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### MARGINALIZED and VULNERABLE POPULATIONS

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COMMUNITY HEALTH SERVICES
Organization: Optimus Health Care
Project Title: Health Team Transformation and Joy at Work

Overview of Project
Students who work on this project will develop and administer an evidence based survey to better understand provider burnout and how it affects patient outcomes. Students will use this quantitative data to inform focus groups with providers who showed high rates of joy at work and those who did not. Students will learn how to conduct a mixed methods research study to better understand workplace factors that contribute to provider burnout. Students will compare the outcomes of two care teams, one team that went through an intervention training and one team that did not. The group will assess how this training influences providers’ ability to administer care by measuring patient outcomes among those who underwent the transformation process and those who did not.

About Optimus Health Care
Optimus aims to serve as the patient centered medical home for communities to achieve and maintain a positive state of wellness, particularly for the uninsured and underinsured. Optimus’ main functions are to provide primary care and specialty medical services to 50,000 patients throughout the greater Bridgeport and Stamford area, and to employ a patient-centered medical home (PCMH) model.

About the Project
The practice of health care is in a drastic transition period since the implementation of the Affordable Care Act. The financial strain experienced by federally qualified health care centers put extreme pressure on health care providers to achieve productivity requirements. At the same time, preparedness for value-based care requires care team to address the social determinants of health. Optimus Health Care benefited from a Project Transformation Grant from CHCACT (Community Health Center Association of CT). This grant is supporting the transformation of a care team, which includes a full range of healthcare providers from MDs to nurse practitioners to community health workers. The goal of these care teams is to be better prepared for higher-quality care outcomes. The transformation started in May 2016 and is in need of a current evaluation.

The purpose of the proposal is to understand the effectiveness of Optimus Health Care’s new care team model in improving patient care and improving worker satisfaction. Specifically, students will compare two types of care teams: those that went through the transformation process and those that did not. Optimus is curious if these transformations are beneficial at reducing provider burnout.

Provider burn-out has been documented and researched and its rate is growing to an epidemic level. Burnout is directly linked to an impressive list of undesirable consequences, such as lower patient satisfaction and care quality, higher medical error rates and malpractice risk, higher physician and staff turnover, physician alcohol and drug abuse and addiction, and physician suicide.

Methodology
Quantitative
- Administer surveys to each care team to assess degree of transformation and joy at work among providers
- Use statistical models to analyze the level of joy at work compared to transformation, daily-expected productivity, daily actual productivity, clinical complexity of patients, no show rates, average length of visit times, etc.


**Qualitative**

- Focus groups: use the data from the surveys to inform focus group questions regarding reasons for joy at work among both care teams
  - The goal should be to explain the reasons and predictors of care satisfaction as it relates to the transformation

**Special Skills of Students (5 requested)**

- Strong interest in Community Health Centers and the challenges involved
- Knowledge of basic quantitative and qualitative research methods

**Resources Available to Students at Agency**

- Access to computer on the health center network
- Access to current and historic data from the EMR
- Access to community health workers and staff for support and guidance
Organization: Planned Parenthood of Southern New England
Project Title: Achieving Pregnancy: Exploring Expansion of Infertility Services at PPSNE

Overview of Project
Students will conduct interviews and/or focus groups to better understand the needs of patients experiencing infertility in their late 20s and 30s. These patients are generally uninsured or covered by Medicaid, same sex couples, and HIV discordant couples, who disproportionately lack access to proper infertility services. Students will conduct key informant interviews among PPSNE staff and other public health officials to better understand their perceptions of infertility services. Students will also explore infertility services among similar providers and create comprehensive recommendations for PPSNE. This will include an in-depth analysis of provider care, which will teach students how to analyze different types of insurance coverage and healthcare payment plans for those who have to pay out of pocket. Overall, students will learn how to synthesize qualitative and quantitative data to produce high quality recommendations for PPSNE that will be incorporated into their infertility services model in 2020.

About Planned Parenthood of Southern New England
PPSNE currently offers a range of reproductive health services—family planning services and supplies, testing and treatment for sexually transmitted diseases, well-woman exams, Pap tests and clinical breast exams, HIV testing, PrEP/Pep, diagnosis and treatment of many cervical conditions. Increasingly, PPSNE has been moving into primary care. Two PPSNE centers—Hartford and Stamford—offer comprehensive primary care, and four other centers offer limited primary care services. All PPSNE centers offer flu shots, vaccinations for Hep B and HPV, and smoking cessation counseling and prescriptions. PPSNE has been encouraged to expand its services as a result of patient demand—for most of their patients PPSNE is the only health care provider they see all year. Demographics compel PPSNE to consider services that affect women and men later in their childbearing years. In keeping with regional trends, the average age of PPSNE’s patients has been increasing. Last year, nearly one quarter of their patients were between 30 and 44 years of age—the age range most likely to be affected by and concerned about infertility.

About the Project
PPSNE’s mission is to not only help women prevent unintended pregnancies, but also to help women achieve healthy pregnancies. A large part of ensuring a healthy pregnancy and positive birth outcome is ensuring women have access to quality reproductive health services before they become pregnant. Focusing on the needs of women and their partners of childbearing age with expanded infertility services is integral to achieving the mission of ensuring all individuals have access to services that enable them to manage their fertility, sexual health and overall well-being. Before the agency devotes significant resources to these services, however, they would like to know more about the need and current market. PPSNE will use the information and analysis of the YSPH students in deciding whether or not to expand its infertility service offerings in 2020.

The following are desired project outcomes that PPSNE has requested.

- Infertility service menu: Explore the full range of infertility services and identify those that could be provided at PPSNE.
  - Include description of services, provider credential or training, and any special equipment or testing.
  - Include information about insurance and Medicaid coverage.
- Summary of infertility providers: An annotated listing of providers currently serving low income, Medicaid and uninsured individuals in Connecticut and Rhode Island. Whether they accept
insurance, Medicaid and/or have discounted services (such as a sliding fee scale) for those paying out of pocket.

