## EPH 542b: Practice-Based Community Health Research 2020

### PROJECT PROSPECTUS

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COMMUNITY HEALTH ASSESSMENT AND OUTREACH

Organization: Farmington Valley Health District

Project Title: The prioritization, collection and analysis of primary and qualitative data for purposes of advancing a local Community Health Assessment

Overview of Project

Students who work on this project will collaborate with Farmington Valley Health District and its recently convened community health assessment (CHA) advisory group to begin the CHA planning and implementation process. Students will 1) identify gaps in secondary data, 2) develop primary data collection tools and methods, including survey instruments, focus groups and key informant interviews, 3) collect primary data including at least two focus groups and two key informant interviews, and 4) summarize primary data collection in support of the CHA. A community health assessment is a systematic examination of the health status indicators for a given population used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community’s health needs and identified issues. In order to perform this community health assessment, FVHD must identify data gaps as well as areas where primary data collection may be necessary. The student work is essential to successful completion of the CHA in a timely manner. Findings from this project will inform FVHD’s CHA, which will serve as the basis for a health improvement plan.

About Farmington Valley Health District

The Farmington Valley Health District is the governmental, local health agency serving ten towns (Avon, Barkhamsted, Canton, Colebrook, East Granby, Farmington, Granby, Hartland, New Hartford and Simsbury) and a population of approximately 110,000 north and west of Hartford. District staff includes a Director, an administrative assistant, eight environmental health professionals, an emergency preparedness coordinator and a community health coordinator. FVHD operates out of a central office in Canton. The current mission of FVHD is: To prevent disease outbreaks and conditions that give rise to poor health, promote health programs and policies that support good health and protect members of our community from health threats-both the everyday and the exceptional.

The key functions of FVHD align with our mission. The environmental health program enforces the Connecticut public health code and FVHD regulations to ensure that the publics’ health is protected while eating in restaurants, swimming in public bathing areas and receiving services at salons. This program also protects the groundwater and ensures that on-site waste water systems are installed and maintained properly. An expanding community health program conducts health education and provides programs on health promotion and disease prevention, often in partnership with community organizations and agencies. Our preparedness program tracks and monitors emerging infections, maintains the FVHD emergency preparedness plans, conducts trainings, drills and exercises and works collaboratively with emergency managers in the towns.

In 2014, the legislature amended Section 19a-245 of the general statutes requiring “Each district department of health and municipal health department shall ensure the provision of a basic health program that includes, but is not limited to, the following services for each community served by the district department of health and municipal health department: (1) Monitoring of health status to..."
identify and solve community health problems; (2) investigating and diagnosing health problems and health hazards in the community; (3) informing, educating and empowering persons in the community concerning health issues; (4) mobilizing community partnerships and action to identify and solve health problems for persons in the community; (5) developing policies and plans that support individual and community health efforts; (6) enforcing laws and regulations that protect health and ensure safety; (7) connecting persons in the community to needed health care services when appropriate; (8) assuring a competent public health and personal care workforce; (9) evaluating effectiveness, accessibility and quality of personal and population-based health services; and (10) researching to find innovative solutions to health problems.” FVHD is striving to ensure that these key services are being provided.

About the Project

Understanding the burden of disease, risk factors and at-risk populations of a community are central to the work of public health. A periodic, comprehensive community health assessment is central to that understanding. Unfortunately, most local health departments do not have enough staff to independently conduct a comprehensive community health assessment. In July 2019, the FVHD convened its CHA Advisory Group and have been identifying and reviewing available secondary data (not collected by FVHD but available from variety of sources including Census, CT DPH, surveillance systems etc.). The Advisory Group is currently in the process of identifying data gaps and areas where primary data collection may be needed. To advance that work, FVHD will need additional resources and students have been extremely helpful in this work at CT DPH, other local health departments and FVHD in the past.

The first objective of this project is to identify gaps in data currently available to the health district that are important to understand public health issues that are actionable at the local level. To date, FVHD staff and the CHA Advisory Group have established criteria regarding what types of data they are most interested in, identified key indicators and measures available across multiple data sources and have begun to analyze the available secondary data. The second objective will be to determine how best to collect primary data that either helps fill some of the established priority areas and/or helps to better inform some of the secondary data. This will involve the development of survey instruments, focus groups and key informant interviews.

Students’ work will inform a critical component of FVHD’s community health assessment and will be written into that document. The CHA will be a public document and will be shared broadly with the communities we serve and our partners. It will serve as the basis for an overall health improvement plan that will outline the specific goals, objectives and measurable outcomes that FVHD’s community partners hope to prioritize and address over the next three-five years. Further, the CHA is a critical pre-requisite to accreditation and will significantly advance FVHD’s efforts to ultimately become accredited.

Methodology

Needs Assessment – Qualitative and Quantitative

- Identifying gaps in secondary data
  - Students will compare existing secondary data to that of other local health assessments to determine data gaps. Emerging data gaps include youth obesity and access to care among specific segments of the population including those experiencing economic insecurity, housing insecurity, employment insecurity, and the aging population.
• Students may conduct key informant interviews, focus group discussions and targeted surveys to further inform some of the data gaps identified. Students would develop the focus group and interview discussion guide, transcribe data, and summarize key themes.

• After identifying gaps in secondary data, students will identify the best methods for collecting primary data necessary to fill the gap in secondary data.

