January 2013

The Need for Caring in North and Central Brooklyn

A Community Health Needs Assessment

Ngozi Moses, Principal Investigator
Executive Director, Brooklyn Perinatal Network

Co Lead Partners:
Judy Wessler, Commission on the Public's Health System
Shena Elrington, New York Lawyers for the Public Interest

"Health Care in Brooklyn is in full crisis mode. From inadequate quality of care to a lack of access to care, the healthcare infrastructure is literally on life support. Barriers to care and growing healthcare disparities have all combined to further compound an already difficult situation."

- State Senator John L. Sampson

BPN With Co-lead Partners CPHS and NYLPI

Table of Contents

EXECUTIVE SUMMARY 6

I. INTRODUCTION 18

Need for this Study 18

Background 19

II. LITERATURE REVIEW 21

IV. ASSESSMENT STUDY APPROACH 26

V. METHODOLOGY 27

A.THE SURVEY 27

Data Collection and Methodology 29

B. THE FOCUS GROUPS 33

Measures 34

VI. FINDINGS 37

A.SURVEY FINDINGS – Drawing a picture of the surveyed population 37

Health Care Experience 47

Access to Care 55

Barriers to Care 71

Open-Ended Qualitative Questions on the Survey 78

B. FOCUS GROUP FINDINGS 87

Focus Group Participants 87

Individuals Living with Physical and Sensory Disabilities (this group did not include any people living with mental disabilities) 88

Immigrants 99

Young Men Aged 18- 30 103

Older Men 45-55 106

Senior Citizens 109

Pregnant Women 112

Lesbian Gay Bisexual Transgender Queer/Questioning (LGBTQ) 115

VII. DISCUSSION 128

VIII. RECOMMENDATIONS 132

IX. ENDNOTES 137

List of Tables

Table 1 – Priority 1 Zip codes 28

Table 2 – Priority 2 Zip codes 28

Table 3 – Priority 3 Zip codes 28

Table 4 – Household Size 38

Table 5 – Type of Insurance (No. of Responses) 48

Table 6 – Health Conditions 51

Table 7 – Location Where Treatment is Received 53

Table 8 – Major Reasons for not going to a doctor 55

Table 9 – Health Care Provider Visits in Community 58

Table 10 – Types of Facilities where care is sought 59

Table 11 – Length of Travel Time to Access Care 60

Table 12 – Mode of Travel to Access Care 61

Table 13 – Responses for Seeking Care outside Community 64

Table 14 – Type of Place Where Care is sought outside Community 66

Table 15 – Length of Travel Time to Access Care outside Community 67

Table 16 – Mode of Travel to Access Care outside Community 68

Table 17 – Emergency Room Use 69

Table 18 – Difficulty Accessing Health Care Providers 72

Table 19 – Issues that Might Limit Ability to Access Care 74

Table 20 – Barriers to Accessing Prescription Medications 77

List of Figures

Figure 1 – Survey Respondents by Age 37

Figure 2 – Survey Respondents by Gender 39

Figure 3 – Survey Respondents by Race/Ethnicity 40

Figure 4 – Survey Respondents Identifying as Latino 42

Figure 5 – Respondents by Country of Origin 43

Figure 6 – Respondents by Language Fluency 44

Figure 7 – Respondents' Length of Residence 44

Figure 8 – Marital Status 45

Figure 9 – Employment Status 46

Figure 10 – Household Health Insurance Status 47

Figure 11 – What Type of Health Insurance 49

Figure 12 – Do you or members of your household Have Health Conditions 50

Figure 13 – Level of Satisfaction with Services 54

Figure 14 – Reason for Seeing a Provider 55

Figure 15 – Care in the Neighborhood 57

Figure 16 - Convenience of Care 61

Figure 17 – Major Reasons for Seeking Care outside Neighborhood 63

Figure 18 – Emergency Room Usage 68

Figure 19 – Barriers to Care 71

Figure 20 – Access to Medications 77

Acknowledgements

Our report, "The Need for Caring in North and Central Brooklyn" is a community health needs assessment (CHNA) project which deliberately applied a community-based participatory research (CBPR) approach. It was a collaborative effort engaging several community-based service providers, partners and the Community Health Planning Workgroup (CHPW), a Brooklyn-based advisory group convened by The Brooklyn Hospital Center (TBHC) and Interfaith Medical Center (IMC). Brooklyn Perinatal Network (BPN), the contractor and project administrator, on behalf of the partnership that led this project, therefore acknowledges all those who participated in this very important initiative.

