Cross-Collaborative Identification of Unmet Health Needs and Disparate Areas on Long Island

Presentation of Primary Data Collection at the Community Level

PURPOSE

In line with New York State health reform efforts, partners of the Long Island Population Health Improvement Program (LIPHIP) worked jointly to identify the most pressing health needs and the predominant social determinants of health barriers facing communities within Nassau and Suffolk Counties.

The Long Island Health Collaborative (LIHC) is a diverse workgroup of committed stakeholders who agree to work together to improve health status and outcomes for Long Islanders. In 2014, the LIHC was awarded funding from NYS Department of Health as the Long Island regional PHIP.

Groundbreaking LIPHIP-led data collection efforts are being used to achieve improved total population health at community, regional, and state levels. The importance of data drilling to reach community-specific conclusions has become apparent as we look to improve health outcomes across sectors. The LIPHIP presents this actionable, scientific data via localized maps, interactive tables, and interpretive analyses.

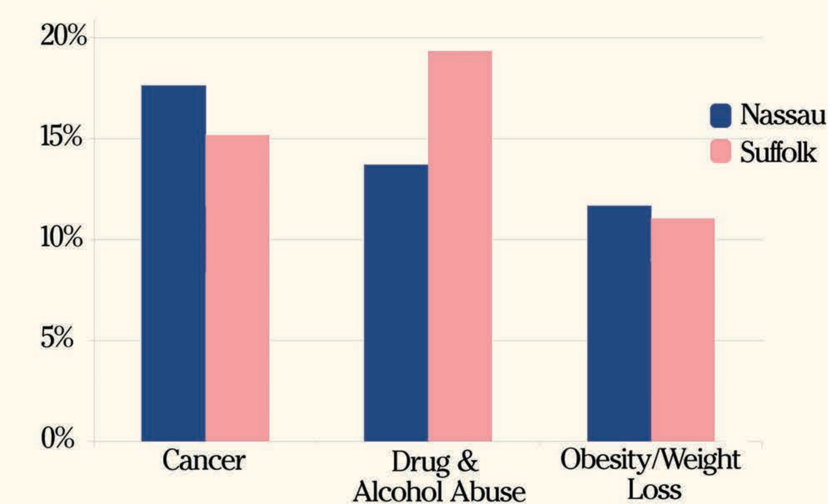
FINDINGS

Quantitative

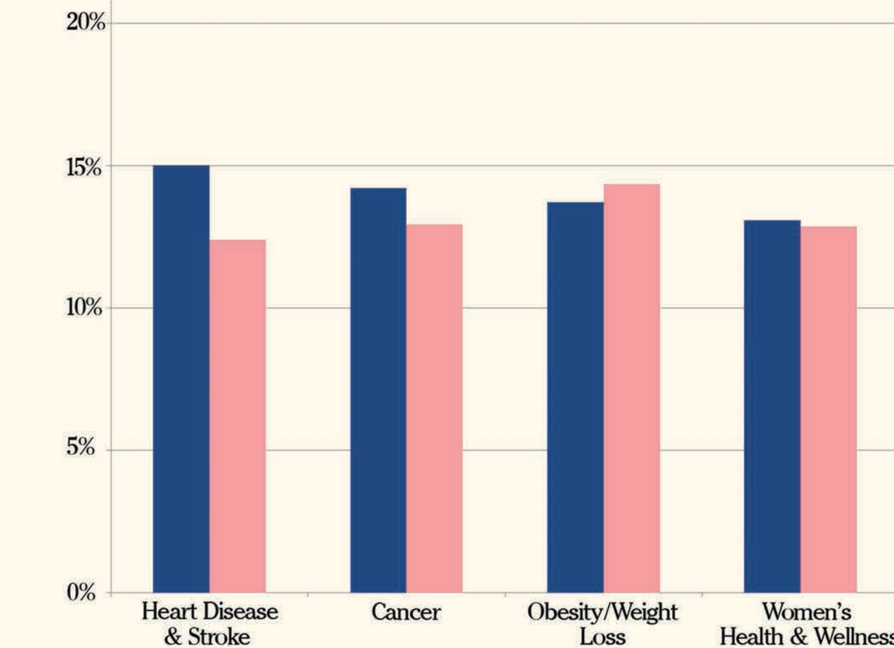
COMMUNITY SURVEY From the surveys collected in 2016, chronic disease incidence and mental health emerged as areas of high-need. Leading barriers to accessing medical care included inadequate insurance, inability to pay co-pays, and fear.

