

CHNA/Data Advisory Meeting Summary

February 6, 2019 | 2:00 – 3:00 pm | Hauppauge, NY

Thank you to everyone who attended Wednesday's CHNA Prep Workgroup/Data Advisory meeting. We had a highly valuable discussion surrounding the Community Health Needs Assessment, and I'm excited to share the following updates with you.

- **DOODLE POLL:** Near the end of March, our hospital/health system partners will be meeting once again to review all the data discussed at this week's meeting, and **jointly select Prevention Agenda Priority Areas** for this cycle of the Community Health Needs Assessment. **PLEASE TAKE THIS DOODLE POLL REGARDING YOUR AVAILABILITY.** Our goal is to have as many people in the room as possible for the discussion.
- PHIP staff (we) will be sectioning the [LIEQ Community Health Assessment Survey](#) data into three geographic breakdowns, rather than the previous two – Suffolk County, Nassau County, and Nassau + Queens.
- We are currently working on remapping the select communities in Suffolk County. Nassau County's will remain the same, except for the removal of Long Beach.
- We will make an addition to the list of ICD-10 codes to be analyzed, to include marijuana-related hospitalizations.
- SPARCS vs Vital Statistics data: While the PHIP staff has access to 2017 SPARCS data, we currently only have Vital Statistics data up to 2015, with an approved application for the 2016 data – download in progress! No matter what data we may have before our next meeting, we will be providing matching data for the CHNAs, so we are fairly confident that the analysis provided to you will include **2014 – 2016 SPARCS** data and **2014 – 2016 Vital Statistics**. This topic may be revisited in the future if the PHIP ends up acquiring more up-to-date information from Vital Stats.
- We discussed the barriers encountered by our contractor, EurekaFacts. One of which was the need to supplement the completed Community Members Focus Groups with phone interviews, due to a lack of RSVPs to those in-person focus groups. The question posed at Wednesday's meeting was this – what is the number of participants needed to make this information significant, in light of this new method of data collection? I want to copy EurekaFacts' answer below, as I am not an expert and don't want to misconstrue the response I received. If you have any questions, please do not hesitate to reach out to myself or Janine.

- “As far as the number of interviews, it is a bit subjective in terms of determining how many to conduct. Most qualitative research guides say to continue interviewing until you reach saturation, i.e. when you begin hearing the same information over and over again. With a homogenous group (in this case, underserved communities in Long Island), that can occur from 6 interviews to 25 interviews, according to other research. We are following the guidance from:

Guest, G., Bunce, A. and Johnson, L. (2006). How many interviews are enough?: An Experiment with Data Saturation and Variability. *Field Methods*, 18(1), pp. 59-82.

This study looked at nonprobabilistic samples, specifically a sample involving 60 in-depth interviews. The researchers examined the degree of saturation occurring in the results and found that saturation was reached within 12 interviews, with the overarching themes becoming apparent after 6 interviews. This article is considered a cornerstone for

guidance in determining the number of in-depth interviews. Thus, we are confident that conducting 12 interviews will provide a robust and valid data set for analysis.”

- LIEQ Community Health Assessment Survey data collection gaps: There was a consensus in the need to spend the next handful of weeks, before our Priority-Choosing Meeting, collecting surveys that fill the demographic gaps our partners saw in the collected data. To address these gaps, we are suggesting the employment of the following two strategies:
 - For both Suffolk County and Nassau County, we will dive into the demographic data provided by the American Community Survey, and compare that to the demographics of current survey respondents. We will create a list of “respondent characteristics” that, if built up, would close the perceived gap. The Long Island Health Collaborative will do online pushes of the survey to these very specific, targeted demographics, especially (but not exclusively) in the counties’ respective selected communities.
 - We will also reach out to LIHC partners with contacts or expertise in these selected communities, and ask them to make an extra effort to distribute the survey. We will, of course, provide these partners with the above mentioned characteristic targeting parameters, in the hope they can employ similar online tactics, while understanding that not every organization has the capacity that the LIHC does, but that the information cannot hurt. Other than that, we have no true control over the demographics of respondents – **only** the ability to target organizations who may typically cater to the clientele of the desired demographic/respondent characteristics
- [Did I mention there is a Doodle Poll and that it’s very important that everyone take it?](#)
- **COMING SOON ARE:**
 - The list of updated ICD-10 codes we will be using for SPARCS analysis
 - The demographic comparison of the American Community Survey vs. the LIEQ Community Health Assessment Survey, and a suggested list of targetable respondent characteristics
 - In addition to this, we will create a, “How To Promote,” document, with suggestions for hospitals, LHDs, CBOs, and other partners, with regards to all levels and capabilities of promotional strategies.
 - Suffolk County’s list of Select Communities
 - Harassing emails about that Doodle Poll