Special Skills of Students (3 requested)

• Experience with data analysis, collection, and interpretation
• Excellent written and verbal communication skills

Resources Available to Students at Agency

• Access to office supplies and office space to work from.
• Access to in-kind staff support, particularly to provide access to data sources, model community health assessments, and public health accreditation requirements that will inform the project.
Organization: United Way of Western Connecticut

Project Title: Developing Stamford’s Vision for the Connecticut Food Action Plan

Overview of Project

Students who work on this project will develop skills in facilitating community conversations/listening sessions, refine their understanding of approaches to improving the state food system and community food security, and present and package their findings for decision makers to understand. Students will support the first phase in the development of a Connecticut Food Action Plan. Primary objectives will be to conduct facilitated conversations (“listening sessions”) with community members to learn what they would like to see in the statewide plan. Students will conduct analysis on these sessions and consolidate findings into a report. In addition, students will conduct secondary research on food systems and food policy using both academic and grey literature, which will further inform recommendations to United Way and its partners.

About United Way of Western Connecticut

United Way of Western Connecticut (UW) was established in 1942 and serves 15 towns and cities in Fairfield County and Southern Litchfield County (Greater New Milford). In Fairfield County UW serves the residents of Greater Danbury and Stamford. United Way is committed to ensuring that every family is financially stable, every child enters school ready to learn and graduates ready to succeed, and every community we serve is healthy and strong. UW’s mission is to improve the lives of hard-working, struggling households by mobilizing the resources of local communities to create lasting change.

United Way of Western Connecticut serves as the backbone entity for the Stamford Food Collaborative. The Stamford Food Collaborative consists of over 40 people representing more than 20 nonprofit organizations, food pantries, shelters, food banks, grocery stores, and schools, as well as passionate community volunteers that work collaboratively to have a greater impact on reducing community hunger and food insecurity in Stamford. The collaborative created and continuously updates the Stamford Food Guide that provides information about access to food. The group has also jointly sought grants that have funded the purchase of new commercial refrigeration units that have allowed food pantries and Fairgate Farm to increase their offerings of fresh, healthy produce.

About the Project

Connecticut has a well-developed food policy landscape, with several local/municipal food policy councils, a state food policy council, and a grassroots food network, the Connecticut Food System Alliance. However, it is the only state in New England without a food action plan, a guiding document with food policy recommendations and indicators to organize all food system actors toward one food system. The food action plan is a framework for supporting farms and food businesses, ending hunger by ensuring food access, and promoting sustainable environmental practices. The outcomes include enhanced public health, stronger state economy, and long-term productivity for a state’s lands and waters.

Stamford is one of the larger, more diverse cities in Connecticut, and faces challenges with food security, yet does not have a plan or vision for how to address it. Stamford has an engaged, multisector Stamford Food Collaborative, but lacks involvement from community members that are unaffiliated with the nonprofit or education sector. Any effort to develop a plan for a better food
system should be led and guided by the people most affected by food insecurity and other systemic injustices in the food system that affect population health.

Conducting listening sessions around food and food security issues will thus engage the people most affected by food insecurity and injustice in the food system. These sessions will help to identify potential allies and partners in order to establish or strengthen relationships to help improve reach, impact and long-term sustainability of efforts. Engaging residents as partners in a food strategy development process has the potential to increase the sense of buy-in, ownership, and legitimacy of a Food Action Plan.

Students’ work will ultimately help to lay the groundwork for a statewide food action plan, which will serve as a blueprint for community organizations, businesses, individuals, and government agencies to build a just food system that can work for everyone. Students’ findings will serve as the foundation for strategic planning and direction for the Stamford Food Collaborative and hopefully the City of Stamford as well.

**Methodology**

**Qualitative**
- Students will conduct 2-3 listening sessions with community members. At each listening session, students will facilitate breakout groups. The goal of listening sessions is to identify what community members would like to see in the Connecticut Food Action Plan.
- After listening sessions, students will perform qualitative analysis to identify themes.
- *Literature review*: Students will perform a literature review (using both academic and grey literature) on food systems and food policy to inform their report and recommendations to UW and Stamford Food Collaborative.

**Special Skills of Students (4-5 requested)**
- Experience with facilitation of small or large-group discussions, qualitative data collection, and qualitative data analysis.
- Familiarity with food access or food justice.
- Spanish fluency would be useful, but is not required.

**Resources Available to Students at Agency**
- Students will have access to office space at UW’s Stamford office, including a printer and copy machine and various office supplies.
- Funding for food and drink to provide at community conversations/listening sessions.
Organization: Milford Health Department

Project Title: Branding Strategies and Implementation for the Milford Health Department

Overview of Project

Students who work on this project will develop skills in framing and characterizing services provided by a health department, together with strategies that will help to promote the vision of Milford Health Department in the community and enhance programming. Students will assess internal and external communication processes by examining the current approaches used at MHD and compare them to other health departments. Students will then develop, disseminate and analyze a customer focused community wide survey as to public health marketing and health promotion strategies that may be successful (or have been unsuccessful) within the community. Students will utilize the results of the survey to create a Standard Operating Procedure (SOP) for communications disseminated internally and externally to increase knowledge and awareness of future health promotion and education programming.

About Milford Health Department

The Milford Health Department (MHD) is comprised of four major divisions: Environmental Health Services, Community Health, Emergency Preparedness and School Health/Public Health Nursing Services. There are over 35 officials and staff at the MHD who are committed to protecting the health and safety of the residents of Milford. The department collaborates with the other branches of the local and State government and health-related associations to ensure strong communication at the city and community levels. The Milford Health Department (MHD) located in Milford, Connecticut serves a primarily suburban population of approximately 54,000 residents. The mission of the Milford Health Department (MHD) is to protect and promote optimal health for all Milford residents through our commitment to excellence and delivery of comprehensive public health services. To that end, agency professionals ensure the maintenance of flexible programs and public health policies based on community need.