ANALYSIS RESULTS

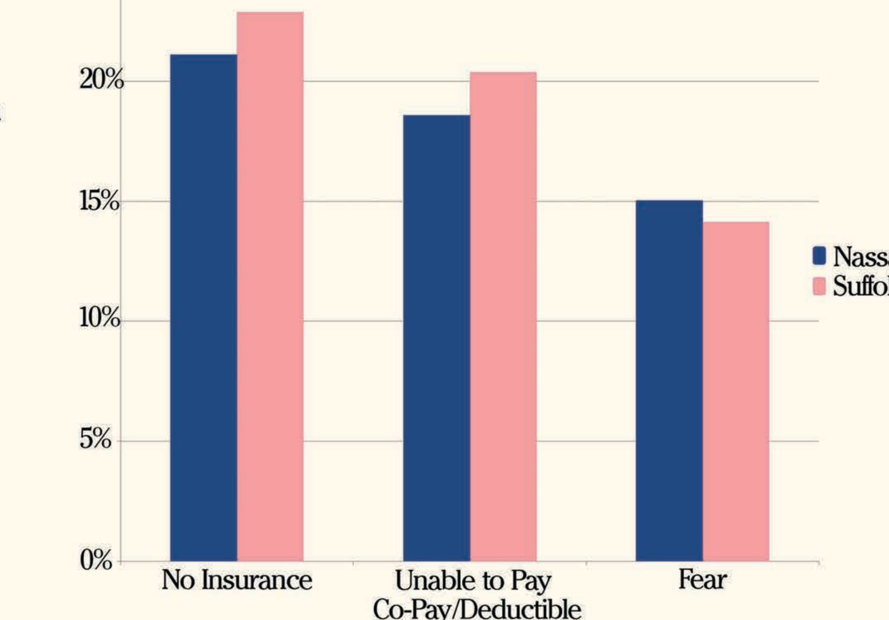
Q1) When asked what the biggest ongoing health concerns in the community where you live are,



Q2) When asked what the biggest ongoing health concerns for yourself are,

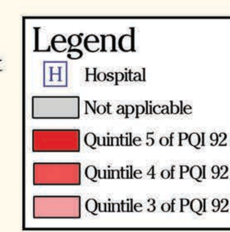


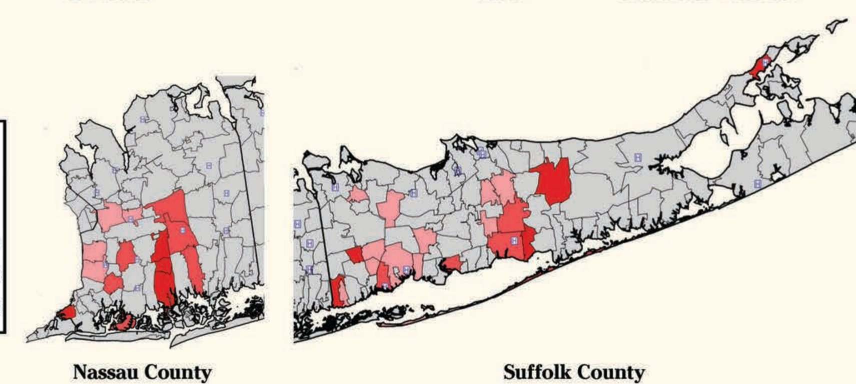
Q3) The next question sought to identify potential barriers that people face when receiving medical treatment,



PQI 92: Chronic Composite and Opinion on Most Important Health Concerns in Communities

PHIP primary data and secondary data from the 2014 NYS Department of Health's SPARCS database support one another, as the top three quintiles of zip codes from the survey mimic quintiles of PQI (Prevention Quality Indicator) data. This helps validate the results of the survey, e.g., when asked about the health needs of the community, those who chose an issue related to chronic disease live in zip codes determined to be at risk by the secondary data.