We deeply appreciate and acknowledge the numerous organizations and individuals who made this project possible from ideation to completion of the report, including:

- *The over 800 Brooklynites who took the time, when approached at various locations throughout several neighborhoods in North and Central Brooklyn, to respond to the field questionnaire interviews and participate in focus group discussions. Seven hundred and twenty three (723) persons were interviewed by surveyors and another 78 participants took part in the focus group discussions.*

- *The thirteen (13) community-based organizations (CBOs), listed below, and their respective staff, who conducted the face–to-face interviews which required about 15 to 20 minutes to complete. They completed 644 valid surveys, which does not capture or include the untold number or persons approached by the CBOs' staff members, who ultimately declined to participate, or were screened out of the interviews. By all measures, this was tough work - particularly given the fact that people are often sensitive about divulging their health care experiences and openly sharing their views of public systems. The CBOs' knowledge of the communities and target populations and their ability to engender the trust of the community members to respond to the survey and participate in focus groups were critical assets. Their work was essential to our success in gathering information from people whom are often unreached by traditional community assessments.*

- *The members of the CHPW, convened by the TBHC and IMC, which is comprised of representatives from 18 organizations, including the two hospitals, community health centers, CBOs and others. Members of these organizations were important contributors and provided a critical sounding board for the development of the project proposal and the reporting of our findings. The CHPW endorsed and encouraged the work, provided input that helped sharpen the proposal and offered insights which were invaluable in helping to identify neighborhoods to be targeted for this CHNA. Efforts by members of the CHPW to review, comment, and offer recommendations to improve the report were immensely helpful. Dr. Jean Ford, the Chair of the Department of Medicine at TBHC and a recognized leader in health disparities and the CBPR approach provided us with expert comments on the draft report and commended the quality and the immense value*

of this report to the CBPR field. His comments helped us to strengthen the presentation of our methods.

- *The Brooklyn Stakeholder Group of the Save Our Safety Net- Campaign (SOS-C) - comprised of unions, community-based organizations, health professionals, advocates and community residents. This workgroup was specifically set-up to address the Brooklyn health care crisis by engaging local stakeholders for comment. One meeting provided valuable input for the targeting of study zip codes.*

- *The co-lead project partners - the Commission on the Public's Health System (CPHS) and New York Lawyers for the Public Interest (NYLPI) - and the CUNY Institute for Health Equity (CIHE), their staff and graduate student/volunteers. All were invaluable, working together as an expert team committed to contributing specific knowledge, skills and experiences to the process. As is often the case with collaborative partnership projects like this one in which decision-making is made by the group under time sensitive conditions, resulting tensions in relationships may occur, which need to be balanced in order to produce the best quality work. Our experience was no exception. I congratulate this team for the great work commitments made when the project overran projections and the high quality product we were able to deliver. The role of each partner, detailed below, was tremendously important to achieving this result. The project would not have been completed without their dedication, attention to detail, and good humor as the project work moved through the different stages from ideation to completion. Key activities included:*

    - *designing the project, assessment tools and methodologies;*
    - *training and supervising field data collection;,*
    - *data analysis and interpretation;*
    - *conducting literature review;*
    - *developing materials for outreach and promotion to recruit residents to participate in focus groups and surveys;*
    - *providing general supervision and technical support for meetings and activities;*
    - *preparing and producing the final report.*

- *Our elected officials and government colleagues, who remain committed to improving the health outcomes and health care services available to all Brooklynites. In particular, we thank the offices of State Senators John L. Sampson and Velmanette Montgomery and the Office of the Brooklyn Borough President, Marty Markowitz. Their staff committed time to the CHPW processes as the CHNA was in progress, reviewing and commenting on the process to improve the quality of the report.*