About the Project

The Milford Health Department (MHD) is currently working on achieving voluntary national accreditation through the National Public Health Accreditation Board (PHAB). With the goal of attaining accreditation, the MHD is currently developing strategies to improve performance and quality measures and enhance sustainability in all programs and divisions. To reach this goal, the MHD has completed its strategic plan for 2018-2023. Action steps in the strategic plan include but are not limited to both extending and creating Standard Operating Procedures (SOPs) for communication. In a community survey conducted in 2018 at a city-wide health fair only 9% of respondents have used or accessed MHD’s monthly immunization clinics and 28% knew about MHD’s parent leadership program. When it came to awareness of MHD’s programming, 24% were not aware of any programs. This survey was the first community survey conducted for the health department in over 10 years.

The MHD has used the same strategies to promote and implement programs for years and every year it becomes harder to spread the word to residents. Students will help MHD enhance its ability to develop branding and communication strategies where such gaps have been identified in order to promote the Department’s mission. The results of this project will allow MHD staff to implement a new procedure/s for public health communications for health department programming. Additionally,
these strategies will be utilized to promote the mission and vision of the Milford Health Department as defined in the Strategic Plan.

Transferable skills that students will take away from the project include the development of public health marketing strategies and solutions, development and implementation of data collection methods to identify gaps in public health marketing, and utilization of data to develop and implement public health marketing strategies.

**Methodology**

**Quantitative**
- Students will develop and disseminate a customer satisfaction survey to gather data to develop and/or revise public health marketing for programs in each division.
- Students will analyze survey data and use results to develop and implement a standard operating procedure for communication to be used by MHD’s divisions.

**Qualitative**
- Review current programs and marketing strategies and comparison with other departments’ programs.
- Research regarding effective branding and health promotion strategies.

**Special Skills of Students (3 requested)**
- Students should have the ability to work independently and as a team, understand public health promotion, along with excellent oral and written communication skills and the ability to interact with professionals at various levels of government.

**Resources Available to Students at Agency**
- Access to resources to print publicity materials.
- Access to a workspace telephone, computer, email, and other MHD resources.
SERVING VULNERABLE POPULATIONS

Organization: DreamKit

Project Title: A Qualitative Study: Disrupting the Cycle of Youth Homelessness Through a Tech-Based Solution

Overview of Project

Students who work on this project will develop qualitative skills in semi-structured interviewing, focus groups, and ethnographic observation. Specifically, students will conduct interviews or focus groups with 5-10 youth (18-25) experiencing homelessness. Students will also interview landlords (5-10) and employers (5-10) to identify homeless youths’ barriers to accessing housing and employment. The goal of this data collection is to find immediate and systemic barriers youth experiencing homelessness face in gaining employment, mentorship, and permanent housing in New Haven. Students will work closely with DreamKit’s tech team to ensure that feedback from landlords, employers, and youth is directly reflected in the app. In addition to qualitative research, students will perform a literature review of current tech-based solutions regarding marginalized communities and best practices around homeless interventions.

About DreamKit

DreamKit is a 501(c)3 social impact start-up rooted in equity and social justice principles. DreamKit aims to introduce a technology-based intervention to end youth homelessness in this country, starting in New Haven.

DreamKit is a web-based app for youth (18-25) experiencing homelessness that financially awards youth for engaging in social services and simultaneously provides the local community a platform to intentionally engage in ending youth homelessness. At the individual level, youth gain points for engaging in social services (case management, workforce development programming, education, parenting classes, etc.) and can redeem these points in the city to meet basic needs (i.e. food, clothing, hygiene products, etc.), thus serving as an immediate positive feedback for participation in transformative activities. At the community level, DreamKit curates individualized resumes for youth based off their social service engagement and shares their skills with the local community (i.e. employers, police, landlords) to build bridges, reduce stigmatization, and promote economic and social stability.

DreamKit’s individually curated profile reports serve as an objective credible source when youth interact with these institutions of power. Lastly, these reports are shared with the community, who can provide social and financial forms of support (e.g., congratulating youth’s achievements or matching their points). DreamKit will then share regular progress updates with participants, such as point spending habits to improve financial literacy and new skillsets generated to improve self-efficacy. Overall, DreamKit helps youth exit homelessness more quickly and facilitates greater resilience that reduces returns to homelessness. Our aggregate data will improve the data management of local and national homeless youth agencies by informing resource development and future programing.
About the Project

We need DreamKit now because our current technology solutions (e.g., dashboards, resource map apps) fail to address critical gaps in the effort to end YYA homelessness. YYA has salient knowledge about their own experiences that system partners miss. They also have the potential to be their own agents for change but are not given the information to play that role. In our monthly meetings with CT’s YYA homelessness service providers, older adults make decisions for new programming largely without the experience and expertise of YYA, delaying decision-making and leading to inefficient solutions. DreamKit unlocks YYA resources by trusting them with their own data and making their participation tangible through rewards. It allows providers to survey YYA and receive feedback in minutes rather than months, and it provides systems with real behavioral data rather than self-reported data that may be unreliable.

Furthermore, as a society, we have no way of tracking and providing shared understanding for the experiences of homeless populations. DreamKit profiles are a way to bridge the gap between homeless youth and systems of power (landlords, employers, police, etc.) that hold the ability either break or perpetuates their cycle of homelessness. If these populations were able to view an objective track record of youth that shares their talents and resiliency, then they will more likely support youth and help them escalate out of homelessness.

Students’ work will directly inform programming and development of the DreamKit app, which will be launched in December 2019. Overall, it will be the goal of students to interview a plethora of stakeholders to uncover barriers youth face in obtaining services, housing, and employment to improve DreamKit and promote solutions on a national level.

