being of individuals who are unable to live independently. Students will develop data analysis skills, focus group skills and interview skills in identifying the clinical needs of people in supportive housing, and identifying opportunities for aligning services provided through an FQHC. In addition, policy implications and the opportunity to identify a best practice model are very opportunities for skill building.

#### **About Partnership for Strong Communities:**

The Partnership for Strong Communities is dedicated to raising public awareness and advancing solutions to end chronic homelessness, create affordable housing and build healthy and economically vital communities.

Reaching Home, an initiative of the Partnership for Strong Communities, is the campaign to end long term homelessness in Connecticut. Through Reaching Home, the Partnership is exploring new systems for creating housing plus services and supportive housing.

The Partnership's goal is to educate the public about the human and financial costs of homelessness and the lack of affordable housing. The Partnership promotes proven solutions that enhance the lives of people who have been homeless, foster the growth of communities and more effectively use public and private resources.

Cornell Scott-Hill Health Center, one of the project partners, is a federally qualified health center that serves the greater New Haven region. The Health Center offers a healthcare for the homeless program and continually improves its practices to meet the needs of its predominantly low-income patients. CS-HHC also offers integrated medical and behavioral health care. The behavioral health services include detoxification, partial hospital, and out-patient care to children and adults at 14 locations. The Health Center would provide information about the services funding it is currently receiving to serve the homeless.

Columbus House is a homeless service provider in New Haven area that people who are homeless or at risk of becoming homeless, by providing shelter and by fostering their personal growth and independence. Columbus House will be a research partner in the project.

#### **About the project:**

Supportive housing is a proven solution to ending chronic homelessness for individuals with psychiatric illnesses, addictions and other chronic conditions such as HIV/AIDS, diabetes, and heart disease. Individuals who ricochet from emergency shelters to emergency rooms to institutional settings have a disproportionate impact on the public health system. Housing, coupled with appropriate support services, can have a rehabilitative affect on the individuals who are successfully housed and reduce costs in other public systems.

The support services that are typically provided as part of supportive housing include case management that connects tenants to clinical services, financial, educational and employment assistance. The focus of support is directed to assuring that the tenants have the support system that assists them in maintaining their housing.

The alignment of community-based behavioral health services with affordable housing remains difficult to achieve on a scale that would address the needs of the 20% of the homeless population that uses nearly 80% of services. Currently, FQHCs provide services to homeless and at-risk of homeless populations.

A severe lack of supportive housing, that is, affordable housing coupled with community-based health and social services, contributes to the public health crisis of homelessness and gridlock in our mental health care system in Connecticut. While supportive housing is an established and proven method for improving health outcomes for people with chronic illnesses who are homeless, the limited availability of affordable housing aligned with mainstream community-based health care constrains this proven solution to homelessness. Federally qualified health centers (FQHCs) serve people who are very low income, including people who are homeless. How can FQHCs align their service delivery model and resources with community partners to achieve the desired outcome a stable home for people who experience chronic homelessness? Students will examine as a case study the partnership between Hill Health Center and Columbus House to assess current practice.

**Methodology:**

Using a case study of current practice, this project is intended to determine the prospects for systems change with FQHCs, homeless service providers and affordable housing to achieve a reduction in homelessness for individuals who have been homeless for extended periods of time. Students will work with two established non-profit organizations in New Haven: Hill Health Center (FQHC) and Columbus House emergency shelter and supportive housing provider) to analyze current services and service needs of an identified population. Based on this analysis, students will evaluate practice and propose options for achieving a greater scale of results with regard to integrated housing/services model.

As part of the needs assessment students will conduct a web search for FQHCs that provide or fund services in supportive housing, to determine the existence of best practice models. Service needs of clients at Columbus House will be determined through interviews with staff, and one or two focus groups with clients. Analysis of services provided to people who are chronically homeless will utilize data from the Homeless Health Care Office at Hill Health Center.

