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MEASURING IMPACT IN COMMUNITY PROGRAMS

Organization: Norwalk Health Department

Project Title: *Filling in the Food Security Gaps: Examining the Farmers Market System in Norwalk, CT*

**Overview of Project**

*Students working on this project will have the opportunity to collect quantitative and qualitative data about farmers markets in partnership with a local health department.* The Norwalk Health Department is looking for help assessing farmers markets in Norwalk, CT. The farmers market system is fragmented and promotion is limited, and this may limit impact as a source for health, affordable foods for all. The project aims to identify barriers to utilization of farmers markets to strengthen the farmers market program going forward. Thus, the Health Department would like to learn if the locations (including proximity to public transit), hours, prices, staff, number of markets, and appeal of existing markets facilitates their utilization or if these aspects create barriers to their utilization.

**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.

**About the Project**

Although the Health Department and Hospital recently conducted a comprehensive community health assessment, the Health Department and its partners (including the Public Library, Norwalk Hospital, Norwalk Grows, and Stepping Stones Museum for Children) have identified a need for more information regarding the community food system, food insecurity, and the retail food environment. Plans are in the works to hire a consultant to conduct a high-level community food assessment, but this project will not be complete until late 2018, and so a narrow-scope preliminary needs assessment will be needed to facilitate this process. This needs assessment will require research and qualitative and quantitative data collection and analysis. The Health Department envisions
working with students to define the most appropriate methods, tools and protocols.

**Methodology**
1) Gather and analyze quantitative and qualitative data regarding:
   a. The existence and accessibility of farmers markets in Norwalk (and possibly nearby areas)
   b. The public awareness of Norwalk farmers markets and barriers and/or facilitators to their utilization
2) Create a report identifying:
   a. Strengths and weaknesses of the farmers market system in Norwalk, including recommendations for improvement and asset mapping, if possible
   b. The availability of related local, state, and federal assistance programs for both consumers and farmers
   c. Potential best practices from research or communities in other parts of the state/country

**Special Skills of Students (4-5 requested)**
1) Willingness/ability to travel to Norwalk
2) Survey design
3) Quantitative/qualitative data collection/analysis

**Resources Available to Students at Agency**
1) Data sources
2) Computers
3) Conference room
4) Phone
5) Contact lists
MEASURING IMPACT IN COMMUNITY PROGRAMS

Organization: Leeway, Inc.

Project Title: Implementation of recommendations from the EPH 542 Spring 2017 Field Action Report (Strengthening the Volunteer Programs – Developing training and evaluation tools)

Overview of Project
Students working on this project will set up an online volunteer management system (applications, web-based training), together with developing and implementing an in-person spring orientation. In addition, this team will develop and pilot evaluation tools for collecting feedback from volunteers, staff and residents for future evaluation and measurement of volunteer engagement at Leeway.

Leeway residents have a primary diagnosis of HIV with comorbidities. Anxiety and Depression are prevalent, as are other diagnoses. Anxiety, Depression and other mental illnesses present behavioral challenges and call for interventions, supports in addition to medication. Most have very little social support from family or the community, which can lead to social isolation. Leeway staff engage with residents through recreation and one-on-one staff interface however, having volunteers would greatly benefit the residents as they would have more opportunity to engage socially.

About Leeway, Inc.

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. We are committed to promoting quality of life and dignity to all those with HIV/AIDS. The Residential Care Facility at Leeway is committed to providing residential, personal and supplement care so that those that live with HIV/AIDS, Hepatitis C, and/or related conditions can live as independently as possible.

About the Project
Approximately 90% of the Leeway residents present with a diagnosis of Depression, Anxiety or other mental illness. Most have very little social support from family or the community, which can lead to social isolation. Leeway staff engage with residents through recreation and one-on-one staff interface however, having volunteers would greatly benefit the residents as they would have more opportunity to engage socially. Students will prioritize
operationalizing the digital/web based volunteer process. This will make the process of becoming a volunteer at Leeway more accessible and further compliment staff efforts, as well as engage residents in social support activities. Student are also expected to educate staff concerning navigation, trouble shooting and updating the digital site. Students will integrate with Leeway Therapeutic Recreation Director, Transition Manager as well as other staff as needed to provide continuity, growth and sustainability of the volunteer program. At the same time, students will create a tool to collect feedback from staff, residents and volunteers about their experience with the future goal of measuring outcomes.

**Methodology**

Build on the previous EPH 542 Spring 2017 Field project:

1) Digitize volunteer process and training resources

2) Begin creating an evaluation tool for volunteer staff and residents to complete post volunteer engagement experience.

3) Matrix building to capture data from volunteers, residents, and support staff for future analysis of the effects of the program implementation on the association between social interaction and uptake of psychotropic drugs.

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

1) Willingness to work closely with the residents of leeway.

2) Experience with diverse cultural differences and challenging behaviors.