Methodology

Qualitative

- Students will conduct interviews, focus groups, and/or ethnographic observation with youth, landlords, and employers (approximately 5-10 per group). Depending on students’ strengths, the team can decide which data collection is most appropriate. DreamKit’s team will provide connections to youth, landlords, and employers for data collection.
- Students will also perform a literature review of current successful tech-based programs for homeless youth which will inform developments in the app.

Special Skills of Students (5 requested)

- Eagerness to learn about trauma informed best practices, qualitative research methods, and overall have a commitment to improving social determinants for folks experiencing homelessness in New Haven and beyond

Resources Available to Students at Agency

- Access to a rolodex of community stakeholders who are willing to interview with students.
- Access to young people experiencing homelessness who are willing to participate in interviews and focus groups.
- $400: cash compensation for youth and/or food, qualitative data analysis software, and transcription fees.
Organization: Community Renewal Team

Project Title: CRT Medicated Assisted Treatment

Overview of Project

Students who work on this project will develop skills in recruiting and providing services for vulnerable and hard to reach populations, particularly in the context of addiction services. Students will review the existing recruitment strategies for CRT’s medicated assisted treatment (MAT) program, which prioritizes formerly incarcerated individuals and individuals with a history of involvement with the criminal justice system. Students will evaluate CRT’s current strategies for recruiting its target population (women and sexual minority individuals) and compare these strategies to other successful MAT programs. In order to gather information on best practices related to the engagement of hard-to-reach populations, students will perform a literature review and interviews with staff, clients, and/or community members. In addition, students will be asked to research, identify, and secure community providers that are potential sources of referral for CRT’s Medication Assisted Treatment (MAT) services. Students may also hope that students can locate protocols for home induction and in-clinic induction for the purposes of streamlining CRT MAT services while adhering to recommended guidelines. Ultimately, students will use their research to develop strategies to increase enrollment of women, sexual minorities, and transgender individuals in the CRT MAT program. Specifically, CRT hopes that these strategies will increase enrollment of women to 20% of all enrollees, sexual minorities to 18% of enrollees, and transgender individuals to 4% of enrollees.

About Community Renewal Team

CRT is Connecticut’s oldest and largest community action agency. It actually was inaugurated just prior to the official start of the government’s War on Poverty. Our primary catchment areas are Hartford and Middlesex counties. In 2018, the agency provided one or more services to 67,110 individuals from 28,166 families. We offer an array of programming that breaks into 10 categories: Basic Needs, Energy and Weatherization, Education and Youth, Housing and Shelters, Senior Services, Mental Health and Wellness, Employment and Training, Money Management, and Veterans Services.

The agency’s mission is “Preparing Our Community to Meet Life’s Challenges.” This mission is advanced by taking a holistic approach in developing individualized service plans for each customer and offering “one-stop shopping.” This translates into numerous services being available either in the same building or close by in the community.

About the Project

With a grant from SAMHSA, CRT has implemented a Medication Assisted Treatment (MAT) program for individuals with Opioid Use Disorder (OUD). CRT MAT has enabled CRT to use of buprenorphine (Suboxone) in the treatment of individuals with OUD. This MAT program prioritizes formerly incarcerated individuals and individuals with a history of involvement with the criminal justice system, though they also accept clients from the greater Hartford area who do not meet these criteria. In creating a Disparity Impact Statement for SAMHSA, it was determined that women and sexual and gender minorities are under-represented in most studies targeting offenders. Therefore, CRT hopes to increase the representation of these individuals in CRT MAT.
CRT has exceeded its contractual goal of enrolling 50 individuals for MAT in Year 1 of the grant. However, they are not meeting our diversity goals. Therefore, CRT requests the assistance of students to develop recruitment strategies in increase representation of women and sexual and gender minorities in its program.

Students will identify best practices for recruiting hard-to-reach populations, which will then be shared with CRT’s SAMHSA contractor and potentially disseminated to agencies throughout the country.

**Methodology**

**Qualitative**
- Conducting interviews with CRT staff, clients, and/or community members to evaluate effective and ineffective recruitment strategies used to date, as well as to identify gaps in current approaches.
- **Literature review**: gathering information on best practices related to the engagement of hard-to-reach populations.
- Students will research, identify, and secure community providers that are potential sources of referral for CRT’s Medication Assisted Treatment (MAT) services. Students will also locate protocols for home induction and in-clinic induction for the purposes of streamlining CRT Mat’s services while adhering to recommended guidelines.

**Quantitative**
- Evaluating CRT’s current recruitment strategies and comparing them to other MAT programs that have had success in recruiting hard-to-reach populations.

**Special Skills of Students (3-5 requested)**
- Familiarity with data collection (interviewing).
- Strong interest in the opioid epidemic, sexual minorities, and/or criminal justice.
- Students should have good interpersonal skills since they will be interviewing individuals at CRT and possibly in the community. Students must be comfortable speaking with individuals who may be from very different backgrounds from their own.

**Resources Available to Students at Agency**
- Access to databases.
Organization: Christian Community Action (CCA)

Project Title: Documenting the Impact of CCA’s Food Pantry in Promoting Stability and Independence

Overview of Project

Students will work on this project will develop skills in developing and conducting surveys to assess program impact and other participant needs. Students will interview clients of Christian Community Action’s Food Pantry (approximately 80 families). Students will therefore develop and administer a comprehensive satisfaction survey that documents the experiences of those utilizing the Food Pantry. Upon analyzing results, students will develop and present recommendations to improve service quality and impact.

Background

Although CCA’s Neighborhood Service Advocate (NSA) collects clients’ basic demographic information, the NSA does not have the capacity to assess client satisfaction with service delivery. Currently, no data are available regarding service improvement, unmet need, or ways to promote personal, family or economic independence.