- Recommended service expansion: This would include possibly offering services at PPSNE or through a partnership with another provider.
  - Include which PP centers are the best suited for infertility services (based on location, patient mix, staff credentials, etc.).

**Methodology**

**Quantitative**

- Compile list of procedures (and procedure codes): This would include researching medical sites, journals for commonly use infertility services. Determine level of expertise (physician, midlevel, RN) and specialty or special training needed.

**Qualitative**

- Needs assessment: Summary of what is known about the need for infertility services among women and men in their late 20’s and 30’s, particularly those that are uninsured or covered by Medicaid, same sex couples, and HIV discordant couples.
- Key informant interviews: This would include interviewing PPSNE staff (clinicians, Medical Director) as well as public health officials, staff at other Planned Parenthood affiliates that are providing expanded infertility services, providers at infertility centers.

**Special Skills of Students (4 requested)**

- Understanding of medical service provision
- Medical credentials (levels of expertise and specialty)
- Proficiency with Excel.

**Resources Available to Students at Agency**

- PPSNE will commit up to $1,000 to cover cost of any directories as well as any student travel within Connecticut and Rhode Island (such as car rental, Amtrak fare to Providence).
- Students will be allowed to use the meeting rooms, telephones, temporary use of computer, printer at the PPSN office.
Organization: Southwestern Area Health Education Center (SWAHEC)
Project Title: Impact of Community Health Worker (CHWs) Certification on CHW Sustainability in Connecticut

Overview of Project
Students will explore the impacts of CHW certification on the work and payment of CHWs in other states to identify possible impacts on Connecticut. Students will conduct a financial analysis of CHWs to identify who pays for CHW services in other states and how they pay for them, and whether CHW certification has changed the payment process. Students will produce recommendations to health providers and insurance companies regarding the effectiveness of CHW certifications. Students working on this project will play a vital role in creating sustainable infrastructure for the CHW workforce in Connecticut.

About Southwestern Area Health Education Center
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 programs to meet the mission by connecting students to careers, professionals to communities, and communities to better health. Three of their main departmental components include the Community Health Workers, health career and diversity awareness programs, and community health education. In 2015-2016, they provided services to 2,881 participants that attend their programs. Their success is based on relationships and on working together to highlight their strengths, and the strengths of their community partners. Specifically regarding the CHWs, SWAHEC provides grassroots training and specialized education for CHWs, and technical assistance to employers and supervisors who are working with the CHW workforce.

About the Project
The State of Connecticut has a State Innovation Model (SIM) Grant from the Centers for Medicare and Medicaid Innovation (CMMI) and has a Community Health Worker Advisory Committee that has been working on developing the CHW workforce since 2016. The 2017 Report of the Community Health Worker Advisory Committee describes the work of the committee in recognizing the CHW workforce in CT. The definition and scope of work were developed and recognized by the State Legislature in 2017 by passing a law "An Act Concerning Community Health Workers" in Public Act 17-74. This law also charged the Commissioner of Public Health and the Director of the SIM Grant to have the CHW Advisory Committee develop a report by October 1, 2018 concerning recommendations for CHWs. The "Report to the Legislature on Community Health Worker Certification" has been completed, and has been submitted to the Legislature for the Spring 2019 session.

Community Health Workers (CHWs) are recognized as integral members of Community Clinical Teams in the new models of health care delivery and payment methodology. A study by RTI, International in February 2018 says most Centers for Medicare and Medicaid Innovation (CMMI) awards did not save significant money - but CHWs did: "Of six types of innovation components that we evaluated only innovations using community health workers (CHWs) were found to lower total costs (by $138 per beneficiary per quarter)."

Certification of CHWs is present or in the process of being developed in nearly 20 states, with Connecticut being one of them. Insurance stakeholders have said that they would not consider payment of CHWs unless there was some sort of certification or credential for the profession. A number of questions can be answered about this credential for the CHW workforce. How has certification of CHWs had an impact in other states? Has it created a system of payment for CHW services? If so, how does it work? Are CHWs a sustainable workforce in those states? CMMI has awarded a number of State Innovation Model (SIM)
grants to develop new models of health care delivery as part of health reform. Many of the SIM grants have embraced CHWs into their health reform and health systems changes.

There is a tremendous need to educate legislators, health and social service systems, public health, payers and the public about this next step. Yet, little is known about the actual impact of certification for CHWs in other states, and how it will impact Connecticut. CHWs need to be recognized part of the public health workforce, and as important members of the health care team – will certification assist with this? And, will certification provide a method of sustainable payment for CHW services? This project will have students explore creative solutions from other states to apply to Connecticut’s healthcare landscape in order to ensure CHWs become a sustainable workforce.

**Methodology**

*Quantitative*

- Track financial measurements of CHWs in other states in order to compare to the Connecticut landscape.
- Identify what payment methods are working in other contexts and create solutions to scale these methods in CT.

**Special Skills of Students (4 requested)**

- Interest in CHWs and policy development
- Understanding of health reform

**Resources Available to Students at Agency**

- Access to surveys regarding CHW payments
- Office supplies, including a computer
- Contacts of CHWs and constituents in other states
ASSESSING IMPACT IN COMMUNITY HEALTH PROGRAMS

Organization: Connecticut Voices for Children
Project Title: Preferred Payment Models for Integrating Community-Based Services with Clinical Care while Improving Health Equity for Children in CT

Overview of Project
Students who work on this project will develop their skills in assessing payment methods for child behavioral health and community-based primary care services, and will also use key informant interviews or focus groups to supplement existing information on payment methods for child health services. The team will identify the best payment methods for behavioral health and community-based services among primary care from a menu of five possible payment options. Students will review and summarize literature that looks at payment structures on the national and local level, and will use demographic and Medicaid data to analyze the potential long-term outcomes of the selected proposal. Students will then conduct semi-structured interviews and focus groups to capture perspectives of key informants and community members on important characteristics of payment methods. Students will learn how to weave existing narratives into the current literature to produce sound recommendations for Connecticut Voices for Children.