This project provides an opportunity for Yale Epidemiology and Public Health, Partnership for Strong Communities, Cornell Scott-Hill Health Center (CS-HHC) and Columbus House to partner together to assess current practice and evaluate opportunities to achieve greater results from providers like Columbus House and CS-HHC in assuring people with chronic health problems who are homeless attain permanent housing.

**Special skills of desired students (4 students requested):**

- Strong data and policy analysis background

**Resources available to students at agency:**

- Data sources, computer access and telephones
- The Partnership for Strong Communities can provide a travel stipend for a set number of trips for a selected number of meetings in Hartford and funding for any photocopying that can't be done at the Partnership for Strong Communities office.

**Additional Information:**

- Background information about FQHCs on the Corporation for Supportive Housing website: <http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageID=705>
- Background information about supportive housing and Medicaid reform from the SAMHSA website:  
[http://dialogue.samhsa.gov/samhsa\\_communications\\_dia/corporation-for-supportive-housing.html](http://dialogue.samhsa.gov/samhsa_communications_dia/corporation-for-supportive-housing.html)
- Health Care for the Homeless providers who have received federal stimulus funding - <http://www.nhchc.org/hchirc/directory/CT.html>



## YSPH PUBLIC HEALTH PRACTICE GUIDELINES ADDRESSED BY EACH PROJECT

PRACTICE GUIDELINES	PROJECTS
Project outwardly focuses on a public health problem or issue.	<ul style="list-style-type: none"> <li>All projects</li> </ul>
Project integrates public health theory, knowledge, and skills, and applies and reinforces the learning objectives in MPH coursework.	<ul style="list-style-type: none"> <li>All projects</li> </ul>
Project and student role are appropriate for the MPH level.	<ul style="list-style-type: none"> <li>All projects</li> </ul>
Project has deliverables of tangible value to the mission of the placement agency/site	<ul style="list-style-type: none"> <li>All projects</li> </ul>
Students participate in the full spectrum of defining, analyzing and addressing a “real life” public health problem or issue (via direct work, observation, consultation with others, participation in meetings or activities, or pertinent reading).	<ul style="list-style-type: none"> <li>All projects</li> </ul>
Project entails role of participating in the development and/or execution of applied public health research in the biological, environmental and social/behavioral realms, that has an immediate impact on public health, including translational, evaluation and epidemiological research efforts that contribute to the evidence-base and efficacy of public health practice	<ul style="list-style-type: none"> <li>All projects</li> </ul>
Project entails role of participating in administrative/management activities of governmental and non-governmental public health agencies and/or health service delivery systems such as hospitals or community health centers. Activities could include organizational analysis and restructuring processes, strategic and business planning, organizational policy and protocol, financial management, budgeting and reimbursement processes, preparation of internal or external reports, human resources management, workforce development and credentialing, and addressing regulatory compliance issues such as audits and accreditation processes	<ul style="list-style-type: none"> <li>Connecticut AIDS Resource Coalition</li> <li>Leeway Community Services</li> <li>Liberty Housing</li> <li>Partnership for Strong Communities</li> <li>Yale New Haven Hospital-Department of Community Health</li> </ul>

<p>Project entails role of assessment, monitoring, and/or surveillance of population health indicators, social determinants of health, inequities associated with race/ethnicity and socioeconomic status, environmental/occupational hazards and exposures, and other public health issues.</p>	<ul style="list-style-type: none"> <li>• All projects</li> </ul>
<p>Project entails role of planning, designing, implementing <u>or</u> evaluating public health interventions.</p>	<ul style="list-style-type: none"> <li>• City Seed</li> <li>• Leeway Community Services</li> </ul>
<p>Project entails role of developing, implementing or evaluating public health laws, regulations and policy.</p>	<ul style="list-style-type: none"> <li>• Partnership for Strong Communities</li> <li>• Community AIDS Resource Coalition</li> </ul>
<p>Project entails role of supporting the development and goals of public health coalitions through community organizing and advocacy efforts, needs assessments, strategic and participatory community planning, leadership development, and assisting with the development and implementation of community health improvement plans that respond to local needs and priorities.</p>	<ul style="list-style-type: none"> <li>• All projects</li> </ul>