About Christian Community Action

Christian Community Action has been providing services as a faith-based organization in New Haven since 1967. Its mission is to offer help, housing, and hope to those who are poor in the community through the provision of essential social services. Over its nearly five and a half decades of work, CCA has consistently served families and individuals in urgent need and helped them get to the root of their struggle so they are able to transition from surviving to thriving. Through this approach, CCA is helping create a pathway to stability and independence, rather than continuing to feed the cycle of poverty. By keeping true to its person-centered, trauma-informed, holistic approach to care and service provision, CCA is able to remain committed to helping families treat the root of their problems rather than just their manifestations.

Looking to the future, CCA intends to consolidate many of its programs into one location to streamline its service provision. CCA is also developing a more comprehensive, universal, client intake form and approach to service delivery, quality assurance, and achieving short term and long-term results that lead to independence leading to which will help staff uncover and address additional needs clients may have beyond the purpose of their initial visit. These steps forward will allow CCA to better serve the community and help many more families achieve independence and stability.

About the Project

The CCA Food Pantry presently serves 70-80 families per month, providing approximately 1,200 meals. The majority of these families live in the Hill neighborhood of New Haven and all live at or below the federal poverty line. Roughly, 63% of families are African American, 28% of families are White, and 32% are Hispanic. For many families, their first point of contact with CCA is through the Food Pantry.
The specific objectives of this project are to create and administer a comprehensive satisfaction survey that documents the experiences of those utilizing the Food Pantry. CCA aims to capture the experiences of all 80 families it serves through the Food Pantry, a group that is also representative of CCA’s broader clientele. Throughout the survey development and administration process, students will have the support of CCA’s Executive Director, Rev. Bonita Grubbs as well as the Neighborhood Services Advocate, Christopher, and Nicole Smith, who oversees the Food Pantry. After administering the survey to clients, students will analyze results and make recommendations regarding service quality and impact.

Each of these steps will help CCA meet the overall goal of developing a deeper understanding of how CCA is helping families improve their lives and move towards stability. The data students collect will offer a better, more complete and comparative assessment of service quantity within the Food Pantry program. Through this project, students will contribute to the development of an agency-wide quality assurance program, which would allow CCA to track and compare outcomes on a weekly, monthly, quarterly, and annual basis. CCA also intends to incorporate this project into the strengthening of ties between and among all of its programs. Furthermore, CCA hopes this project will guide the efforts of its Advocacy and Education Project (AEP) to advocate for those experiencing food crisis and poverty.

Ultimately, CCA’s mission is to create a pathway out of poverty, homelessness, and hopelessness. Its three-year goal is to increase access to independence among the families and individuals it serves. Results from this project will thus contribute to this goal by evaluating the impact of its Food Pantry services on client independence and stability.

Methodology

Quantitative
- Development and distribution of a food pantry client satisfaction survey, reaching approximately 80 families
- Analysis and report of survey results

Qualitative
- Interviewing food pantry clients

Special Skills of Students (4 requested)
- At least one Spanish speaker would be helpful, although not explicitly required

Resources Available to Students at Agency
- Students will have access to CCA staff, particularly during the development and distribution of the survey.
- Students will also have access to CCA’s office space, telephones, and computers.
Organization: Yale Regional Lead Treatment Center

Project Title: Primary Prevention for Childhood Lead Poisoning: Stop Using Children as Lead Detectors

Overview of Project

Students who work on this project will undertake home visits with patients and families to help identify potential lead hazards within the home and to understand the complex psychosocial impact of childhood lead poisoning. At these visits, students will also distribute resource folders assembled by YRLTC staff. Students will be asked to log participating patient information, so that the YRLTC may track blood lead level outcomes at the one and two-year-old blood lead level screenings. From these home visits, students will log participating patient information that will enable YRLTC to track blood lead level outcomes. Students will also have the opportunity to implement primary prevention interventions in the community. Finally, students will also screen for pre-1978 addresses among patients in participating Yale-New Haven clinical sites (e.g., Pediatric Primary Care, Women’s Center, etc.).

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. One of two regional treatment centers in Connecticut, our integrated approach is carried out through educational efforts and initiatives at the local, regional and state levels. Core functions of the treatment center include a monthly specialty clinic, routine home visits to lead-impacted patients, and community/professional education to increase lead awareness. The YRLTC is not a regulatory body, but is trained in being able to identify potential lead hazards within the home and uses a strengths-based perspective to help parents manage their environment in response to the child’s activities of daily living.

About the Project

In 2017, the Connecticut Department of Public Health reported 175 new cases of elevated blood lead levels in the City of New Haven, more than any other city in Connecticut. About 70% of the current housing stock in Connecticut had been built prior to 1978 when lead paint was banned from residential use. Debris and dust created from deteriorating paint shows to be the primary source of lead hazards impacting children under the age of six.

Connecticut statutes mandate that pediatricians draw two blood lead level screenings between the ages of nine and thirty-five months. While nearly all children receive one blood lead level screening, only half of the same population receives their second screening by the age of three. An analysis of 352 resolved lead poisoned cases (completed by the 2019 Yale MPH group) showed that blood lead levels peak around the age of twenty-seven months when there is an increase in mobility within an unidentified leaded environment and can easily be missed due to delayed screenings.

Positive feedback from the 2018 and 2019 MPH research groups reflects that parents become better able to regulate their environment when staff helps facilitate a custom care plan that is relevant to the family’s unique circumstances. Interim controls can be highly effective even when abatement or relocation are not immediately available options. Project outcomes are intended to reduce the rate of childhood lead poisoning by educating parents on how to identify and prevent lead hazards within
their home before the child ever becomes poisoned. Ultimately, efforts towards primary prevention and housing rehabilitation seek to restore equity among New Haven households.