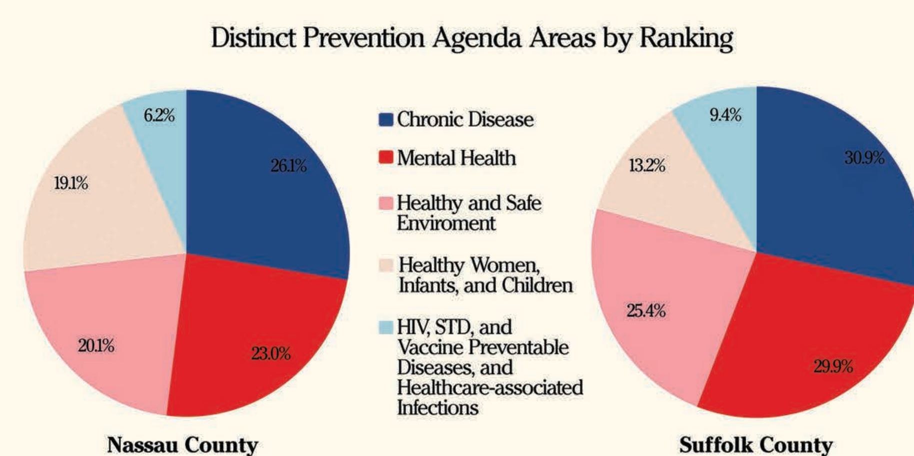


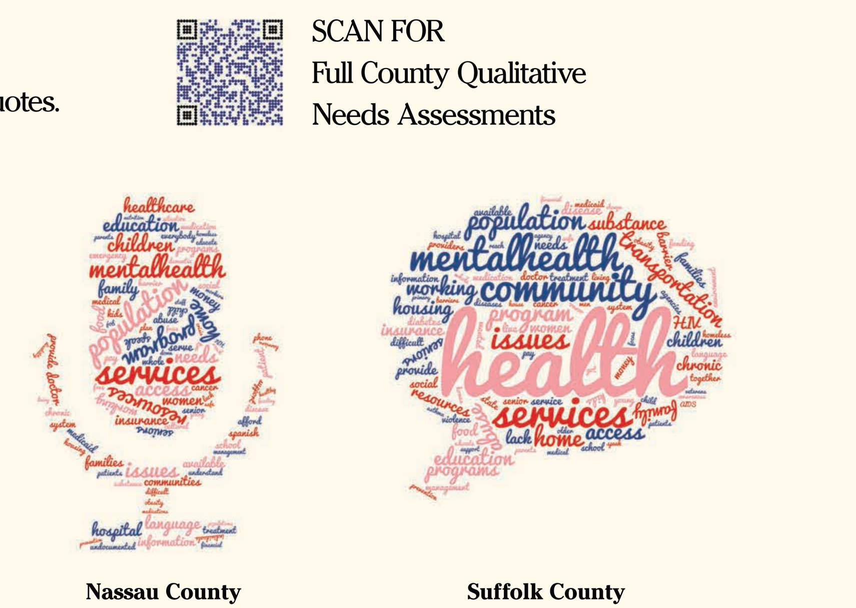


Qualitative

CBO SUMMIT EVENT Distinct Prevention Areas by Ranking reflects the number of quotations where the focus area is mentioned at least once and counted once, divided by the total number of Nassau/Suffolk County quotes.