About Connecticut Voices for Children
Connecticut Voices for Children is a research-based child advocacy organization working to ensure that all Connecticut children have an equitable opportunity to achieve their full potential. In furtherance of its mission, Connecticut Voices for Children produces high-quality research and analysis, promotes citizen education, advocates for policy change at the state and local level, and works to develop the next generation of leaders. Their vision is that all Connecticut children have the opportunity to achieve their full potential, and their mission is to promote the well-being of all of Connecticut’s children and families by identifying and advocating for strategic public investments and wise public policies.

About the Project
This project aims to better understand how primary healthcare among Medicaid-enrolled families is paid for and create recommendations to better integrate payment methods for behavioral health and community based services. Connecticut Voices for Children will use the final State Innovation Model reports on primary care practice transformation and health enhancement communities to create a list of five potential proposals that the student group can choose from. Before the semester starts, students will choose one proposal to study for the entirety of the project. The group will conduct a literature review, qualitative interviews, and census data review to better understand the payment structures and healthcare delivery systems among Medicaid-families regarding primary care.

Methodology
Quantitative
- Data analysis and literature review: summarize how reimbursement efforts have been carried out in other states and use summary data to interpret applicability to state context.
  - If possible, use demographic information from the American Communities Survey database and Medicaid reimbursement data to create basic models of potential long-term impact

Qualitative
- Semi structured interviews: supplement literature review by interviewing clinical and care coordination staff at various Federally Qualified Health Centers (FQHCs) about the challenge and successes of early efforts at community-clinical integration
**Special Skills of Students (3 requested)**

- Data analysis and/or statistical software competency
- Understanding literature search tools

**Resources Available to Students at Agency**

- Meeting space on site, but prefer students to work off site
**Organization:** Leeway Outreach  
**Project Title:** Characteristics of High and Low Utilizers of Emergency Departments and Hospital Services among Leeway Community Living Clients

### Overview of Project
Students who work on this project will develop skills in electronic medical record (EMR) data analysis and interview methods. This team will compare the characteristics of individuals who continue to over-utilize hospital services versus those who do not by analyzing existing medical records and conducting qualitative interviews. Students will learn how to identify key characteristics in super-utilizer patients that contribute to high healthcare costs. Students will learn how to analyze EMR data from a sample size of about 100 patients to gain a deeper understanding of characteristics that contribute to high hospital utilization. The group will also learn how to create an interview guide that acknowledges upstream determinants of these behaviors, and to conduct interviews to gain a deeper understanding of why patients at Leeway engage in these behaviors. The team will make recommendations for Leeway’s next steps in the development and scaling this project within their current grant to reduce high cost admissions and/or ED visits.

### About Leeway
Leeway started off as a 30 bed Hospice to Care for those living with HIV/AIDS when no one else would answer the call. Today Leeway possesses 30 skilled nursing beds, 30 residential care beds, and 41 units of housing. In 2016, Leeway started the community focus groups to develop a plan to implement Community Case Management and it was launched in October of 2017. To date, Leeway has had outstanding success with reducing skilled nursing placements, hospital admissions and emergency room visits.

### About the Project
Leeway seeks to use tracking measurements to better understand upstream determinants for high hospital utilization. This project is a case control study comparing those who have had repeated ED admissions and those who have not. The objective of the project is to reduce skilled nursing placement, ED visits, and hospital admissions for Leeway community clients. Students will highlight characteristics of those individuals who continue to demonstrate high utilization of hospital services versus those who do not.

### Methodology

**Quantitative**
- Medical record analysis: compare the medical records of those with high hospital admissions rates to those who have not been readmitted. This will be in the form of a pre and post hospital utilization comparison. Students will search for trends among both groups in order to recommend best practices to reduce hospital readmission.
- Analyze records among super-utilizers and those who have not been readmitted using the following variables:
  - Number of medications per patient
  - Number of providers involved in care
  - Number of chronic illnesses
  - Pre-hospital utilization
  - Time in care
  - Percent of patients who have the same primary care physician
  - Percent of patients who have the same homecare providers
Adherence to medication regimen
Cost of hospital visit

**Qualitative**
- Participant and staff survey: implement the preexisting survey in order to obtain data regarding super-utilizer and control group characteristics

**Special Skills of Students (2 requested)**
- Statistical analysis using medical records

**Resources Available to Students at Agency**
- Access to electronic health records
- Access to office space and supplies
**Organization:** The Salvation Army, Southern New England Division  
**Project Title:** Pathway of Hope: Assessing Impactful Outcomes After a Family's Journey

**Overview of Project**

Students who work on this project will build skills in data analysis and qualitative data collection, using existing longitudinal data to assess trends in indices of client sufficiency and hope complementing the longitudinal data with interviews. Students will gain skills in working with a real data set that suffers from data collection and documentation issues, such as participant loss to follow up, to identify potential epidemiologic solutions. Students will work with two national matrices: The Client Sufficiency Matrix and the Herth Hope Index. Students will use Pathway of Hope (POH) data from these two matrices to analyze the success of the program. Students will also learn how to interview marginalized populations effectively. Thus, students will be able to understand the effects of POH at various points during the family's journey.

**About The Salvation Army**

The Salvation Army has been working to ensure that the basic needs of Connecticut residents have been met since 1884, serving thousands of households each year with care and compassion. They provide food from their food pantries, clothing and furniture vouchers, and seasonal assistance such as toys for children, etc.

To counteract the effects of intergenerational poverty, The Salvation Army provides targeted services to families with a desire to take action in order to disrupt the cycle of crisis & intergenerational poverty. This approach focuses on possibilities, not problems, as families work towards self-sufficiency. This strengths-based initiative is known as Pathway of Hope (POH). The Salvation Army houses Pathway of Hope in the existing Corps Community Centers, which are intentionally embedded in economically distressed communities so that candidates can have ease of access. Pathway of Hope offers motivated families another perspective on life through case management, goal setting, and community referrals. Pathway of Hope case managers guide families to new ways of thinking and problem solving for up to two years, with the average being for 18 months.