**Methodology**

*Qualitative*

- Outreach and home visits to patients identified within the YRLTC who present with lead levels below 5μg/dL.
- Partnering with local home visiting and early childhood agencies to provide lead hazard training to staff and resource folders to distribute to the population served as a possible referral source.
- Screening for pre-1978 addresses among patients in participating Yale-New Haven clinical sites (e.g., Pediatric Primary Care, Women’s Center, etc.).

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

- Students should have an interest in learning about the medical implications of childhood lead poisoning and be able to apply practical knowledge of how normal developmental milestones in early childhood contribute to the susceptibility of plumbism.
- Students may need access to personal or public transportation if home visiting.

**Resources Available to Students at Agency**

- Office space for computer and phone use; provision of folders and printing materials
- Data sources
- Transportation to YRLTC activities and invitation to state and community meetings
IMPROVING PUBLIC HEALTH ASPECTS OF CLINICAL CARE

Organization: New London Homeless Hospitality Center (NLHHC)

Project Title: Community-Clinical Integration in New London

Overview of Project
Students who work on this project will develop skills in assessing client flow in social service/clinical systems, identifying appropriate screening points, and developing ways to integrate screenings into client flow. Drawing upon existing practices at YNHH, students will develop a detailed plan to implement a system for better identifying patients at Lawrence and Memorial (L+M) Hospital for whom social determinants are a major contributing factor to poorer health outcomes. The project will also help detail the early stage process for linking identified patients with housing related needs to staff at NLHHC. Students will work with YNHH social staff to understand EPIC features that support efforts to identify patients for whom social determinants of health (namely, housing) are a major contributor to health outcomes.

Background
As it becomes increasingly clear that addressing social determinants will be key to improving health outcomes, discussion is increasing focused on how to best address key social determinants. Much work remains but efforts already unfolding in Connecticut all posit the need for more effective partnerships between health care providers and experienced community-based providers. Although there exist free-standing systems that address social determinants and other systems that address health care, more effective interfaces between these systems will improve the quality and effectiveness of both. L+M hospital, which is now part of the Yale New Haven Health system, thus seeks a process for identifying patients whose health is impacted by social determinants and linking them to services at NLHHC.

About New London Homeless Hospitality Center
NLHHC’s mission is to offer hospitality to single homeless adult neighbors and to provide a bridge for them to permanent housing. Their daytime hospitality center serves as a “front door” for individuals seeking access to services through the New London County Coordinated access process. In addition, NLHHC offers a short-term emergency shelter that helps people regroup and set a course to permanent housing. A specialized respite section of their shelter provides emergency shelter specially designed to address the needs of individuals who are both homeless and facing serious health challenges. Services aim to provide a bridge to permanent housing. As such, NLHHC seeks to act as partners and advocates for their guests as they take the lead in finding ways to return to housing. Their primary tool in this area of our mission is rapid rehousing. Where their resources permit, NLHHC manages a variety of high-quality affordable housing options that address the needs of their guests who face the greatest barriers to finding safe and affordable housing. In some cases, this housing is financed with public rental subsidies, especially rental assistance program (RAP) vouchers. The Veterans Administration finances one of these housing options. In other cases, NLHHC has had the opportunity to purchase multi-family buildings, which they then rent out at very reasonable, all-inclusive, weekly rates.

NLHHC seeks to offer this hospitality and bridge to permanent housing to all single adults facing homelessness in the 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.

**About the Project**

Connecticut is working to improve health outcomes, increase health equity, and reduce unnecessary medical costs. Extensive research has demonstrated that an individual’s social situation—access to healthy food, housing, transportation, social inclusion, environment etc.—has a dramatic impact on overall health. Inadequate living conditions too often lead to poor health outcomes and increased avoidable hospitalizations and emergency room use. Inadequate housing, lack of access to healthy food and transportation challenges, disproportionally experienced by people of color, all represent avoidable risks with a direct impact on health outcomes. We will not be able to dramatically improve health outcomes, increase health equity and reduce unnecessary medical costs without finding ways to better address social determinants.

L+ M Hospital, which is now part of the YNHH system, seeks a process to identify patients whose health is impacted by social determinants and to link those patients to NLHHC. YNHH has existing practices for identifying patients impacted by social determinants. So as to not “reinvent the wheel,” students will document YNHH processes for identifying and referring patients and determine which approaches can be transferred to L+M Hospital. Students will work with YNHH social work staff to understand EPIC features that support efforts to identity patients for whom social determinants of health (namely, housing) are a major contributor to health outcomes. They will document how identified patients are currently linked to navigation resources and meet with Navigators currently receiving referrals from the CMS study underway at Yale to see how existing patient identification and referral process is working. Students will then prepare a summary of key process features that should be considered for migration to L+M and present these recommendations to L+M staff.

Students will gain skills related to the development of well-designed data collection systems. Furthermore, they will develop a deeper understanding of hospital-community partnerships and the interaction between social factors and health. Systems developed with this project will lay the foundation for subsequent phases of the project where we will provide housing interventions to selected patients.

**Methodology**

**Quantitative and Qualitative:**

- Students will work with YNHH social work staff to understand the key EPIC features (data elements and reports) that support efforts to identify patients for whom social determinants (especially housing) are a major contributor to health outcomes.
- Prepare a summary of key features that should be considered for migration to L+M, including EPIC features.
- Students will work with YNHH social work staff to document how identified patients are currently linked to navigation resources—information sharing, releases, feedback etc.
- Students will meet with Navigators currently receiving referrals from the CMS study underway at Yale to see how existing patient identification and referral process is working.