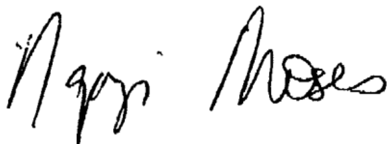
- *BPN consultants, and student/community volunteers, those funded by the project and the numerous others who were not, but contributed time. All of whom helped to tackle the*

listless number of needs that arose and needed to be addressed immediately to keep the project on track, including helping to prepare for the many meetings that took place and identifying/engaging residents for focus group participation. Denise West, BPN's Deputy Director and Project Overseer, played a critical management and oversight role – we extend a very special thank you to you for all that you have done for this project.

- *And finally to the CHNA project funders: the New York State Department of Health (NYSDOH), The Brooklyn Hospital Center, and the I.M. Foundation. This project would not have been possible without the vision to engage in this initiative, the funding provided, and your invaluable insights contributed.*

Thank you for all of your contributions. As a result of this effort, there has been considerable interest in the CBPR CHNA approach. For example, a representative from a community- based organization in an outer borough facing a similar community health system crisis to the one in North and Central Brooklyn participated in one of the listening sessions we held to present our CHNA findings to community members. Following the session, the representative of that organization contacted us to explore the possibility of undertaking a similar project in his borough. This confirms the potential value of this CBPR approach to serve as a model to inform replication efforts. In addition, the CUNY Institute for Health Equity (CIHE) has expressed interest in continuing to partner with interested Brooklyn stakeholders for other similar CBPR projects.

In closing, I offer our heartfelt thanks to all of you. This tremendous work and report would not have been possible without all of your contributions.



Ngozi Moses

Principle Investigator/Project Director

Executive Director, Brooklyn Perinatal Network.

CONTRIBUTING ORGANIZATIONS & INDIVIDUALS

<u>Project Co-lead Organizations</u>

Brooklyn Perinatal Network, Inc. (BPN)

Jasmine Milliner – Project Coordinator
Leo Okezie – Project Coordinator
Denise West – Deputy Executive Director & Project Overseer *(a very special thank you)*
Ngozi Moses – Principal Investigator/Project Director
Carolyn M. Springer, PhD – Community Research Consultant
Cathleen Freemantle – Project Associate
Arthur Ashe Institute/Brooklyn Health Disparities Center – High School Students

Commission on the Public's Health System (CPHS)

Judy Wessler – Director
Mary Li – Education and Outreach Coordinator
Jonathan Garellek – Intern

New York Lawyers for the Public Interest (NYLPI)

Shena Elrington – Director, Health Justice
Alyssa Aguilera – Community Organizer, Health Justice
Jennifer Bright – Intern
Ariel Linet – Intern

<u>Academic Partner</u>

CUNY Institute for Health Equity (CIHE)

Marilyn Aguirre-Molina, EdD, MS – Executive Director & Professor of Public Health
Justin T. Brown, PhD(c), MA – Executive Research Associate
Nika Lunn, MA – Deputy Director
Amy Lukin – Intern
Anna-Carina Sporri – Intern

<u>Brooklyn Community Based Organizations</u>

Field Surveyors

Arab American Family Support Center
Brooklyn Perinatal Network
Caribbean Women's Health Association
East New York Diagnostic and Treatment Center
Ft. Greene Strategic Neighborhood Action Partnership
Make The Road New York
New Dimensions in Care

New York Communities for Change
Progressive Community Center for Children and Families
The United Jewish Organizations of Williamsburg, Inc.

