



# **Qualitative Research Analysis of Key Informant Interviews Conducted Among Community-Based Organizations on Long Island**

**Presented May 3, 2022**

## **EXECUTIVE SUMMARY**

The Long Island Health Collaborative (LIHC) is a partnership of Long Island's hospitals, county health departments, health providers, community-based social and human service organizations, academic institutions, health plans, local government, and the business sector, all engaged in improving the health of Long Islanders. Collaborative members are committed to improving the health of people living with chronic disease, obesity, and behavioral health conditions in Nassau and Suffolk counties.

The LIHC assists its members with their Community Health Needs Assessment by providing data for members to use in their final CHNA reports. Members are charged with this task by both the federal and state government, and they are required to obtain feedback from community-based organizations (CBOs) during the CHNA process. The LIHC performed the following to gain feedback from CBOs.

## **METHODOLOGY**

A purposeful sampling procedure was initiated: a form of non-probability sampling in which the researcher relies on their own discretion to choose variables for the sample population, deliberately selecting participants who have information in the phenomena being studied. As a first step, surveys were sent to 400+ community-based organization leaders, which yielded quantitative results about their observed health needs and barriers among the populations they serve. One question on this survey asked the CBO leaders if they would be interested in further discussion. 23 informants expressed interest in being interviewed and were contacted for further discussion. Consistent outreach (first two email correspondences,

then one phone call) and follow-through yielded 12 informants who were able to fully proceed to the interview stage. The interviews were conducted between February 23<sup>rd</sup>, 2022 and March 4<sup>th</sup>, 2022.

The interviews were conducted and recorded via Zoom with two different interviewers, reading from an interview instrument with five questions (Appendix A). Two of the five questions were closed-ended, and prior to the qualitative analysis, these two questions were analyzed separately. One asked about New York State Prevention Agenda topics, and the other asked about the most pressing social determinant of health needs (Appendix B). Audio recordings were transcribed and uploaded to Atlas TI Web software for analysis with interviewee permission. Participation in the interview was voluntary, with both interviewee identity and responses kept confidential.

The first necessary step of the data analysis was becoming informed on the history and goals of the Long Island Health Collaborative and the purpose of the Community Health Needs Assessment: to determine the health needs and barriers affecting Long Islanders at the individual and community level.

The interviews were revisited, reread and open-coded with a wide net. Atlas TI version 22 web-based software was used for the qualitative analysis. The variety in backgrounds and expertise of the key informants permitted an expansive open-coding format such as social interactions, personal accounts of the key informant's healthcare experiences on Long Island, the essential tasks and services their organizations provide, their thoughts on what are the most pressing health issues affecting Long Island's populace, and more were coded. The

interview instrument invited open-ended responses yet still kept the topic of discussion narrowly focused on Long Island's systemic health needs. These codes were then parsed through and related back to the interview transcripts, and several concepts reappeared frequently under these wide-ranging codes. These included economics, healthcare service infrastructure, burden of disease and systemic inequality. These frequent concepts shared a near identical level of abstraction yet remained exclusive enough in identity to be categorized separately and were then drafted as some of the initial focused codes. Open codes were read again alongside the interview transcripts to see if additional categories could be drafted, rearing a total of 15 categories to be established as the focused codes. The interviews were reread and aptly recoded with these 15 focused codes.

Borrowing classification schemes wholesale from external sources risks funneling the data through a biased filter, muddying levels of abstraction and running risk of trivializing crucial data points. The researcher defined the focused coding list and their meanings but still respected the Kaiser Family Foundation Social Determinants of Health (Merriam & Tisdell, 212). This was also the case for the five priorities identified in the [New York State Prevention Agenda](#). The focused codes aimed to encompass the entirety of the interview data featured, defined with apt exclusivity so several codes handled similar but not identical data points (Merriam & Tisdell, 213).

Across all 12 transcripts, the interviewees shared their professional background, organizational goals, social determinants and health issues most affecting Long Island and the communities they serve, along with personal stories on healthcare issues affecting their constituents. The process of establishing the focused codes was a gradient of transition from

inductive to deductive analysis, best defined as “grounded theory.” The process opened inductively, reading the transcripts and deriving tentative codes, then continuing to read additional transcripts and noting whether these early codes remained applicable. Proceeding through the data revealed some earlier codes to be of low value while others were only strengthened, and the latter half of the analysis process transitioned to a deductive stance of seeking data that supported the finalized set of codes. Viewing the transcripts through this complete set of parameters yielded several critical themes.

## **KEY FINDINGS**

Despite the key informants hailing from a variety of different yet highly specialized education, expertise, and management experience, several common themes were drawn between all 12 transcripts (with the interviewees remaining anonymous).