The Salvation Army has seen significant gains among the families who have graduated from Pathway of Hope since it was implemented in Meriden, New Haven, and Bridgeport in 2016:

- 100% acquired new life-skills and improved overall stability
- 90% improved job skills/education
- 60% increased family income
- 60% achieved a higher level of employment
- 45% engaged children in enrichment programs.

**About the Project**

Without proof of Pathway of Hope's impact and efficacy, the program sustainability and growth are limited. The objective of the project is to learn what difference POH is making in the lives of those served so resources can be strengthened in the three existing Pathway of Hope service sites (Bridgeport, Meriden, New Haven, CT). To this end, The Salvation Army is looking to answer the question, “Does participation in Pathway of Hope truly increase a family’s sense of hope and self-sufficiency?”

For this project, students will gather qualitative data among the current and graduated families of the Pathways of Hope and case managers to evaluate POH’s success metrics. The data will measure POH’s impact on three metrics: increased self-sufficiency, increase hope, and increased income among the POH families.
Methodology

Quantitative

- Measure the outcomes of Pathways of Hope by creating an impact achievement analysis
  - Data will be available on the New Haven site only, dating back about two and a half years from the start of the POH program in 2016
- Students will analyze three variables in particular to measure the success of the current POH model: increase self sufficiency, increased hope, and increase income
  - Increased self sufficiency was measured using the Client Sufficiency Matrix
    - This matrix examines the family's self-reliability across different domains: income, employment, housing, food, child care, children's education, adult education, legal, healthcare, life skills, mental health, substance abuse, family relations, mobility, and community involvement.
    - The family receives a score from 1-5 in each domain (with 1 representing an extremely low ability to achieve stability in the corresponding domain and 5 representing a complete lack of need for assistance in achieving stability independently), resulting in an overall sufficiency score with a range of 15-75.
  - Increased hope was measured using the Herth Hope Index
  - Increased income can be found in previous reports

Qualitative

- Semi-structured interviews with families: conduct a program evaluation of POH using family narratives and lived experiences to supplement quantitative data
  - Graduates of POH were enrolled for an average of 18 months and are available for interviews
  - Students should attempt to understand the different familial experience at different points in time during the 18 month time span
- Observational data and interviews with case managers: analyze the quality of data being collected by observing the case managers of the POH program
  - Students will observe how case managers input data into ServicePoint and create recommendations for better data collection methods

Special Skills of Students (3 requested)

- Outcomes measurement analysis
- Understanding of limited resources of non-profits
- Understanding of complex barriers that confront families living in poverty
- Articulate expression of key areas for outcomes measurement

Resources Available to Students at Agency

- Pathway of Hope data collection sources
- Access to Salvation Army leadership, community partners, Pathway of Hope case managers, and Pathway of Hope graduates and participants
**Organization:** Yale Regional Lead Treatment Center  
**Project Title:** Time Under the Curve: Do Regional Lead Treatment Center Home Visits Impact Length of Exposure in Lead Poisoned Children?

**Overview of Project**
Students who work on this project will develop skills in interviewing, health education, development of health information materials, and data analysis using electronic medical record (EMR) systems. Students will be stationed in three prenatal care clinics throughout New Haven and develop/administer a screening tool to rule-out families at risk of living in homes with potential lead hazards. During the semester, students will provide on-site lead prevention education. Students will learn how to create infographics that utilize high level research analysis that are informative and digestible for a public audience. Graphics will include a visual model of how lead impacts various parts of the human anatomy to be used as an educational tool. In addition, students will learn how to manage the Yale-New Haven Health System’s electronic medical record (Epic) in order to verify existing data. Students will gain a deeper understanding about how to bridge data from existing health departments to cross-reference lead inspections completed at appropriate residences. Lastly, students will observe at least one specialty clinic with the YRLTC’s Medical Toxicologist and at least one home visit with the Healthy Homes Specialist (MPH, HHS) and Clinical Social Worker (LCSW).

**About Yale Regional Lead Treatment Center**
The Yale-New Haven Children’s Hospital Lead Poisoning and Regional Treatment Center is a medical treatment and social service program that provides comprehensive care to lead poisoned children and their families. Established in 1991, the Yale Regional Lead Treatment Center (YRLTC) is one of two medical facilities in Connecticut dedicated to assisting those families with children impacted by plumbism, with its sister site located at Connecticut Children’s Medical Center (CCMC). Every year, the Yale Regional Lead Treatment Center (YRLTC) monitors the screening of over 4,000 blood lead level draws throughout Southern Connecticut and is actively following over 400 children with elevated blood lead levels. As one of two regional treatment centers in Connecticut, YRLTC’s integrated approach is carried out through educational efforts and initiatives at the local, regional, and state levels. Every year, the Yale Regional Lead Treatment Center monitors the screening of over 5,000 blood lead level draws throughout Southern Connecticut and is actively managing over 400 children with elevated blood lead levels that are at or above the reference level of 5 ug/dL established by the Centers for Disease Control (CDC) Action Guidelines in 2012.

In 2015, the YRLTC experienced a pivot as its model shifted from a predominantly medical approach to an interdisciplinary model, introducing increased influence from public health and social work perspectives. The new methodology put greater emphasis on securing home visits with trained clinical staff to develop care plans relevant to realities of the environment in which these families live. The YRLTC collaborates with local health departments to identify both environmental and non-environmental lead hazards. Home visits focus on the child-in-the-environment to assess developmental benchmarks and highlight behaviors that put each specific child at risk for plumbism. The YRLTC works with parents to identify gaps in knowledge and equip them with concrete tools to modify the condition of their homes in effort to reduce access to exposure risks.