Focus Group Hosts

Brooklyn Center for Independence of the Disabled, Inc.
Brooklyn Community Pride Center
Caribbean Women's Health Association
Central Brooklyn Economic Development Corp.
Spanish Speaking Elderly Council - RAICES

The Community Health Planning Work Group (CHPW) Member Agencies

Bedford-Stuyvesant Family Health Center
Brooklyn NAACP
Brooklyn Perinatal Network
Brooklyn Plaza Medical Center
Brownsville Multi-Service Family Health Center
Commission on the Public's Health System
Community Healthcare Network
Interfaith Medical Center
Kings County Hospital
Lutheran HealthCare
New York Lawyers for the Public Interest
NYC Department of Health - Brooklyn District Public Health Office
Office of State Senator John L. Sampson Office
Office of State Senator Velmanette Montgomery
Office of the Brooklyn Borough President
The Brooklyn Hospital Center
The Brooklyn Hospital Center - Community Advisory Board

THE NEED FOR CARING IN NORTH AND CENTRAL BROOKLYN

EXECUTIVE SUMMARY

Introduction

The study, *The Need for Caring in North and Central Brooklyn*, was undertaken as a community health needs assessment (CHNA) to determine residents' perceptions of needs, barriers, and gaps in access to health care services in 15 zip codes in North and Central Brooklyn. These communities have long been designated as medically underserved and in need of more equal treatment. The neighborhoods prioritized in this assessment were: Bedford-Stuyvesant, Bushwick, Brownsville, Crown Heights, Cypress Hills, East Flatbush, East New York, Flatbush, Fort Greene, Prospect Heights and Williamsburg. In addition, the communities of Downtown Brooklyn, Gowanus, and Greenpoint were included since they lie within the catchment area of The Brooklyn Hospital Center (TBHC).

Brooklyn Perinatal Network (BPN) led the study with co-lead partners, the Commission on the Public's Health System (CPHS) and New York Lawyers for the Public Interest (NYLPI) and with significant academic back-up by the CUNY Institute for Health Equity (CIHE). The study's intent is to inform proposed changes to the health care delivery system in North and Central Brooklyn financed by the Health Care Efficiency and Affordability Law for New Yorkers Capital Grant Program (HEAL NY), as a first phase. The research was funded by the New York State Department of Health (NYSDOH), The Brooklyn Hospital Center (TBHC), and the I.M. Foundation.

Methodology

Approach

A two-pronged approach, field surveys and focus groups, was used to capture the voices of community residents. The field surveys were open to the community as a whole, as long as they met requirements for age (18 or older), household location (must live in one of the 15 designated zip codes), and income and family size (must meet income guidelines developed by the New York City Housing Authority). Respondents were screened so that the surveys would capture perceptions from low-income residents in the study area. Focus groups targeted those whose voices were likely to be underrepresented in the survey population, e.g., those with special needs. The

research study was given exemption status by the institutional review board (IRB) of an independent research agency. A convenience sampling procedure was used, but the socio-demographic characteristics of the sample do match several of the characteristics of North and Central Brooklyn residents in terms of race/ethnicity, gender and insurance status. In addition, listening sessions were conducted to present the preliminary findings to community stakeholders where the majority present confirmed that findings were representative of their experiences. The study used data from multiple sources - surveys, focus groups and listening sessions – to assess the perceptions and experiences of residents and these aligned with the findings from previous community assessments. A community based participation research (CBPR) approach allowed for a collaborative process in which key stakeholders had a role in the study design, data collection, and data interpretation.

The use of a non-probability based convenience sample limits the ability to generalize the findings. Data collection was primarily done during the hours of 9 AM to 5 PM and may have excluded those who work during those hours. Only one focus group was conducted with each specific population which may limit generalizability. Finally, the survey process did not focus on specific illnesses but asked general questions about overall health.

Study Sample

A non-probability based sample of 644 community residents completed valid surveys which contained 10 demographic questions, 29 questions that addressed experiences in accessing health care and three open-ended questions.

Seventy-nine residents from 13 of the targeted zip codes participated in nine focus groups conducted with: teens, people living with disabilities, Spanish-speaking people receiving mental health services, immigrants, men aged 18-35, men aged 45-55, senior citizens, pregnant women and individuals identifying as LGBTQ. Participants completed a 10 item survey (nine socio-demographic questions, one open ended question) about challenges faced in accessing health care) and then took part in a discussion about their utilization of medical services, access and barriers to care, types of health services and accommodations needed in their community and changes they would like to make in the health care system. Focus group questions paralleled the questions asked on the survey.