3) Ability to speak or understand Spanish (helpful but necessary, translator services available)

**Resources Available to Students at Agency**

All technical resources will be made available to students.
MEASURING IMPACT IN COMMUNITY PROGRAMS

Organization: New Haven Farms

Project Title: Strengthening a Community Advisory Board guided by Community-Based Participatory Research Principles for a farm-based wellness program in New Haven

Overview of Project
Students working on this project will have the opportunity to work with New Haven Farms (NHF) in strengthening their Community Advisory Board (CAB) through review of CAB best practices, development of guidelines for recruiting and running a CAB, and interviews with NHF stakeholders (clients, board, staff, volunteers) to identify approaches to integrating the CAB into the NHF structure. NHF has been providing farm-based wellness programming for adults with risk factors for chronic, diet-related diseases for over five years. The wellness program curriculum is adapted from the CDC’s evidence-based Diabetes Prevention Program (DPP). The programming and evaluation is run and developed mostly by non-community members. In 2015, a CAB was started with the idea that the CAB would inform the decisions of NHF. At the time, our former Executive Director headed the CAB. All CAB members committed to attending meetings for 6 months. The CAB was mostly made of Hill neighborhood residents, a group that was instrumental in helping NHF start our first farm in the Hill neighborhood, and much of the focus of CAB meetings was on working to open this new farm in the Hill. As of 2017, the program manager is organizing the CAB and needs to recruit new members and define, more specifically, the mission of the CAB, given the previous de facto project of opening the farm in the Hill neighborhood has been accomplished. Further, students working with NHF will help the CAB develop a greater role in advising the staff and board of directors at NHF.

About New Haven Farms
New Haven Farms promotes health and community development through urban agriculture. Through our signature Farm-Based Wellness Program, we lead members of our community that are at risk of or are currently experiencing chronic diet-related illness, such as diabetes, in a sixteen-week series of educational nutrition, cooking, and gardening classes and workshops. Participants come in for two hours each week and leave with a share of our farms’ produce, enough to feed their family the recommended amount of fruits and vegetables for the coming week. After the program season, participants continue to meet monthly to maintain and advance the skills that they have developed.
Further, they are invited to join second-year programs such as our Incubator Garden Program and Community Health Ambassadors Program, where they use and spread their new skills in their communities. Through all of these initiatives, we create access to fresh produce in our community and help community members to develop the long-term tools to better take control of their health.

About the Project
Since the beginning of NHF in 2012, program planning, implementation and evaluation has been largely top down and hiring practices have focused too little on hiring community members. NHF is working on a strategic plan and internal operations to change this systemically. Through our CAB NHF would like to begin greater representation and power to community members. While NHF would like to work towards CBPR principles of complete inclusion of community members organization-wide, NHF is still at the beginning stages of this process. To create an evidence-based plan & facilitation guide for NHF staff to implement an effective CAB using CBPR principles, the plan will include:

- A short history and definition of CBPR and CABs (so that any staff member or board member could understand)
- A guide to CAB recruitment and retention
- A guide to establishing a CAB mission statement with CAB members
- Recommendations for how often the CAB should meet and how meetings should be facilitated
- Recommendations for norms/expectations for CAB members and for CAB leader/NHF staff
- Recommendations for how the CAB can be involved in research and how the research can be informed by the CAB (including recommendations for forming relationships/meeting regularly with research team)
- Recommendations on how to structure relationship with Board of Directors so that the CAB has potential formal voting rights

The plan will need to be approved by program directors and coordinators. Simultaneously, Preceptor, Liz Marsh will work with the YSPH team of students on refining the mission statement and recruitment and retention strategies. NHF would also like past program participants, Community Health Ambassadors and other program affiliates and community members to contribute to this planning process.

Methodology
1) Literature review of other CABs and CBPR
2) Qualitative interviews with staff, board members, CAB members, etc.
3) Focus groups with past participants, Community Health Ambassadors, Fair Haven Clinic Patients, Cornell Scott Hill patients, Fair Haven residents, Hill residents, etc.

**Special Skills of Students (3-4 requested)**

1) Spanish language – at least one student should be able to converse in Spanish for interviews with Spanish-speaking participants

**Resources Available to Students at Agency**

1) Use of shared office space
2) Shared files from previous CAB meetings
NUTRITION SERVICES & FOOD SECURITY

Organization: CitySeed

Project Title: SNAP Recipient Perspectives on New Haven Farms Market Incentive Program: A Behavioral Assessment and Report

Overview of Project

Students working on this project will analyze secondary data and design and implement qualitative data collection methods focused on capturing perspectives of SNAP recipients about farmers markets. This year, CitySeed is designing a “Friends of the Market” program to provide additional incentives to SNAP recipients to grocery shop at farmers markets. To both inform this program and help CitySeed better reach SNAP recipients in the New Haven area, students are being asked to conduct an assessment of this population. In particular, students will have the opportunity to design a SNAP recipient assessment based on review of secondary data and describe SNAP recipient perspectives and perceptions on Farmers Market SNAP Double Value program – focusing on key behavioral facilitators and barriers to uptake of the program. Students will also provide actionable recommendations for CitySeed on how to improve appeal of Farmers Markets to SNAP customers and/or engagement with SNAP customers regarding the program.

About CitySeed

CitySeed is a nonprofit organization that seeks to provide access to fresh, local food for all New Haven residents while supporting farm viability across the state of Connecticut. They operate a network of farmers markets and a series of food-related programs and activities toward that end. CitySeed’s mission is to engage the community in growing an equitable, local food system that promotes economic development, community development and sustainable agriculture.

CitySeed’s network of 4 Farmers’ Markets and a Mobile Market enable residents to eat fresh, locally grown food, contributing to the improved health of our community. All CitySeed Farmers’ Markets are certified to accept Farmers’ Market Nutrition Program coupons, which are distributed to nutritionally at-risk women, infants, children and senior citizens, as well as Supplemental Nutrition Assistance Program benefits (SNAP), accessed through Electronic Benefit Transfer (EBT) cards. In fact, on June 4, 2005, CitySeed farmers’ market at Wooster Square became the first farmers’ market in the state to accept SNAP/EBT. We were also nationally recognized in October 2007 as the “Golden Grocer Hunger Champion” in the farmers’ market category by USDA for CitySeed Food Stamp and nutrition education programs. The work of ensuring urban food
access is particularly important given that low-income communities are at greater risk for obesity and other diet-related illnesses. In addition, by supporting local farmers and keeping food dollars in the community, our markets have an immediate, positive impact on the local economy while promoting sustainable agriculture and community development.