**About the Project**
Since the implementation of the treatment model, a total of 315 home assessments have been completed and 528 cases have been marked “resolved.” Resolved cases indicate any patient whose blood lead level has decreased to < 5 ug/dL, moved out of state, or declined further intervention from the treatment
center. Since involvement from the YRLTC is referral based and voluntary, not every patient observed receives a home visit. The YRLTC tracks the blood lead level trends of all patients, starting from the very first elevated level. The YRLTC would like to verify whether there is any significant correlation between patients who receive a home visit from the treatment center and the overall length of time a child is diagnosed with plumbism. The YRLTC would like YSPH students to evaluate the validity of the interdisciplinary approach and will use these results to compare outcome measurements to others sits that continue to practice under the old medical model.

**Methodology**

**Quantitative**
- Data analysis: measure lead toxicity through the following variables:
  - Length of exposure time for peak levels of 5-9 ug/dL, 10-14 ug/dL, 15-19ug/dL, 20-44 ug/dL, and 45+ ug/dL
  - Intervention type (phone call, home visit, specialty clinic, local health inspection, relocation, or none)
  - Rate of re-exposure
  - Occurrence of co-occurring disorders such as Autism Spectrum Disorder, anemia, and speech delay (at the discretion of the analysts given data availability)
- Info-graphic production: synthesize quantitative data into aesthetically pleasing lead health educational material

**Qualitative**
- Observations among specialty clinics and at home visits: improve understand of the lead treatment approach and data under analysis

**Special Skills of Students (4 requested)**
- Previous data analysis experience
- Development of info-graphics
- Interest in the physiology of lead toxicity

**Resources Available to Students at Agency**
- Previous data regarding lead toxicity levels in New Haven households
- Office space and supplies
- Transportation to home visits
**Organization:** Yale New Haven Health  
**Project Title:** Identifying and Mapping Community Resources and Assets

**Overview of Project**
Students working on this project will learn about an assets-based framing for community needs assessments, and will use a combination of literature review, web search and key informant interviews to identify community assets across five communities served by the Yale New Haven Health System. Non-profit hospitals across the country are required to conduct Community Health Needs Assessments on a triennial basis as part of the Health Care Reform Law. The 2019 assessment is the first to require the identification of community assets or resources, which are broadly defined as anything that can be used to improve the quality of community life - it can be a person, a physical structure or place, and/or a community service. Students will work to capture the assets and resources within the five different communities served by the hospitals and develop a final report, which will be included within the 2019 Community Health Needs Assessments.

**About Yale New Haven Health**
Yale New Haven Health includes Bridgeport Hospital, Greenwich Hospital, Lawrence + Memorial Hospital, Yale New Haven Hospital and Westerly Hospital, and a physician foundation, Northeast Medical Group. With 25,199 employees and 8,287 medical staff, the Yale New Haven Health System had 125,932 inpatient discharges in the 2017 Fiscal Year, and 2.4 million outpatient encounters. As part of the Yale New Haven Health System, corporate members may take advantage of services and clinical specialty networks designed to increase patient access to care, improve quality and safety, and reduce costs. Corporate members can take advantage of integrated, centralized services designed to increase efficiencies and reduce costs. YNHH remains committed to working with their corporate members, network participants and their affiliated physicians, and other partners to find solutions that yield results.

**About the Project**
Community assets or resources are broadly defined as anything that can be used to improve the quality of community life. It can be a person, a physical structure or place, and/or a community service. They can be used as a foundation for community health improvement particularly when external resources or grants may not be available.

Yale New Haven Health’s five hospitals are charged with identifying community assets/resources in each of the communities they serve and in turn include them within the 2019 Community Health Needs Assessments. Subsequently identified assets or resources will be utilized in the 2019 – 2021 Community Health Improvement Plans to improve health and wellbeing of the community. Non-profit hospitals across the country are required to conduct Community Health Needs Assessments on a triennial basis as part of the Health Care Reform Law. The 2019 assessment is the first requiring the identification of community assets or resources. Assets and resources vary within each community and are not currently available in a mechanism suitable for reporting and using within the needs assessment documents.

The objectives of the project are to capture the assets and resources within the five different communities served by the hospitals and develop a final report which will be included within the 2019 Community Health Needs Assessments.
Methodology

Secondary data collection will include reviewing and compiling various resources that identify potential community assets and resources. There may be some primary data collection required to fill in gaps particularly in priority areas identified for the 2019 – 2021 community health improvement plans.

The Yale School of Public Health Student Consulting Group has decided to take on the project starting in October 2018. The work related to identifying the methodology as well as data collection for the asset mapping will be clarified before the end of the calendar year. This will provide better direction for the YSPH Practicum Team. This is a large project and YNHH is well aware of that in terms of size and scope. Their hope is that the YSPH Student Consulting Group team and YSPH Practicum Team can leverage one another as a resource. By having two teams it also provides clear direction in terms of geography being covered by each team with five different regions to cover this should make the project easier to accomplish. The project management skills and general experience of the preceptor should help to alleviate any concerns about two teams working on this project.

Special Skills of Students (5 requested)

- At least one student should have experience with GIS mapping

Resources Available to Students at Agency

- Access to internal staff, public health professionals, and data specific professionals from across the state
MARGINALIZED AND VULNERABLE POPULATIONS

Organization: APNH: AIDS Project New Haven/A Place to Nourish your Health
Project Title: Evaluation and Prioritization of Behavioral Health Service Needs of LGBTQ Community in Greater New Haven

Overview of Project
Students in the course will conduct a community needs assessment involving surveys with existing clients and interviews with key informants to determine which behavioral health services are most needed for specific stigmatized population and what should be the prioritization in building APNH’s new program. Students will engage with medical and behavioral health professionals in the community and members of stigmatized populations to evolve a comprehensive understanding of the current climate surrounding behavioral health services. Students will also gain a better understanding for analyzing existing reimbursements available that are needed to provide these behavioral health services. Students will produce recommendations that will be used in future grant funding applications.