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

- Ability to understand data reporting systems and the ability to develop practical approaches to collecting agreed upon data.
Resources Available to Students at Agency

- Access to YNHH and L+M staff
- $500
Organization: Connecticut Voices for Children

Project Title: Pediatric Primary Care and the Community

Overview of Project

Students who work on this project will develop skills of interviewing, conducting process evaluations, and implementing best practices in collaborative projects. Students will evaluate the process of this project and build on recent efforts to inform community-clinical integration for children and their families. More specifically, students will interview staff at both the clinical and community sites in a newly funded collaborative project to better integrate pediatric services. Students will also review relevant literature related to the collaboration and produce a report containing findings. The aim is that this early process evaluation will be of use to pediatric practices and advanced networks considering child-focused collaborations with community-based organizations in the future.

Background

Community-clinical integration has been a focus of health reform efforts in Connecticut for many years and has recently been included in the state’s pilot Medicaid payment reform effort (PCMH+). Less attention has been paid to pediatric primary care offices and their interactions with community-based organizations, in part because such collaborations have the potential to improve health, but not necessarily to decrease costs. A recent grant from the Children’s Fund of Connecticut to pediatric primary care practices offers the opportunity to evaluate collaborations between primary care and community-based services for children.

About Connecticut Voices for Children

Connecticut Voices for Children believes all children in Connecticut should have an opportunity to achieve their full potential. CVC’s mission, therefore, 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. Connecticut Voices advances its mission through high-quality research and analysis, policy development, strategic communications, and establishment of a sustainable and powerful voice for children. CVC’s policy priorities include ensuring healthy child development and access to universal high-quality education; ensuring equity and opportunity regardless of race, ethnicity, geography, or family structure; and strategic investments in children as its primary budget priority.

About the Project

Connecticut boasts strong overall health indicators while also reporting dramatic disparities in access to health and health outcomes by race and income. By connecting traditional health systems with services based in communities, primary care offices can better address the needs of entire families. Pediatric primary care offices often ask about social and economic barriers to health, but may lack the resources or expertise to offer more than a list of phone numbers to parents. Collaboration with local providers of services that improve wellbeing can help connect families to the resources they need. For example, if a pediatric practice is able to connect a mother who recently lost her job with a local community center that houses both a food pantry and an employment counseling service, the family may be able to avoid unnecessary hardship that could endanger their physical, oral, and mental health. Or, if a child has an emergency room visit for asthma, the pediatric practice could connect the family with help addressing mold or pest infestations or with legal services to address a dispute with a landlord over these issues.
This project will add to existing examples of community-clinical integration in pediatric primary care and highlight pathways to overcoming cultural and systems barriers to providing whole family care. CVC aims to publish a brief summary of the results in collaboration with the Children’s Fund of Connecticut, which has published a study of pediatric primary care reform and funded the project to be evaluated. The aim is that this work will be of use to pediatric practices and advanced networks considering child-focused collaborations with community-based organizations in the future.

**Methodology**

**Qualitative**
- Interviews with staff of varying levels at both the pediatric primary care practice and the community-based partner organization (3-6 interviews).
- Literature review: students will perform a literature review of literature relevant to the collaboration to explain the potential impact of the collaboration in the specific practice and across the state.
- Students will transcribe interviews and prepare a brief report detailing methodology and results, while also framing the results in the context of the academic literature and relevant data.

**Quantitative**
- Students may also survey the availability of community-based services in the community and review the demographic makeup of the patient population to assess the potential impact of the collaboration.

**Special Skills of Students (3 requested)**
- Strong communications skills for both interviews and writing.

**Resources Available to Students at Agency**
- Access to sources of information relevant to project.
Organization: Southwest Community Health Center (SWCHC)

Project Title: Improving Clinical Workflow to Help Increase Provider Satisfaction

Overview of Project

Students who work on this project will observe and conduct interviews with clinicians to assess the workflow of clinical staff during patient encounters. Based on findings of the observations and interviews, together with best practices from the literature review and environmental scan, students will recommend strategies to improve delegation of clinical tasks and therefore increase provider workplace satisfaction.

Background

Numerous studies demonstrate the rising prevalence of provider burnout, leading to professional and personal dissatisfaction. Factors leading to provider burnout include increasing hours in the clinic, demands of professional practice, and adjusting to ever-changing technology (such as e-health records). Because of the shortage of primary care clinicians, providers are also being asked to attend to more patients, work more hours in the clinic setting, and work at home to finish their daily work.

About Southwest Community Health Center

Southwest Community Health Center is a multi-specialty, multi-site community health center and is designated as a Federally-Qualified Health Center by the Bureau of Primary Health Care of HRSA. Southwest offers a full breath of primary care services delivered by physicians, nurse practitioners, physician assistants, nurse midwives, dentists, dental hygienists, social workers, counselors and other support staff. In the medical service we offer: internal medicine, pediatrics, family medicine, obstetrics/ gynecology, infectious disease, podiatry, nutrition. In the dental service both dental hygienists and dentists offer a wide array of preventive and restorative services. In the behavioral health department, psychiatry, social work, counselling, and treatment for substance use disorders are offered. Southwest serves the uninsured, underinsured, and insured (mostly Medicaid) residents in the Greater Bridgeport area. Last fiscal year, almost 27,000 unique patients had 150,000 visits to our 19 Department of Public Health- licensed and Joint Commission- accredited sites. Ninety (90) percent of our patients are under 200 percent of the Federal Poverty Level. For the past five consecutive years, Southwest has earned “Quality” recognition awards from the Federal Government. Special programs include: HIV/AIDS Program, Refugee and Immigrant Health Program, Homeless Services, Trauma Services to youth who have experienced trauma, Substance Use Disorder Programs.