CitySeed also has a licensed commercial kitchen, built with the aim to joyfully build community and cultural exchange through education, entrepreneurship, and breaking bread together. All of CitySeed kitchen related programming aims to impact health, racial and economic inequities. We are engaged in community cooking education, healthy cooking and eating education for patients with chronic disease, kitchen incubation for food entrepreneurs, and a new program called Sanctuary Kitchen that supports refugee and immigrant cooks to share their culture and cuisine while earning supplemental income.

**About the Project**

CitySeed’s 4 producer-only Farmers’ Markets, Winter Market, and Mobile Market, have changed the landscape of local food access in New Haven since launching in 2004. CitySeed serves a diverse population of New Haven residents and CT farmers. CitySeed Farmers’ Markets served 61,678 people in 2016, and we expect this number to rise in 2017. Through their Mobile Market, they reach almost 2000 people per year, with 50% of those being through nutrition coupon redemption: either SNAP or WIC and Senior Farmers’ Market Nutrition Program (FMNP) coupons. CitySeed aims to reach all income levels through their Farmers’ Markets, and we redeem SNAP and FMNP coupons as part of their effort to do so. They also offer double value for SNAP at all our markets up to $10, for a total of $20 of fresh local fruits and vegetables. This program provides low-income individuals and families with extra produce, keeping cash in their pockets for other expenses. In 2016, CitySeed redeemed $10,800 in SNAP and $50,857 in FMNP.

CitySeed conducts active outreach to residents receiving SNAP benefits – over 25% of New Haven’s population – using consistent marketing and rewards programs for new and returning customers. CitySeed recognizes transportation as a major barrier to food access, and operates a Mobile Market to address this by driving to food insecure areas, senior and disabled living sites, and housing authority sites. Over 50% of sales through the Mobile Market are through nutrition coupon redemption.

Despite seeing an increase in the total number of customers attending our Farmers Markets in 2016, we have seen a decline in the amount of SNAP
redeemed at the market over the past two years. This decline is in line with a downward trend in SNAP redemption across the state. CitySeed is seeking to engage the population of over 25% of New Haveners receiving SNAP benefits – roughly 37,000 low-income individuals and families – with a fresh approach that takes into account perspectives of SNAP recipients on the appeal, social acceptability, cultural relevance, and other barriers and facilitators to attending our Farmers Markets.

**Methodology**

CitySeed recommends conducting an assessment (quantitative or qualitative) of SNAP recipients – collecting data from both those who have accessed the Farmers Markets and those who have not. Suggested methodology could be Barrier Analysis, but any methodology used should be based in a theory of behavior change, such as the Health Belief Model or the Theory of Reasoned Action. A report of findings should provide actionable program recommendations for CitySeed on how to make CitySeed farmers markets more appealing for SNAP customers, or how to best engage SNAP customers through outreach or incentive programs to increase use of SNAP benefits at CitySeed Farmers Markets.

The following steps are recommended:

1) Background review: Conduct initial literature review of SNAP incentive programs at farmers markets, looking at previous studies of SNAP populations who access vs. do not access Farmers Markets. Interview CitySeed staff to determine our approach to outreach and incentive structures for SNAP recipients at our farmers markets. Review CitySeed’s market data in Excel on SNAP customers.

2) Design and conduct an assessment among SNAP recipients in New Haven, comparing SNAP recipients who have used SNAP benefits at our farmers markets to those who have not, and looking at barriers and facilitators to use.

3) Analyze the data (whether qualitative or quantitative), comparing both groups based on:
   a. Basic characteristics: sex, age, race/ethnicity, neighborhood, etc.
   b. Perspectives of the farmers markets
   c. Knowledge of double value program (and source of knowledge)
   d. Social acceptability attending the farmers markets
   e. Cultural relevance of the farmers markets
   f. Ability to access the farmers markets (e.g. transport, etc.)
   g. Perceived benefits of going to the farmers markets
h. Other factors that facilitate (or would facilitate) using SNAP benefits at the farmers market
i. Other barriers to using SNAP benefits at the farmers market
j. Universal motivators

5) Prepare a brief report, summarizing findings and making programmatic recommendations for CitySeed.

Special Skills of Students (4-5 requested)

1) Research skills – quantitative and qualitative, including:
   a. Study design - Questionnaire development
   b. Knowledge of best approaches to interviewing / sensitivity to ethical concerns and to concerns around conducting research among low-income residents of New Haven

2) Data analysis

3) Knowledge of or interest in food / nutrition / SNAP is beneficial Knowledge of / interest in behavior change or social behavioral science is a plus

Resources Available to Students at Agency
CitySeed can provide a space for students and CitySeed staff to meet during the project period, printing of survey materials, access to SNAP market data, and landline for telephone calls as needed.