Survey Findings

Study Sample

The population captured in this survey mirrors the general population of the community in which the 15 zip codes are located in North and Central Brooklyn. A majority of the survey respondents, 352 or 54.7%, were between the ages of 26-and 50. According to 2010, Census Data, the range of North and Central Brooklyn residents between the ages of 25 and 64 ranges from 48.5% to 63.4% (median=53.8%) Almost two-thirds (65.8%) were women. According to 2010 Census Data, the percentage of North and Central Brooklyn residents who are women ranges from 46.1% to 56.3% (median=53%). 40% of the respondents in this survey are foreign-born. According to the Furman Center for Real Estate and Public Policy (2011), the foreign born population in North and Central Brooklyn ranges from 19.6% to 52.6% (median= 30%). The population of Central Brooklyn is 80% Black, including African-Americans and Caribbean/West Indians. Over 66 % of the respondents in the survey are Black (African-American and Caribbean), 21% are Latino and 15% are Multiracial. The income for people who are working in this study appears to be lower than the median income in the identified zip codes ($39,669 in 2010). In this study, 65% indicated an income less than $30,000 per year.

Health Experiences

- 76% of the respondents made health care decisions for themselves and their family. 73% reported that they and their household members had health insurance; primarily Medicaid, Child Health Plus, Family Health Plus.
- The most often reported illnesses/health conditions were: high blood pressure/hypertension (24.8%); asthma (19.9%); diabetes (15.7%); and hearing or vision problems (15.2%). For African-Americans and Latinos asthma and hypertension were the conditions most often treated in the ER.
- 89% of the sample had seen a health care provider in the past two years, primarily for a regular check-up; and 86% indicated that they were able to get regular checkups when they were healthy.
- The primary sources of health care both within and outside of the community and for respondents with identified health conditions were doctor's offices (36.2% to 43.8 % of responses), hospital clinics (24% to 27.2% of responses) and community health centers (16.2% to 23.8% of responses).

- 85% of respondents said that it would be most convenient to receive care in their neighborhood and 72% received some or all of their care in their community; almost 20% of the sample (18.7%) received none of their care in their community. The major reasons for seeking care outside of the community were: the need to see a specialist (25.7 % of responses); being referred or assigned a doctor in another neighborhood (14.7 %); low satisfaction with neighborhood services (8.8 %); waiting too long to get an appointment / too long to be seen at an appointment (13.4%).

- The majority of those who received care within their community travelled 30 minutes or less and the most common modes of transportation were walking or using the bus or subway. Those who received care outside of the community travelled for 30 minutes to an hour, and also did so mostly by bus or subway.

- 50% reported using the emergency room in the past two years. The majority made 1-2 visits; asthma, high blood pressure were the major reasons most cited.

- Dental care (86 respondents), more [primary care] doctors and clinics (76), OB/GYN (38), pediatrics (35), mental health (32), and geriatric services (18), were the most frequently mentioned as services needed in the community. Specialty care services were viewed as needed, as were specialists in general (44 respondents), eye doctors (14), and cardiologists. Services for special populations (10 respondents) and recreation and preventive services (10) were also identified.

- About half (51.4% of the respondents) had a limited ability to secure health care services. Barriers to health care identified included: waiting too long to get an appointment (13.5% of responses); waiting too long at appointments (9.6%); lacking health insurance (12.2%) or problems with insurance (7.6%); the cost of care (9.1%). Quality of care, lack of information on where to find care, culture and language differences, hours of service, and problems with the attitude of providers were also common concerns.

- 83% of the sample was able to obtain prescription medications when they needed them. The major barriers for the remaining 13 % (4% were not sure) were lack of health insurance, cost and problems with their health care plan.

- African-Americans 56.5% (of 130), followed by Latinos 52.5% (of the 63 who identified as Latino) had the highest utilization of the Emergency Room (ER) in the last two years. African-Americans' problems included asthma (31.5%), high blood pressure (28.5%), hearing or vision problems (18.5%); bone, joint or muscle problems (13.8%) and mental illness (12.3%). Latino respondents

indicated ER use for problems with asthma (31.7%), high blood pressure (28.6%), hearing or vision problems (23.8%); diabetes (27.0%); overweight/obesity (20.6%).