SCAN FOR Full County Qualitative Needs Assessments





Improving communities' ACCESS TO HEALTHY FOODS, coupled with youth education focused on healthy living and nutrition, is needed to curb the increasing rates of diabetes, heart disease, and obesity in young populations.

"There is a real concern with diabetes and heart disease among impoverished children and the communities that LI Cares serves. Absolutely, diabetes and heart disease, and we are seeing them at a young age. One of the barriers is not having access to health and food, and nutrition education. By providing that, coupling that with access, being able to buy food from the food bank, is really important."
–LI Cares, Nassau County Event

Availability of MENTAL HEALTH and SUBSTANCE ABUSE TREATMENT and RECOVERY SERVICES is not adequate considering the high demand for service. Prevention and strategies focused on maintaining follow-up care for mental health are equally important.

"The major issue is the long waiting list and by the time their appointment comes up they're no longer with us and they fall through the cracks. We don't know where they're going. We don't know if someone is going to follow up so that's part of, you know that lack of prevention as well. It's a long waiting list just to get psych evaluations."
-Community Housing Innovations, Suffolk County Event

SOCIAL DETERMINANTS OF HEALTH play an integral role in addressing issues concerning mental health and substance abuse.

"It all falls together. When you have people who are in poverty they are not eating well; when you have people in poverty they tend to be depressed and have mental disorders, which very often leads to alcohol or substance abuse, heroin, which is a huge problem in this area. It's all interwoven"
-Catholic Home Care, Nassau County Event

Lack of adequate TRANSPORTATION SERVICES are a deterrent to those accessing care, particularly those who require preventive screenings or follow-up health services.

"Transportation would be helpful. They are creating more barriers to limit access to transportation, rather than opening it up. All the research shows if you're accessing care after the follow-up appointments or going to the doctor, that you are going to utilize fewer resources. It is better for your patients, but there are barriers in place so you can't access them. If you can't get an ambulette, a person uses the ambulance. We want the people to follow-up. We want them to be healthy, but by limiting what they can use, we are limiting their ability to follow up."
-John T. Mather Memorial Hospital, Suffolk County Event

METHODOLOGY

With data collection and analysis serving as the backbone for selection of regional population health activities, LIPHIP partners worked collectively to identify a regional data analysis strategy. Primary data collection tools were developed in collaboration with stakeholders following the collective impact approach.

Quantitative Primary Data Collection

SCAN FOR Prevention Agenda Survey Tool

Zip code level quantitative data elements collected from community members using a culturally sensitive Prevention Agenda Survey Tool

Surveys were distributed - by hand through paper and electronically through Survey Monkey - to community members on Long Island. The electronic version placed rules on certain questions; for questions 1-5, an individual could select three responses and each question was mandatory. To accommodate inconsistencies made on paper versions, paper surveys were sorted into two categories, "rules" and "no rules." The "rules" surveys were entered into the public Survey Monkey collector, while the "no rules" surveys were entered into a separate, closed collector, where any number of responses could be selected and others could be skipped.

To address inconsistences within the paper "no rules" surveys, each answer that included more than three responses went through a weighting system. The weight for each response option was $3/x$, where x is the count of responses. A weight of one was applied to each response when less than three responses were selected, due to the fact that respondents had the option to select more. After this formula was applied to the "no rules" data, the results were added to the "rules" survey results.

The survey results were downloaded multiple times throughout the year to create windows of data comparison - on March 21, June 2, and November 1. 6,568 surveys were collected between January and November 2016; 2,335 responses for Nassau County, and 3,910 responses for Suffolk County, making our confidence values 2.03 and 1.57, respectively, at a confidence level of 95%. Confidence values are based on the 2010 census for Nassau and Suffolk counties.