CitySeed can provide in-kind:

1) Up to 2 hours per week of staff time provided to supervise student work
2) Printing of questionnaires or other materials
3) Incentives (as needed) for participation in research (e.g. CitySeed market coins)
4) Meeting space at CitySeed offices
NUTRITION SERVICES & FOOD SECURITY

**Organization:** Downtown Evening Soup Kitchen (DESK) & CitySeed

**Project Title:** Health and Community: Finding a Balance between Nutrition and Culture at Downtown Evening Soup Kitchen

**Overview of Project**

*Students working on this project will develop skills in conducting nutritional assessment of menus, and also developing and implementing qualitative data collection tools to assess dietary preferences among DESK clients.* DESK serves a varied clientele—often coming from different cultural backgrounds as our volunteers. To meet our guests where they are, DESK aims to provide a culturally sensitive menu that will appeal to those we serve. Past attempts to introduce healthier dishes have fallen short, and we believe a more deliberative process to determine appropriate foods, combined with stronger outreach and education, would produce better results. This project will be in collaborating with CitySeed, a nonprofit working to build an equitable food system in Greater New Haven, while ensuring farm viability in the state of Connecticut. Through this collaborative project, students will have the opportunity to review comprehensively DESK’s current nutritional standard, assess culinary preferences of clients in consideration of cultural backgrounds, produce revised nutritional standards, and Create a comprehensive plan for implementing new nutritional guidelines over the coming three years, to be included in DESK’s strategic plan.

**About DESK**

The mission of Downtown Evening Soup Kitchen (DESK) is to serve people who are experiencing homelessness or living in poverty by providing food assistance and services that promote health, community, and equity. DESK provides a hot, healthy, and wholesome meal to up to 150 men, women, and children nightly in the heart of New Haven. We are the only organization that provides this critical service in the area. In addition, DESK offers groceries to over 100 people each week through our Food Pantry program, and we deliver groceries to the homes of over 100 school-age children each week during the summer months as a way to help fill in the nutritional gap left when school meals are not available. Altogether, DESK serves over 2,200 unduplicated individuals from across Greater New Haven annually.

In addition to providing basic sustenance, DESK fulfills its commitment to promoting community and equity by creating a space in which our guests, volunteers, and staff interact with each other and with those from the broader community. We open our dining room each night to providers of basic services...
(including registered nurses and SNAP enrollers), policymakers (including local
-elected officials), and entertainers (musicians, choirs, artists, and others). In
doing so we aim to offer a level of dignity that throws off the stereotypes of “soup
kitchens” as gloomy halls of the last resort, and realize a space of hope, recovery,
and wellness. Ultimately, we aim to create a place that people WANT to come to
rather NEED to come to.
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. Our staff
works with up to 25 volunteers each day to prepare and serve hot, nutritious
meals to as many as 200 individuals per night at the height of the year, as well as
provide bag-lunches which are distributed at the end of the night. 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,
professional musicians treat the guests on occasion to performances from Dignity
Music, and beginning this summer, DESK will host elected officials regularly to
meet and engage clients on issues that affect them.

The Food Pantry program operates weekly and provides groceries to up to 150
households per week, totaling about 1,700 unduplicated individuals over the
course of the year (some of whom overlap with those served through the Evening
Meals program). The program offers frozen meats, fresh produce and bread, and
canned goods. The Food Pantry program is predominantly staffed by seven
volunteers from the Dept. of Veterans Affairs’ Errera Community Care Center in
West Haven as part of their “Vets as Volunteers” program, as well as youth in
treatment at Turnbridge Rehab Center, all of whom benefit greatly from the
experience as part of their own recovery.

About the Project
Common to the mission of both DESK and CitySeed is the provision of both
healthy and equitable food access in New Haven. While DESK’s work has
included more direct care—such as hosting weekly health clinics on-site—its
commitment naturally extends to the meals served. The provision of healthy food
for DESK’s guests is paramount, largely because the sorts of chronic ailments that
affect the general population are amplified among people who are experiencing
homelessness and food insecurity, or living in poverty. Obesity rates, for example,
are increasing nationwide; but while the wealthier suburbs of New Haven have seen only a 2 percent increase in obesity rates between 2000 and 2015, New Haven proper has seen a staggering jump from 21 percent to 32 percent (see DataHaven’s 2016 Community Index, p. 21). Similarly, New Haven sees each year a significantly higher mortality rate from heart disease as compared to the wealthier, surrounding suburbs (ibid.), as well as higher rates of Type 2 diabetes (ibid., p. 22). Finally, while New Haven’s overall rate of food insecurity is at 22% (already higher than the national average), this rate goes up to 35% in New Haven’s low-income neighborhoods.

At DESK we believe that our commitment to our clients’ health should not end at our dining room’s threshold; part of our goal is to ensure healthy choices beyond our walls by exploring ways to encourage better eating habits. To do so, however, we require a plan-of-action based on best-practice research and a clear understanding of the facts-on-the-ground, i.e., our clients’ willingness and interest in engaging new and different foods. CitySeed can bring its experience in healthy cooking education among low-income populations and populations facing chronic disease in New Haven to the table. However, CitySeed’s material and educational approach must be adapted to this specific population, ensuring cultural relevance.

**Methodology**

1) **Assessment of current nutritional standards:** Interview DESK kitchen staff, collect information on current menus, help develop a system for recording menus and recipes used each night, and review items distributed during weekly Food Pantry.

2) **Assessment of culinary preferences of clients:** Conduct one-on-one interviews, small focus groups, and/or surveys.

3) **Production of revised nutritional standards:** Conduct secondary research into generally accepted nutrition standards employed elsewhere (e.g., schools, hospitals, in-patient care facilities, etc.), including those aligned with the 2015 Dietary Guidelines for Americans. Potential local resources include partners at Connecticut Mental Health Center.