About APNH: AIDS Project New Haven/A Place to Nourish your Health
APNH is the oldest AIDS service organization in the state of Connecticut, founded in 1981. APNH offers medical case management, mental health counseling, pharmacological evaluation and management, substance abuse counseling, emergency financial assistance, transportation, support groups, home meal delivery, medical nutrition therapy, nutritional counseling, emergency food pantry, outreach, health education, risk reduction, HIV-testing and linkage to care, complementary alternative therapies, medication adherence nursing and 340B pharmacy services.

APNH is in the process of re-identifying themselves as an organization. In October 2018 they took on a new name in order to adapt their services to a broader range of individuals. Their mission is to deliver high quality, relationship based, and culturally competent care to individuals living with HIV, and now they have expanded their services to include non-HIV infected clients. APNH is uniquely positioned to address communities that are affected by four sources of stigma: gender identity, sexual orientation, addiction, and mental health. A recent search of behavioral health services in the greater New Haven area found no agencies that are specifically identified as serving the LGBTQ community and their behavioral health needs.

About the Project
As APNH expands its mission and vision to the HIV non-infected client, they aim to focus on building a safe environment with high-quality, relationship-based, and culturally competent care, thus meeting a vital need in the community. Today, APNH has 290 active case managed clients and of those 63 are engaged in behavioral health programs, 37 receive both mental health services and substance use treatments, 16 receive only substance use treatments, and 10 receive only mental health treatment. The objective of the project is to determine which behavioral health services are most important for certain stigmatized populations and what should be the prioritization in building the program.

Methodology
Quantitative
- Review medical billing practices: gather information regarding current reimbursements available for different behavioral health services and create suggestions for APNH based on this knowledge

Qualitative
- Needs assessment: survey existing clients, interview key informants (medical and behavioral health professionals), conduct focus groups with members of stigmatized populations
Special Skills of Students (5 requested)
- Familiarity of medical billing practices
- Survey and interviewing development skills

Resources Available to Students at Agency
- All office supplies at APNH, including desk, computer, telephone, copy machine
- Information regarding past service delivery and utilization data
- APNH will contribute $1,000 to ensure project success
Organization: Leeway Clinical Services  
Project Title: Resident Satisfaction and Patient-Centered Care in a Long Term Care Facility: Developing a Metric for Assessment and Quality Improvement  

Overview of Project  
Students will learn how to develop and pilot a validated tool to assess patient perspectives and promote client-centered care in a long-term nursing facility. Students will utilize a breadth of qualitative research methods to produce desired outcomes. Students will learn how to create a survey that holistically addresses patient needs and seeks to provide a voice to patient concerns. Students will learn how to incorporate observational data and qualitative interviews into the creation of a patient survey that assess the quality of resident satisfaction. Students will learn how to empower and build self-efficacy among residents by communicating their existing needs to healthcare providers at Leeway. The survey will build off an existing needs assessment from Leeway residents in an attempt to create a culture of patient centered care.

About Leeway  
Leeway, an integral part of the continuum of AIDS care, 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. 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 mind, body and spirit. Leeway is committed to promoting quality of life and dignity to all those with HIV/AIDS.

About the Project  
The purpose of this project is to develop a “pilot” survey to address resident satisfaction, resident needs, and opportunities of improvement from the resident’s perspective. These results will provide measurements for hospital quality improvement and increase resident ability to provide person-centered care. Person-centered care promotes choice, purpose, and meaning in daily life. Person-centered care means that long-term care residents are supported in achieving the level of physical, mental and psychosocial well-being that is individually practicable. This goal honors the importance of keeping the person at the center of the care planning and decision-making process. Care plans are living documents that are revised to reflect a person’s changing needs. In person-centered care, staff places a premium on active listening and observing, so staff can adapt to each resident’s changing needs regardless of cognitive abilities. The descriptive results and suggestions from this “pilot” resident experience survey will provide a clearer and more comprehensive picture of the resident’s needs and assist staff in providing person-centered care.

The residents at Leeway have identified a list for potential areas of improvement, which include the increase of recreational services (i.e. additional out trips), timely response from nurses to their call lights, a diversity of food options (i.e. food not recommended by doctor), environmental changes (i.e. room is too cold), and general improvements in quality of life (i.e. additional smoke breaks and enhanced social activities).

Methodology  
Qualitative  
- Observe skilled nursing residents  
- Interview department staff  
- Interview 3-5 former residents to formulate survey questions  
- Develop qualitative questions for the resident experience survey
• Conduct resident experience survey with 30 skilled nursing residents
• Provide Leeway with a resident satisfaction baseline

**Special Skills of Students (5 requested)**

• Willingness and ability to develop trustworthy relationships with residents
• Ability to establish a safe and comfortable environment that enables residents to share their concerns and recommendations without reservation

**Resources Available to Students at Agency**

• All technical resources will be made available to students
**Organization**: Norwalk Health Department  
**Project Title**: Characteristics of High Risk Groups: Analysis of Student Body Mass Index (BMI) Data Report

**Overview of Project**
Students on this project will work with school district data to identify prevalence and risk factors for childhood overweight and obesity. Students will learn how to clean and analyze pupil body mass index data from Norwalk Public Schools to determine rates of childhood overweight and obesity in the community. Students will work with data from multiple sources, including pupil Health Assessment Records (from Kindergarten, 6th, and 9th grade) and measurement data from school nurses (3rd grade). The team will calculate pupil BMI and assess levels of community obesity. The group will also learn how to aggregate data to find trends among obesity rates. Students will learn how to think critically about a child’s environment and to show how that shapes their social determinants of physical health. In addition, students will create and publicize a report communicating the results of the analysis for the usage of families affected by childhood obesity.