Qualitative Primary Data Collection

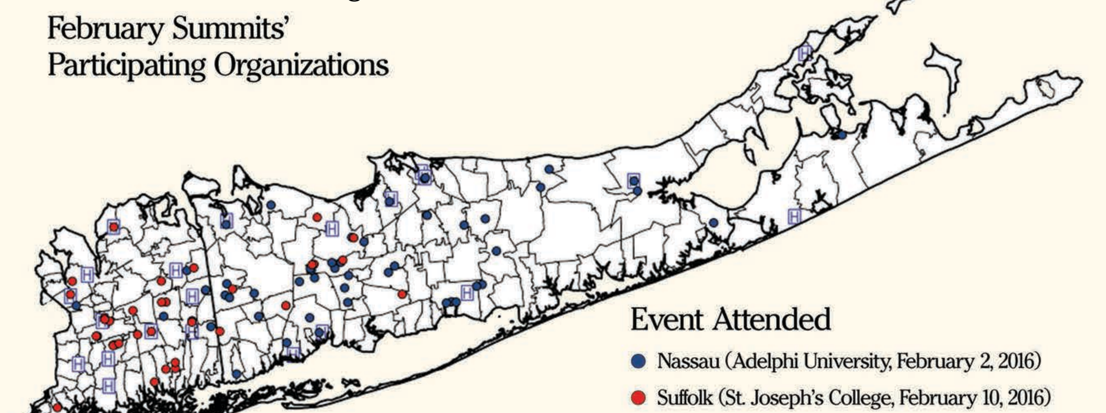
SCAN FOR Facilitator Script

Comprehensive qualitative data collected during Summit Events from community-serving professionals during facilitated discussions

To capture professional expertise from representatives working directly in the community setting, three summit events for representatives from community-based organizations were held in February 2016. Regionally, 119 organizations participated, contributing to the diversity and breadth of qualitative data collected during events. Seating assignment of participants at facilitated discussion tables was randomized, with seven to twelve participants seated at each table. After permission was granted by participants, the groups were guided through scripted, facilitated discussions by trained facilitators. Discussions were recorded and transcribed by certified court reporters.

ATLAS.ti qualitative data analysis software was used to guide and structure the analyses of these transcriptions. Members of a Qualitative Analysis team discussed strategy and logistics of this project, from the planning of the events through to the completion of the reports. The strategy for the selection of codes was multi-layered, ensuring all themes were captured on the code-list. Key terminology from the New York State Prevention Agenda blueprint was selected and applied to the coding process, while reading through each transcript and identifying words spoken in vivo allowed the analysis team to compile this comprehensive list of selection codes. Specific data elements were exported following analysis: speaker quotations, code co-occurrence frequencies, and tabular frequencies of quotations according to the county being represented by the speaker. A focused set of secondary analyses was completed after the initial identification of key themes and priorities, in order to better understand the population needs within broad categories of health and/or access issues.

February Summits' Participating Organizations



CONCLUSION AND APPLICATION

In March, stakeholders reviewed primary data findings and unanimously agreed upon selection of Preventing Chronic Disease as the Prevention Agenda Priority with focus areas (1) Reduction of obesity in children and adults (2) Enhanced access to chronic disease self-management programs in clinical/community settings.

The group also agreed to overlay strategies of the promotion of mental health and the prevention of substance abuse in coordination with DSRIP milestones.

Pursuing a cross-collaborative approach to identifying unmet health needs and disparate areas on Long Island has led to improved,

- Information sharing
- Pooling of resources
- Partnership formations
- Adoption of standardized policies and evidence-based interventions
- Streamlining of activities to expand community reach
- Focus on total population health strategies.

Meaningful data applications stemming from this approach include,

- Guidance of state-required Community Needs Assessments and community level interventions for hospitals and local health departments
- Unparalleled access to tailored reporting for community-serving organizations, to support the funding of and reasoning for evidence-based programming and community intervention strategies
- Data collection planned in coordination with DSRIP Performing Provider Systems as they work to meet their milestones and assess Medicaid/uninsured populations
- Standardization of primary data collection tools
- Meaningful synthesis of qualitative data elements to develop two county-level research reports with analytic interpretations.

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