4) **Outreach and Encouragement:** Under CitySeed staff guidance, conduct secondary research into best practices for encouraging healthy eating (including a review of CitySeed’s current approach to healthy cooking and eating education and outreach).

**Special Skills of Students (4 requested)**
The desired students must be familiar with proper data collection methodologies, specifically appropriate tactics for client interviewing and surveying, including knowledge of ethical concerns surrounding interviewing populations considered as “vulnerable” by IRBs. In addition, students who complete the proposed project successfully will have an interest in systemic approaches to practical problems, with a keen eye toward the human factor associated with food choices and an acute cultural sensitivity.

**Resources Available to Students at Agency**

DESK can commit to providing full access to our current client-level data (including full demographic information and place of residence). In addition, DESK can provide one desktop computer terminal for up to 20 hours per week, as well as basic office amenities. CitySeed can provide access to educational materials around healthy cooking, eating, and shopping. CitySeed’s Kitchen Program Manager is a registered dietician and their Executive Director holds an MPH with a focus in food security and nutrition; both staff members will be available to consult with the student team. CitySeed can also provide a meeting space for occasional meetings pertaining to this work.
Organization: Bella Vista & Department of Psychiatry, Yale School of Medicine

Project Title: Societal costs of evictions – landlords, tenants, and taxpayers

Overview of Project
Students working on this project will build their awareness of the societal costs of homelessness and evictions, while working with secondary data and developing a case study estimating societal costs for a particular housing complex. Evictions are “perhaps the most understudied process affecting the lives of the urban poor” and negatively impact the lives of residents, their communities, and the country as a whole (Desmond, 2016). Various studies have shown that evictions are associated with various negative health outcomes, including long-term stress, medical problems, substance abuse, depression, suicide, and homelessness for adults and their children. However, the costs of evictions at micro- and macro-levels have not been examined, which is important for public policy and understanding the economics of this important psychosocial problem. Students will have the opportunity to investigate the causes of evictions at Bella Vista from multiple perspectives, including landlords, tenants, and court administrators, and estimate costs of evictions for landlords, tenants, courts, and society at large using Bella Vista as a case sample.

About Bella Vista
Bella Vista is a large group of apartment complexes mostly for senior citizens, many of whom have disabilities. Bella Vista is located in the city of New Haven, is privately owned by Carabetta, and is one of the top three evictors in New Haven. Court records show there have been over 100 evictions at Bella Vista in the past 3 years. Examination of court records also showed that the mean time to dispose and conclude a case in New Haven was approximately 62 days, with a median of 32 days. In comparison, Carabetta/Bella Vista cases took a mean time of 130 days, with a median of 62 days. It appears that Bella Vista cases took twice as long to resolve as other New Haven eviction cases. Bella Vista has an active tenant association that represents the concerns of its tenants.

About the Project
Millions of individuals and families across the U.S. are evicted each year. Evictions are landlord-initiated forced moves from rental properties and are most often due to non-payment of rent. Because low-income individuals devote upwards of 80% of their household income to rent (Desmond, An, Winkler, & Ferriss, 2013), any major (e.g., hospitalization) or minor life events (e.g.,
reduction in work hours) can cause individuals to miss a full payment. In cities throughout the country, the number of evictions that occur annually has been steadily increasing resulting in an epidemic of evictions.

Tenants who are evicted through the court system have a record of their eviction. And just like a mark of a criminal record can negatively affect one’s experience on the job market, an eviction history can negatively affect one’s ability to find subsequent housing. There is a growing body of literature documenting the negative effects of evictions on tenants, including long-term stress, medical problems, substance abuse, depression, suicide, and homelessness for adults and their children (Desmond, 2012; Rojas & Stenberg, 2016; Van Laere, De Wit, & Klazinga, 2009). However, there is little examination of the perspectives of landlords and administrators in eviction courts, their challenges in handling evictions, and the costs of all parties involved. Surprisingly, little is known what are actual costs of evictions for the multiple parties involved, and the costs for society.

Examination of eviction court records in New Haven have discovered that Bella Vista, an active senior living community located in the city, has evicted over 100 residents in the past 3 years. It is unclear what are the causes of these evictions, how Bella Vista views and handles these evictions, and the associated costs for all parties involved. The project will investigate the causes and costs of evictions.

Methodology

1) Attend Bella Vista tenant association to discuss how to recruit study participants
2) Interview at least 15 tenants who are at-risk for eviction or former tenants who have already been evicted (located through tenant association or known feeder apartments for Bella Vista evacuees). Students will also interview 3-4 leaders from Bella Vista administration. To interview court administrators, there is an ongoing study in the New Haven eviction court and can help facilitate access to some court personnel for interviews. This project will also be supported by the New Haven Commission on Disabilities, which preceptors serve as commissioners for.
3) Students will also be expected to seek information from public reports and other paper sources for information about costs.
4) Some questions of interest are: How much does one eviction cost Bella Vista? How much does one eviction cost the courts and taxpayers? How much does one eviction cost the tenant in terms of personal finances and lost productivity? Some interviews will be audio recorded and transcribed, but when possible, extensive note taking will be relied on. Students will be
expected to help transcribe interviews with assistance from research assistants of Jack Tsai.

**Special Skills of Students (3-5 requested)**
Familiarity with housing, evictions, Section 8, and cost analyses would be a plus.