### **Barriers to healthcare**

Acknowledging and tackling barriers to healthcare was the strongest sentiment presented between the 12 transcripts. Health insurance tied to employment status or poor insurance options was the most outstanding healthcare access issue: many without insurance do not approach medical health services due to fear of extensive burden of costs, and many programs are trying to alleviate or outright eliminate this issue:

*“A lot of people end up in emergency rooms because they don’t have primary care; they don’t have access so they end up with a bill that they can’t pay so we work with them to negotiate with the hospitals and advocate for them to expunge bills.”*

Consistent marketing and outreach by healthcare services was also highlighted as being vital:

*“I think that is the best strategy that I have is just keep on connecting and reaching out to everyone letting them know that we’re here. Let’s work it out. Let’s find out what we can do what people would like to see, what people need to see.”*

## **Financial Insecurity**

Rising costs of living put enormous pressure on Long Island’s residents. Several informants have lamented the United States healthcare system and that many of the systemic issues start at the very top:

*“A fragmentation of funding for public health [...] and the barriers it creates to accessing whole care for individuals beyond demographics and beyond disease conditions, all of that is coming from our healthcare system that is broken. It is a barrier written, it is money driven exclusively if people are willing to admit it or not, that’s the underlying realities.”*

There is still both respect and a need for local, smaller-scale community programs and services, but many of these are seen as effectively Band-Aid fixes that are not tackling the issue of a healthcare system that is driven to maintain a reasonable profit margin at the absolute top level. In addition, wages are not keeping up with the costs of living:

*“It’s not true that people can live on \$15 an hour, I mean let’s just get right down to the basics [...] but if we look at the poverty uptick in Nassau County you know that the percentage of poverty in Nassau County is through the roof.”*

An informant expressed that financial insecurity can be a permanent stressor and stress itself can yield physical health consequences in line with chronic disease. Stress can also cause mental health issues, demonstrating how several of these shared themes throughout the interviews can be interconnected:

*“And in order to prevent cancer, you have to de-stress because yes stress is cancer causing, and it is a silent killer. So, and stress, little break you down mentally, so I think if you address those issues and find ways to, guess, alleviate. [...] Here in Suffolk County, most people have to work two to three jobs.”*

## **Education**

Education was a critical discussion point, with virtually all key informants cementing it as an absolute necessity. Multiple facets of education were strongly emphasized, including completion of K through 12, college education, vocational training and increased health and healthcare literacy:

*“I think that on all levels, both adult education and traditional K through 12 education is the key to both a community’s survival and personal success.”*

Creation of free and affordable programs that facilitate active learning and personal growth beyond a classroom was also emphasized, such as a six-week cooking and nutritional education program:

*“Being able to consistently have healthy food, cook it and compare it. Vegetables and fruits are foreign to them. Touch base on all these components and additional nutrition education.”*

Education leads to self-empowerment, which leads to making more informed choices and then proceeds to greater stability and income:

*“...she’s able to get a job or to go for training, education or some skill to become more independent and more stable. That would be one prong of the fork.”*

## **Mental Health**

Multiple key informants expressed large concern with tackling the stigma of mental health and providing better access to mental health services. Despite the difficulty the COVID-19 pandemic caused every individual, it did provide greater clairvoyance on the societal issues of mental health stigma and perhaps provided a cultural shift towards lessening it:

*“And it’s just that stigma that you need mental health care. However, when we move from that stigma and just say, you know, any small problem that you think you need to express your thoughts about and that we can listen, and perhaps together we can find a pathway to clear that.”*

*“People’s mental health needs to be supported and they need a helping hand. Tearing away at the stigma of mental health.”*

The link between mental health issues and substance abuse and how they cyclically fuel each other was also a discussion point:

*“And, you know, mental health, obviously substance use goes hand in hand, many times obviously people are using substances to mask the symptoms and the pain of the mental health issues.”*

## **CONCLUSION**

The key informants shared their expertise, personal histories and what social determinants of health are currently most important on Long Island’s healthcare landscape. The categorized codes were analyzed both on an individual level and across all collective interviews and yielded a narrative of rising economic pressure, infrastructure barriers to healthcare, a necessity in funding mental health awareness and a need to increase education endeavors at all levels. This analysis provided strong evidence that the themes of mental



health, education, economics, and barriers to healthcare most affect CBO leaders and the populations they serve. The primary domains and sub-domains uncovered through this inductive and deductive reasoning process provide a deeper understanding of the healthcare issues and barriers faced. The findings primarily align with results from the CBO quantitative assessment that asked closed-ended questions, and the [Community Health Assessment Survey](#) distributed to individuals. That survey sought to uncover individuals' perceptions about barriers to care and health concerns for themselves and their communities.

## **AUTHORS AND RESEARCHERS**

Michael Pape, Masters in Public Health Student, Stony Brook University Program in Public Health performed the qualitative analysis and wrote this report to fulfill his degree's practicum requirement.

Janine Logan, MS, APR, Vice President, Communications and Population Health; and Brooke Oliveri, Manager of Communications, Health Outreach, and Research—both principals of the Long Island Health Collaborative— conducted the interviews and designed the study.