About the Project

Clinicians of all primary care disciplines are faced with greater workloads than ever before. For instance, clinicians are faced with the mastery and use of several electronic health records, telemedicine, and other external systems. They also must be attentive to and adhere to accreditation standards, payer rules and regulations, and quality standards required by various quality monitoring organizations. Because of the shortage of primary care clinicians, they are also being asked to attend to more patients, often working more hours in the clinic setting or at home. Consequently, an alarming rate of clinicians, both new to the profession as well as veteran providers, are experiencing “burnout.” Burnout not only impacts clinicians personal and professional lives; it also impacts patients’ access to primary care services.
SWCHS therefore aims to identify how the clinical workflow impacts provider satisfaction. Students will work with SWCHC to conduct a needs assessment of clinicians and clinical staff to determine how clinical workflow might be improved. Project objectives include 1) identifying activities and actions that clinicians take during “typical” primary care encounters, 2) assessing staff workflow during patient encounters to encourage team-based care, and 3) making recommendations regarding delegation of activities to appropriate support staff within patient encounters.

Students will develop skills in qualitative data collection and analysis and implementation of quality improvements. Students will also develop familiarity with community health care center operations. SWCHS will use students’ findings to improve the workflow of patients through their health centers, while simultaneously improving the well-being of their clinicians by preventing burnout and fostering satisfaction.

**Methodology**

**Qualitative**

- Direct observation of clinical workflow; interviews with clinicians; analysis of qualitative data
- Assessment of staff workflow during patient encounters
- Development of recommendations to improve staff delegation and clinical workflow

**Special Skills of Students (3-5 requested)**

- Workflow analysis, analytical skills, and familiarity with primary care.
- Students will undergo an orientation to the organization to ensure patient confidentiality (e.g. HIPAA) and safety (e.g. Joint Commission standards).

**Resources Available to Students at Agency**

- SWCHC will provide $2,500 and any resources necessary to complete the project.
STRUCTURAL APPROACHES TO IMPROVING PUBLIC HEALTH

Organization: Yale Office of Sustainability

Project Title: Health Impact Assessments at Yale University: A closer look at Materials Management

Overview of Project

Students who work on this project will pilot the process of conducting a rapid Health Impact Assessment (HIA) for the Yale Office of Sustainability. The HIA will be of municipal solid waste disposal at Yale and its processing in Bridgeport, including considering how the Bridgeport community may be impacted by the processing facility. Following the rapid HIA, students will evaluate the process with a goal of producing recommendations for future HIAs at Yale. The Office of Sustainability hopes to better understand 1) what (if any) health impacts result from Yale’s waste processing and 2) determine whether Health Impact Assessments are a potential tool to advance Yale’s sustainability efforts and identify health co-benefits of policies and procedures aimed at improving sustainability. Students’ findings and recommendations have the potential to influence decision-making processes at Yale and improve the impact of Yale’s sustainability efforts on the health and wellbeing of the campus community and those impacted by university practices and policies.

About the Yale Office of Sustainability

Established in 2005, the Office of Sustainability’s mission is to advance sustainability within the Yale community by acting as a catalyst for information exchange and facilitating capacity building, innovation, streamlined operations, and preparation of tomorrow’s sustainability leaders.

About the Project

The Yale Sustainability Plan 2025 (YSP25) aims to “encourage decision-making and behavior that leads to a healthy, vibrant campus and surrounding community.” The goals in the plan aim to create a campus environment where people thrive, recognizing that many decisions around sustainability (e.g. transportation, food, energy, etc.) also provide windows of opportunity to enhance the health and well-being of the community. The YSP25 includes a number of goals around materials management, including an effort to increase waste diversion, particularly through reuse. As the Office of Sustainability communicates to the campus community about the importance of this effort, they are hoping to better understand what (if any) health impacts result from waste processing practices and policies at Yale.

Health Impact Assessments are one of the tools decision makers can use to assess the health impacts of policy proposals and economic initiatives. According to the World Health Organization, a Health Impact Assessment is “a practical approach used to judge the potential health effects of a policy, programme or project on a population, particularly on vulnerable or disadvantaged groups. Recommendations are produced for decision-makers and stakeholders, with the aim of maximising the proposal’s positive health effects and minimising its negative health effects.”

Students will walk through the steps of HIA (Screening, Scoping, Appraisal, Reporting, and Monitoring) to assess the municipal solid waste (MSW) processing system at Yale. MSW is collected from trash bins across campus, consolidated in dumpsters, and trucked to a waste-to-energy facility.
in Bridgeport, CT, where it is burned to generate electricity. The rapid HIA will thus consider health impacts of the process on both the Yale and Bridgeport communities. After conducting the HIA, students will evaluate the HIA process to determine if it is an effective tool for informing decision-making. Moreover, students will provide recommendations for how the process might be improved.

Results from this project will be used to determine whether rapid HIAs could be used as a strategy to advance the university’s sustainability goals, and whether this could be a model utilized by other universities. Ultimately, this project has the potential to influence decision-making processes at Yale and improve the overall impact of Yale’s sustainability efforts on the health and well-being of our campus community as well as those by impacted by university policies and practices.

**Methodology**

*Qualitative and Quantitative:*
- Students will perform a rapid HIA through a series of steps (Screening, Scoping, Appraisal, Reporting, and Monitoring). As part of this process, students will consider how the broader community may be impacted and provide a list of key stakeholders for potential key informant interviews (may include community groups in Bridgeport, those associated with Yale’s waste management processes, etc.).

**Special Skills of Students (3-5 requested)**
- Knowledge of or experience with health impact assessment (HIA) is helpful but not essential.

**Resources Available to Students at Agency**
- Work space at Yale Office of Sustainability (70 Whitney Ave.) for student meetings and group work.