**Resources Available to Students at Agency**
Telephone and computer access; Funding
Organization: Errera Community Care Center, VA Connecticut Healthcare System

Project Title: Identifying barriers and facilitators for homeless veterans who are also sex offenders seeking housing

Overview of Project
Students working on this project will develop an understanding of the housing challenges faced by veterans and sex offenders by developing and implementing tools to capture perspectives of landlords on criteria that are used in screening potential tenants.

Housing for sex offenders is a national problem. Homeless veterans with sex offenses face tremendous difficulties finding an apartment even when they have a Section 8 voucher that provides a rental subsidy. Landlords have different requirements and while some absolutely exclude any potential tenants with sex offenses, others will consider renting to them. There has been little work to examine exactly how landlords differ in their application process, what can help mitigate their concerns, and whether a tenant who is a veteran or involved in VA care is a factor. Students working with Errera Community Care Center will have the opportunity to identify barriers and facilitators in applying for apartments in New Haven/West Haven for veterans who are sex offenders.

About Errera Community Care Center
The Errera Community Care Center (ECCC) has been locally and nationally recognized as one of the best models for delivery of services for veterans struggling with mental illness, substance abuse, and/or homelessness. Success within the ECCC infrastructure is the continual development and implementation of new resources and expansion of current resources via veteran involvement and leadership, community networking and partnerships.

The ECCC’s mission is to enable individuals struggling with mental illness, substance abuse, and/or homelessness to live successfully within their communities. The goal is to maximize independence through recovery and rehabilitation plans designed to meet each individuals’ needs.

About the Project
Past studies have found that many homeless adults, including veterans have criminal records that can impact their ability to be approved for housing by landlords. For example, one study of 751 chronically homeless adults across 11 cities found that 71% had a history of incarceration with 35% having been
incarcerated for one year or more (Tsai & Rosenheck, 2012). Another study of over 1,000 homeless veterans found that 79% had history of at least one criminal charge with the most common charges related to disorderly conduct, vagrancy, and public intoxication (Tsai & Rosenheck, 2013). Veterans with more extensive criminal histories had more employment, housing, and substance abuse problems than those with no criminal histories. Annual national surveys of homeless veterans have revealed that housing for registered sex offenders is consistently one of the top unmet needs of homeless male and female veterans. Aside from criminal histories, recent studies have highlighted money management problems among veterans who served in Iraq and Afghanistan (Elbogen, Johnson, Wagner, Newton, & Beckham, 2012) and these problems can lead to poor credit and other financial issues that can hinder a veteran’s ability to be accepted for housing.

It is not clear how much these issues matter to landlords, and what factors determine which landlords are more stringent than others when considering potential tenants. There may also be situations in which landlords may be able to be convinced to take tenants they would not otherwise take (e.g., if they are a veteran in VA treatment, offer of larger security deposit, etc.). The purpose of this work is to shed light on some of these factors.

**Methodology**

A random stratified sample of landlords in New Haven and West Haven will be obtained through public listing. Stratification will be by major neighborhoods in New Haven and West Haven. Students will be asked to:

1) Interview at least 25 landlords in each city for a total of 50 landlords.
2) Assess whether the landlords are willing to consider a veteran who is a sex offender, what other criteria landlords may use, whether veteran status is a factor, and what other barriers/facilitators there are for gaining approval for housing for those with sex offenses.

Note: This project has been discussed with the Connecticut VA IRB (Chair of IRB and Professor of Psychiatry- Morris Bell, Ph.D. and Associate Chief of Staff of Research and Professor of Medicine and Cellular and Molecular Physiology- Fred Wright, M.D.), which have deemed the project “definitely not human subjects research.”

**Special Skills of Students (3-5 requested)**
Familiarity with housing and homeless issues, Section 8, and qualitative methods would be a plus.

**Resources Available to Students at Agency**
Telephone and computer access; Funding
Organization: Yale New Haven – Regional Lead Treatment Center (YRLTC)

Project Title: Is There a Lead Poisoning Problem in Our Region? YES!: Prioritizing Intervention for Primary Prevention

Overview of Project
Students working on this project will strengthen their awareness and understanding of the issue of environmental lead contamination, as well as developing skills in interviewing, and implementing a brief intervention about lead risk for families with young children. In 2013, the Connecticut Department of Public Health (CT DPH) lowered the case management action level from 10 mcg/dl to 5 mcg/dl of blood lead level, to correspond with the recently lowered CDC reference value. The change was based on research findings that had shown blood lead levels as low as 5 mcg/dL can affect a child’s IQ, ability to pay attention, and academic achievement. However, according to the Connecticut Health Department, there were 64.5% of children among those with levels exceeding 5 mcg/dL were new cases in 2015. Thus, there is need for an intervention. Students will have the opportunity to develop and implement a screening tool at prenatal and family-centered care programs throughout New Haven to assess the risk of living in homes with potential lead hazards.

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.

About the Project
Students will be stationed in various prenatal and family-centered care programs throughout New Haven to develop and administer a screening tool to rule-out families at risk of living in homes with potential lead hazards.

Those who yield positive screenings, as well as voluntary participants, will be referred to the YRLTC for a home assessment and education as a means to prevent possible exposure risks before the child enters the home.

Families enrolled in the project will be logged into a database maintained by the treatment center, so that the sample cohort can be observed when the infant has
their venous blood lead level drawn at the one and two year old screenings, as mandated by the State of Connecticut.

During their rotation, students will provide on-site lead prevention education. Students will create a Preventative Care brochure as a sub-service of the YRLTC. The brochure should explain the purpose of the project and inform participants that the treatment center will be interested in knowing their child’s one and two year old blood lead level screenings to evaluate the impact of primary prevention. The brochure should also provide an overview of common lead hazard sources and intervention practices.