**About Norwalk Health Department**
The Health Department’s vision statement is "excellence with efficiency," and its mission is to prevent and control the spread of disease, promote a healthy environment, and protect the quality of life within our changing community. As a municipal health department serving the 88,000+ residents of Norwalk and numerous community members from surrounding towns, the Health Department offers programs and services in Environmental Health, Clinical Services, Health Education, Emergency Preparedness and more. Norwalk achieved national public health accreditation in June 2014.

As part of its work to measure the community’s health, the Norwalk Health Department works with Norwalk Public Schools to monitor rates and trends of childhood obesity. Obesity and chronic disease, especially among children, are important community health priorities in Norwalk, but local data about these issues are not easily accessible. Much of the obesity data available through the Centers for Disease Control and Prevention and other sources are only available at the county level. With multiple agencies, organizations, and individuals working on interventions to address these priorities, the Health Department believes it’s essential to have local data to better target Norwalk Health Department’s resources, track their progress over time, and identify trends.

**About the Project**
The Norwalk Health Department requests assistance in data analysis and visualization to update its periodic Student BMI Data Report, which has not been updated in 5 years. The Health Department will partner with Norwalk Public Schools (NPS) to export and de-identify height, weight, school, grade level, gender, and race/ethnicity from student medical records. Students working on this project, under the direction of the Health Educator and Director of Health and in partnership with NPS will clean the data and work with partners to identify and solve any data issues; analyze the dataset to determine the rates of overweight and obesity in NPS as a whole and among relevant subgroups; identify any significant findings or trends; compare results in Norwalk to other relevant comparison groups; assist with the preparation of a report to communicate findings to the public and specific stakeholder groups; and if time allows, collect qualitative data from stakeholders about the results and childhood obesity prevention efforts. Students will not be required to spend time at schools for the quantitative data collection/analyses, but they may want to visit schools for qualitative data collection.
Methodology

Quantitative
- Clean and analyze rates of childhood obesity in Norwalk schools

Qualitative
- Key informant interviews with stakeholders (e.g., school administrators, school nurses, Wellness Committee members, City officials, others)
- Small group discussion with others (e.g., students, Wellness Committee members, school staff, parent groups).

Special Skills of Students (5 requested)
- Qualitative and quantitative data analysis

Resources Available to Students at Agency
- Public school data sources
- Office supplies, such as computer, conference room, phone, etc.
**Organization**: Downtown Evening Soup Kitchen  
**Project Title**: Developing a Trauma-Informed Environment for Food Assistance Programs

**Overview of Project**

Students working on this project will develop skills in understanding use of physical space in a community health services setting, while applying best practices of Trauma-Informed Care to a soup kitchen. The team will assess DESK's current physical space through the lens of a Trauma-Informed Care, offer recommendations for redesigning the physical space, design and administer surveys, focus groups, and interviews with clients, staff, and volunteers to determine current perceptions of DESK's physical space and cultural environment, as well as general preferences that elicit physical comfort. Since this project is heavily situated in qualitative interviewing, students will learn how to engage with marginalized and vulnerable communities in the context of academic research. Students will learn how to collect data from these communities, while being hyper-aware about how one’s past experiences could lead to traumatization during the interviews. Throughout the project the group will learn how to extract data from the literature and synthesize it with a real-world example in order to make recommendations for DESK’s physical space. Lastly, students will be able to explain how the built environment has potential to shape an individual’s self-efficacy, various social networks, and create systemic change in benefiting the community's health outcomes.

**About Downtown Evening Soup Kitchen**

DESK's Evening Meals program operates year-round: seven nights per week from September to May and five nights per week during the summer months. Over the course of the year, the program serves just over one thousand unduplicated individuals, providing roughly 45,000 individuals meals. Many of the volunteers come as part of regularly scheduled groups from local faith-based congregations, schools, businesses, and social groups. DESK also works with volunteers from several other agencies who provide day-programs for people with mental health disorders who are working to acquire skills to enter the workforce. The evening program regularly hosts staff and volunteers from the Yale School of Nursing and the Cornell Scott-Hill Health Center to offer onsite health services. In addition, the guests are treated on occasion to performances by professional musicians from Dignity Music, and beginning this summer, DESK will host elected officials regularly to meet and engage clients on issues that affect them.

For over thirty years, Downtown Evening Soup Kitchen (DESK) has provided nightly meals and weekly groceries to the most vulnerable segment of the community: people experiencing homelessness and living in poverty. But in thirty years, a lot has changed in how service providers work with the population. While DESK’s volunteers have long endeavored to provide a safe, warm, and welcoming environment, there is a growing concern that our failure to be entirely cognizant of the effects of the space, room, flow-of-movement, program structure, and staff/volunteer culture may have inadvertent impacts on those with a history of trauma. DESK aims to offer a safe-space, free from physical injury, stigma, fear, and discomfort. At DESK, more than half of the people served have experienced an episode of homelessness at least once in the past four years. Additionally, more than half have histories of substance abuse and mental health disorders. Although no formal study has been undertaken to assess levels of trauma at DESK, comparative studies suggest an overlap between trauma, on the one hand, and behavioral health disorders and homelessness, on the other.

**About the Project**

DESK proposes to undertake an atmospheric assessment of their Evening Meals program, with specific attention toward Trauma-Informed Care. A trauma-informed approach considers the various types of trauma individuals might have experienced and the ways that programmatic structure and physical space...
play a role. According to the National Council for Behavioral Health, trauma has emerged as a near universal experience among people dealing with behavioral health disorders, substance abuse, homelessness, and poverty. Trauma can be defined in various ways, but all definitions characterize trauma as a breakdown of one’s coping capacity. It can involve actual or threatened death or physical injury, chronic or episodic abuse, neglect, sexual assault or abuse, domestic violence (direct or as witness), or public forms of trauma (such as natural disaster, war, or community violence). Most people experiencing homelessness today entered the system at some point already with a history of trauma; to compound that history, the experience of homelessness is, for most individuals, traumatic itself.