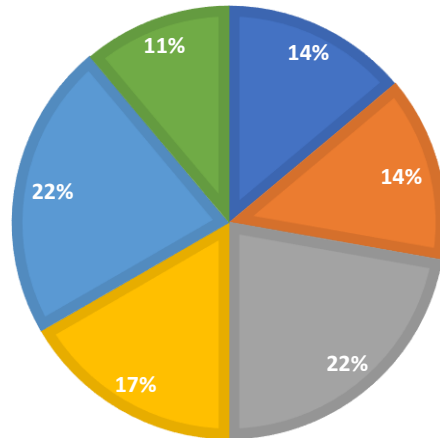
## **APPENDIX A - INTERVIEW INSTRUMENT**

1. Please describe your organization?
  - a. Describe your role in the organization
  - b. What specific services does your organization provide?
  - c. Who is the target population?
  - d. Describe services your organization provides to minority populations
  - e. ...to low-income
  - f. ...to uninsured
  - g. ...to other specific populations?
  
2. Many factors affect the health care community members receive. Of the Kaiser Family Foundation Social Determinants of Health, which 3 most affect the healthcare of the community members you serve?
  
3. Please elaborate on why you chose those three determinants, and elaborate on how they affect the community you serve.
  
4. Of the three social determinants you identified, which are essentially barriers to care, what strategies do you recommend for overcoming these barriers?
  
5. The current New York State Department of Health Prevention Agenda has identified 5 health issues to address. Please choose your top 2 priorities for the community you serve.

## **APPENDIX B**

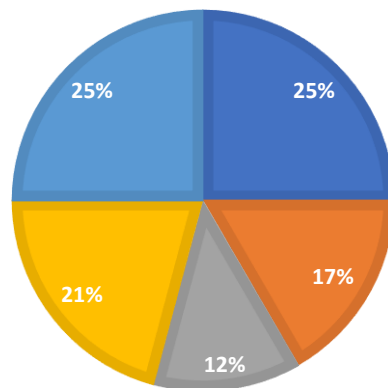
## SOCIAL DETERMINANTS

- Community and Social Context
- Economic Stability
- Education
- Food
- Healthcare System
- Neighborhood and Physical Environment



## PRIORITIES

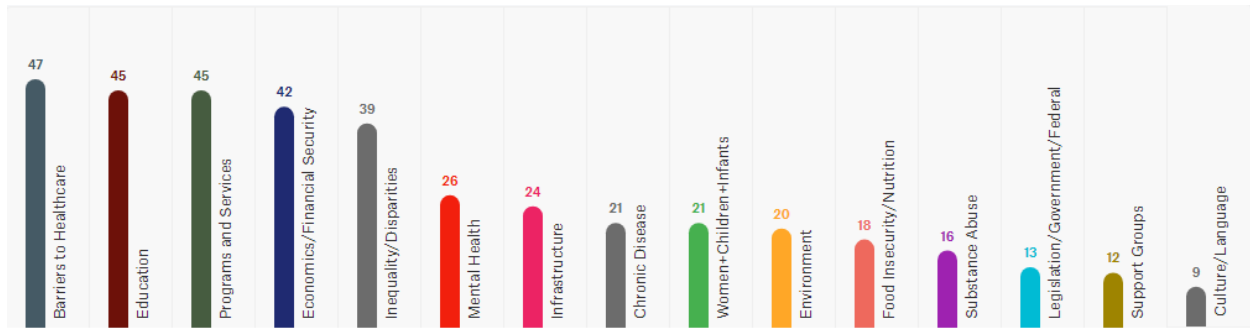
- Prevent Chronic Disease
- Prevent Communicable Diseases
- Promote a Healthy and Safe Environment
- Promote Healthy Women, Infants and Children
- Promote Well-Being and Prevent Mental and Substance Use Disorders



## CODES

<b>Primary Domain</b>	<b>Sub-domain</b>
Access/Barriers	Location, Quality, Transportation
Chronic/Communicable Disease	Cancer, Cardiovascular, HIV, HPV, Hypertension, Obesity, Oral Health, Immunization, Physical Activity, Vaccination
Culture/Language	Culture, Ethnicity, Language, Minority, Race, Similarity
Economics/Financial Security	Cost of living, Inflation, Economics, Expenditures, Expenses, Money, Unaffordable
Education	College, High School, Knowledge, Literacy, Vocational School
Environment	Air Quality, Biking, Injury, Physical Environment, Road Quality, Traffic, Safety, Walk
Food Insecurity/Nutrition	Cooking, Food Desert, Nutrition
Inequality/Disparities	Elderly, Homeless, Racism, Red-Lining, Unemployed, Veteran
Infrastructure	Healthcare, Hospital, Insurance, System, Tax, Technology
Legislation/Government/Federal	Federal, Government, Lobbying, Medicaid, Medicare
Mental Health	Depression, Hopeless, Mental illness, Psychiatric, Psychotic, Stigma, Stress
Programs and Services	Application, Initiative, Partnership, Program, Project, Service, Solution, Volunteer
Substance Abuse	Addiction, Alcohol, Heroin, Opioids, Treatment
Support Groups	Empowerment, Outreach, Support
Women+Infants+Children	Baby, Child, Childcare, Maternal Mortality, Mother, Women, Reproductive Health

## CODE DISTRIBUTION



## SOURCE INDEX

Merriam, S. B. & Tisdell, E. J. (2016). Qualitative Research: A Guide to Design and Implementation [4<sup>th</sup> Edition]. Jossey-Bass.