Students are asked to develop a visual model of how lead impacts various parts of the human anatomy to be used as an educational tool (see Appendix A).

Students are also invited to take part in 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).

The YRLTC will provide ample support and education to help prepare students to discuss the issue of lead exposure/toxicity with the public and help dispel common myths associated with lead. Several educational materials are available through both the treatment center and the Connecticut Department of Public Health to utilize and reference.

**Methodology**

1) Data collection – students will create a screener that will assess expectant mother’s current knowledge around lead and lead poisoning as well as determine if there may be potential lead hazards in the home. Students will create a database, which will assist the treatment team in identifying participants, implemented strategies, environmental finding, and future screening outcomes.

2) Screener for First Time Mothers – students will create a screening tool that will be provided to expectant mothers, which will be implemented at research locations.

3) Needs Assessment – students will rotate through 3 sites collecting data regarding patients’ general knowledge around lead and lead poisoning to serve as a needs assessment- including, but not exclusive to first time mothers on site.

4) Patient Satisfaction Survey – Available with YRLTC through Survey Monkey

**Special Skills of Students (3-4 requested)**

Bilingual (Spanish preferred, but not required)
Resources Available to Students at Agency
Data sources, computer time, telephone, clinical supervision
Educational materials available through YRLTC & DPH
VULNERABLE POPULATIONS

**Organization:** Planned Parenthood of Southern New England (PPSNE)

**Project Title:** Evaluation of Pre- and Postnatal Education Programs and Maternal Health Care Services in Connecticut and Rhode Island

**Overview of Project**

*Students working on this project will develop qualitative and quantitative data collection tools focused on capturing prenatal and post-natal health care needs among PPSNE clients.* PPSNE is interested in evaluating the unmet need for all patients (our patients and broader population) since we currently do not offer these services. To assess the needs of women of childbearing age looking for a health provider, students will conduct a needs assessment of pre- and post-natal health care and health education through online research, key informant interviews, and online surveys to determine where PPSNE may fill unmet needs.

**About PPSNE**

PPSNE is the largest provider of reproductive health services in Southern New England. PPSNE has a budget of nearly $36 million dollars and a staff of about 200. PPSNE operates 18 health centers in Connecticut (17) and Rhode Island (1). Last year, PPSNE served 70,000 women and men with 111,000 visits in our 18 health centers in Connecticut and Rhode Island. Our community educators from our Education Department annually reach more than 6,000 teens, young adults and parents across Connecticut and Rhode Island.

The mission of Planned Parenthood of Southern New England is to protect the fundamental right of all individuals to manage their own fertility and sexual health and to ensure access to the services, education, and information to realize that right.

PPSNE’s clinical services include primary gyn care, family planning services and supplies, Pap tests, STD and HIV colposcopy/cryosurgery and pregnancy termination. 90% of visits to PPSNE are for gyn care, including STD testing and treatment. In the last two years, PPSNE has been implementing primary care services in selected health centers. This includes diagnosis and treatment for upper respiratory infections, skin conditions, school/ work physicals, flu shots. PPSNE is offering comprehensive primary care in our Hartford North center, a newly recognized primary care Patient Centered Medical Home (PCMH). PPSNE also offers PrEP and PEP, the HIV prevention protocols.
Most of PPSNE patients are under the age of 30, 11% are men. About 45 percent of PPSNE patients are people of color (African-American/Black, Latino, Asian, more than one race). About 40 percent of our patients are covered by Medicaid (including the CT Medicaid Family Planning Expansion plan), 30 percent are covered by commercial insurance and 30 percent are uninsured and are charged according to a sliding fee scale that is based on income and family size.

**About the Project**

PPSNE’s mission compels us 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 birth control and reproductive health services before they become pregnant. Recent studies, however, show that birth spacing and intra-conceptional care are also key factors for healthy births and infants. Further, our center staff hear from women in some areas of the state that there are limited options for low income women and women relying on Medicaid who are seeking prenatal, labor/delivery classes and even parenting programs.

PPSNE also maintains a substantial Education & Training Department whose goal is to further PPSNE’s mission by providing individuals with the information, resources, behavioral skills, and motivation necessary to achieve and maintain healthy sexuality. In recent years, PPSNE’s Education department staff have been largely involved in providing and training other professional to provide multi-session, evidence-based teen pregnancy prevention programs. Much of this work has been funded by national teen pregnancy prevention funding initiatives implemented by the Obama administration. The current administration has announced that nearly all of this funding will end in 2018. PPSNE is looking for new areas where its current Education & Training staff can be successfully and effectively redeployed.

In general, PPSNE is looking to ensure its services are attractive to all young women and men who need them. Focusing on the needs of women and their partners of childbearing age with additional education programs and health care services is integral to achieving our mission of ensuring access for all individuals to services that enable them to manage their sexual health and overall well-being. Before we devote significant resources to researching and implementing these services, we would like to know more about the need and current market for them.

**Methodology**
1) **Needs assessment**: Summary of what is known about the currently identified needs women of childbearing age for pre- and postnatal health care services and education programs, and what needs their partners have.

2) **Key informant interviews**: This would include staff at organizations identified above, as well as representatives from public health community.

3) **Focus groups or online survey**: That might reach those who are most hidden and/or disenfranchised.

4) **Asset mapping**: Identify current providers, towns/cities where located, serving men and women of childbearing age. We don’t envision this being as detailed as GIS mapping, but we are looking for the team to identify towns or areas where there are gaps between resources and need that PPSNE could fill.