Trauma-Informed Care (TIC) is a widely-accepted treatment framework used by direct service providers—especially in health services—that involves understanding, recognizing, and responding to a variety of traumatic histories. TIC emphasizes physical, psychological, and emotional safety for both those receiving care and those providing care, while helping to rebuild a sense of empowerment.

The objectives of the project are to assess current physical space though the framework of trauma informed care, and solicit feedback from clients, staff, volunteers, and partnering agencies in order to offer recommendations for redesigning the physical space. The proposed project is designed to produce practical and actionable results. The recommendations regarding immediate, short-term, and long-term changes to DESK’s physical space will be incorporated into DESK’s strategic plan, with the ultimate goal of providing a safer and more welcoming atmosphere, conducive to the clients’ wellbeing and recovery. Additionally, research and recommendations can be shared with other service providers, both locally in New Haven, as well as beyond the immediate service area, so as to be a model in deploying trauma informed approaches in food assistance settings.

**Methodology**

**Quantitative**
- Literature review: outline best-practices and successful case studies in which Trauma-Informed Care was implemented in a social service setting, preferably in the context of a food assistance program. The literature review will also consider best-practices in designing or modifying spaces for soup kitchens.

**Qualitative**
- Focus groups and interviews: determine current perceptions of DESK’s physical space and cultural environment, as well as general preferences that elicit physical comfort. (Note: Special care will be taken to avoid questions of personal histories of trauma.)
  - Recommended target samples sizes for client feedback are: 50 respondents for survey, 15 for focus groups, and 5 for one-on-one interviews. Recommended target sample size for staff interviews is 2; and recommended target sample size for volunteer interviews is 5.

**Special Skills of Students (5 requested)**
- Data collection methodologies, specifically skills involving interviewing and surveying vulnerable communities

**Resources Available to Students at Agency**
- Access to staff, volunteers, and clients for the purpose of interviewing
- Access to a desktop computer for 20 hours a week
- Limited number of gift cards as compensation to clients who participate in study
**Organization**: New London Homeless Hospitality Center (NLHHC)

**Project Title**: Integrating Diabetes Care Services in a Homeless Hospitality Center: A Process Evaluation

**Overview of Project**
Students who work on this project will develop skills in using existing data metrics and qualitative data collection to assess the second phase of NLHHC’s ongoing pilot project targeting people experiencing both homelessness and diabetes. Students will conduct a process evaluation of the pilot to identify approaches to improve recruitment and service delivery to better achieve program objectives. Students will assess health metrics regarding shelter guests’ participation, medication compliance, health education engagement, and linkage between participants and primary care providers. Students will use qualitative methods to capture client and provider perspectives on the ongoing pilot program.

**About New London Homeless Hospitality Center**
NLHHC’s mission is to offer hospitality to their single homeless adult neighbors and to provide a bridge for them to permanent housing. NLHHC mission involves four key components: hospitality, emergency shelter, bridge to permanent housing, affordable and supportive housing.

NLHHC’s daytime hospitality center serves as the primary “front door” for individuals seeking access to services through the New London county coordinated access process. The emergency shelters helps patients regroup and set a course to permanent housing. NLHHC partners with other organizations to ideally provide every adult experiencing homelessness in the region with access to emergency shelter. NLHHC also contains limited beds to serve its members more immediately. Preference is given to those experiencing homelessness and facing serious health challenges. With a focus on rapid rehousing, NLHHC manages a variety of high-quality affordable housing options, which are financed by public rental subsidies such as rental assistance program (RAP) vouchers. NLHHC also purchases multi-family buildings and rents them out at reasonable rates.

NLHHC seeks to offer this hospitality and bridge to permanent housing to all single adults facing homelessness in our region. Their 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. Those most in need of our hospitality are also, in many ways, the hardest to “serve”. To reach these individuals NLHHC needs to be as flexible as possible.

“We need to open doors not set up barriers. We need to be patient. We need to meet them where they are. We need to respect their rights to make their own choices about their lives so long as those choices to not harm other people.” - NLHHC

Finally, NLHHC is committed to achieving cost effective results on behalf of their guests and funders. They recognize both local and national trends in order to improve their outcome metrics.

**About the Project**
One in five dollars currently spent on health care relates to diabetes. For people experiencing homelessness the percentage could be even greater. Improved outcomes for people experiencing diabetes will be achieved with improved medical care but also by lifestyle changes very much linked to stable housing. LNHHC aims to use their resources as a homeless response system to partner with other health care providers to leverage social determinants (especially housing and nutrition) to improve health outcomes and reduce health care costs among their clients.
NLHHC seeks to leverage shelter based and housing services to support the improvement of health among individuals experiencing homelessness. Specifically, the project aims to educate super utilizers of health care resources and teach these individuals how to better manage their diabetes in the context of their current lived experiences.

NLHHC has done extensive research on social determinants of health, but they acknowledge that action to engage providers about these factors has been limited. Students will assist in the implementation of NLHHC’s second pilot as feasible, and use public health best practices to develop a set of recommendations for NLHHC.

**Methodology**

- Assess the second phase of NLHHC’s second pilot program
- Below are a set of project objectives that should be assessed by the student group:
  - Identify shelter guests or other HHC program participants who are diabetic and interested in taking part in the pilot
    - Are all available sources of referrals being tapped into?
  - Offer basic health education on self-management and medication compliance.
  - Increase linkage to primary care provider for those who elect to take part.
  - Increase medication compliance where appropriate.
    - Based on interviews with participants, is medication usage increasing or decreasing due to their involvement in the pilot program?
  - Support adoption of improvements in diet for housed guests
    - How can the pilot improve methods of encouraging healthy eating?
  - Increase engagement in diabetes education programs.
    - What are key resources that participants could be encouraged to use to manage diabetes?
  - Increase linkage to specialty care.

**Special Skills of Students (3 requested)**

- Experience in community based health interventions

**Resources Available to Students at Agency**

- Staff and participants will be made available for interviews