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

1) MS Excel
2) Survey Question preparation (possibly even online surveying)
3) Focus Group management
4) Presentation preparation

**Resources Available to Students at Agency**

1) Assistance with recruitment,
2) Meeting rooms, telephones, temporary use of computer, printer (at PPSNE office).
3) Data sources: PPSNE does have some data on patients that have used our health care services. If patient data is necessary, we can provide some demographic data (age, gender, race/ethnicity, poverty level, insurance status, zip code) in a HIPAA compliant format. This would need to be approved by Yale IRB and PPSNE’s HIPAA privacy and security officers.
VULNERABLE POPULATIONS

Organization: New Haven Health Department (NHHD)

Project Title: Measuring and Mapping Mortality in the Elm City: Identifying and Addressing Health Inequities in New Haven with Years of Potential Life Lost (YPLL) and Other Health Determinants

Overview of Project

Students working on this project will develop strong skills in GIS analysis of health outcomes, by mapping social determinants and health outcomes for the New Haven community. The Health Department would like to analyze and to map the following data on a sub-city level (e.g., neighborhoods, census tracts, zip codes, etc.): the top causes of death, years of potential life lost (YPLL), social determinants of health, and the availability of health and social services. While some of this information is available at the city level, a closer examination at the sub-city level will help inform programmatic changes to improve the quality and longevity of residents’ lives, by ensuring they have access to needed services. Students will have the opportunity to analyze mortality data for New Haven residents, create maps to visualize data trends and identify social and health services located in the city to determine potential gaps in services.

About New Haven Health Department

As the municipality’s primary public health agency, the New Haven Health Department’s mission is to advocate for and to ensure the health and well-being of all New Haven residents. Since its establishment in 1872, the New Haven Health Department (NHHD) has implemented a variety of health programs to address the many health needs of City residents. Some of the programs currently offered include lead poisoning prevention, asthma prevention and management, child passenger safety education, and preventive health care services. All NHHD programs and activities are overseen by the Director of Health and conducted under the guidance of the Board of Health. The NHHD is experienced in grant management and contract administration, including federal contracts, and is skillful in the management of financial and auditing operations.

About the Project

The Health Department requires neighborhood-specific cause of death data and data on the YPLL for New Haven residents. While the leading causes of death for city residents are available, it requires further analysis/evaluation at the sub-city level. Additionally, the Health Department does not have sub-city data regarding YPLL and other measures.
To better understand inequities in access to medical and social services, the Health Department would like to map the locations of these entities in the city. With these and other analyses, the Health Department can augment its effectiveness with programs and services to meet the health needs of city residents and to ensure all citizens have equal opportunity to live healthy and fulfilling lives.

**Methodology**

1) Data collection, cleaning, and analysis using statistical software

2) Develop visualizations using geographic information systems (GIS) and graphics packages

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

1) Data analysis software (STATA, R, MS Excel, etc.)

2) Geographic Information Systems (GIS software)

**Resources Available to Students at Agency**

Computer, software, printer, Internet, fax, data sources
VULNERABLE POPULATIONS

Organization: Optimus Health Care

Project Title: Investigating and Addressing Significant Young Male Attrition from Primary Health Care Services in an Urban Community Health Center

Overview of Project

Students working on this project will develop an understanding of health issues affecting male transition-age youth (TAY, ages 18-21) through quantitative analysis of electronic medical records and qualitative data collection (interviews or focus groups). Students will provide the background work and make recommendations for an intervention to address and reduce the attrition rates of male transition-age youth, resulting in more continuous, preventative health care. This will be achieved by identifying the primary demographic and socioeconomic predictors of attrition using historic medical record data and regression modeling and conducting focus groups with patients to discuss possible reasons for the observed attrition.

About Optimus Health Care

The mission of Optimus is to serve as the patient centered medical home for our communities to achieve and maintain a positive state of wellness, particularly for the uninsured and underinsured. Optimus provides primary care and specialty medical services to 50,000 patients throughout the greater Bridgeport and Stamford area, employing a patient-centered medical home (PCMH) model.

About the Project

As an urban federally-qualified health center (FQHC), most of our patients have numerous risk factors for significant, chronic diseases later in life due to a confluence of social, environmental, economic, racial, and gendered social determinants. One approach to minimize the burden of these factors on the health of our population is to provide continuous and holistic preventative medical care throughout the life of our patients. One sub-population that is particularly vulnerable is male transition-age youth (TAY), young men ages 18 to 21 who stop going to the doctor’s regularly. Recent internal reports at Optimus indicate that approximately 1/3 of 18 year old men stop having regularly doctor’s appointments after they leave the care of their pediatrician. The potential long-term effects of this gap in care are significant and can lead to the exacerbation of existing disparities as well as increased future strain on our healthcare system. Thus, identifying socioeconomic predictors of attrition using through medical record data and focus groups can inform the development of an intervention to address attrition rates of male TAY.
Methodology
1) Literature Review – students will conduct literature to distill national efforts and current data trends to inform their quantitative and qualitative research

2) Quantitative – students will perform regression analysis to identify demographic, socioeconomic, medical history, and other predictors of attrition

3) Qualitative – students will conduct focus groups to discuss non-quantitative, non-medical record reasons for attrition

4) Intervention – students will develop their intervention based on the above three steps

Special Skills of Students (4 requested)
1) Knowledge of logistic regression modeling and data cleaning
2) Conversational knowledge of Spanish

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