Focus Group Findings

Focus groups were conducted with teenagers, people living with disabilities, Spanish-speaking people receiving mental health services, immigrants, men aged 18- 35, men aged 45-55, senior citizens, pregnant women and individuals identifying as LGBT.

Overall, participants ranged in age from 13 to 88 years with an average age of 44 years. Over 60% of participants identified as women and 2/3 identified as Black. The annual median income was $20,000 or less. 1 in 6 was employed; about 7 of 10 had insurance.

Key Group-specific Concerns

Focus Groups provided an opportunity for residents of North Central Brooklyn to share their experiences more in-depth and to identify issues that they may have encountered due to their ascribed statuses. Focus group findings echoed those of the survey findings but also highlighted some of the unique challenges faced by different populations

- **Individuals Living with Physical and Sensory Disabilities** noted that: health insurance does not cover all of their needs especially when other medical conditions are present; a need for more physical accommodations at facilities; they relied on public transportation because of problems experienced with Access-A-Ride, New York City's paratransit service.
- **Teens** reported: treatment at health care facilities appeared to differ by the type of insurance individuals had and that it was important to address social issues in the community including violence, poverty, lack of employment opportunities, and low/poor education and obesity.
- **Spanish-Speakers Receiving Mental Health Services** focused on the need for culturally competent and linguistically competent care including the need for more qualified interpreters or medical professionals that speak their language; that having Medicaid resulted in rude treatment and a lower quality of care, including difficulties accessing specialists, long wait times and inadequate services.

- **Immigrants** identified: fears in seeking care and the need for more caring and compassionate health care; insufficient information. They were also concerned about the side effects of medications prescribed for existing health conditions; there was a preference for more natural healing methods.
- **Young Men 18-30** were most concerned about the lack of health care that resulted from having no or inadequate health care insurance and perceived the health care facilities in their community as providing a lower standard of care. They also identified social factors which impact the lives and health of community residents including race, limited income, lack of employment and job training opportunities and poor education.
- **Older Men 45- 55** stressed the need for better health care coverage, the need for information about health care insurance, and better communication with health care providers. They noted that health care treatment varied by race, social class and type of insurance and also voiced concerns about medication side effects
- **Seniors** focused on the need for information about health insurance plans; the poor quality of care provided at community facilities, more accommodations needed for seniors at facilities; the costs and other problems associated with using Access-A-Ride. A key issue was the lack of professionalism of providers and staff and the need for improvements in provider-patient relationships.
- **Pregnant Women** stressed the need for support especially for first time moms and were concerned about the long waiting times to see a doctor during scheduled appointments. They noted that accommodations that would enhance care for pregnant women included comfortable chairs, food and beverages and better triage.
- **LGBTQ** noted that: the lack of awareness and knowledge among health care providers about LGBTQ issues hampers communication and good relationships with providers and lessens compliance by patients. Mental health needs are not being addressed and that existing stigmas and perceptions make it difficult to seek care. They also noted that the lack of insurance or lacking awareness of insurance benefits is a barrier to care.

Overall Findings

The overall Findings of the survey and focus groups were also supported by feedback received from over 40 attendees at two listening sessions convened with constituents from the community. The residents of North and Central Brooklyn are a diverse group and specific health care conditions, access and barriers to care, and facility and emergency room utilization differ by zip code and by socio-demographic factors. However, there was a high level of concordance between the survey responses and focus groups themes, thus highlighting critical issues regarding health status, health access and service delivery in North and Central Brooklyn that need to be addressed.

The key points are:

- There is a perceived higher quality of care and quicker provision of services at health care facilities located outside of the community, thus prompting residents to travel elsewhere for care. Nearness to the facility was the top reason given for seeking care in the community. Participants with illnesses, disabilities or high risk conditions were more likely to seek care in their community of residence.
- For both groups, access to dental care and mental health services was hampered by inadequate or no health insurance. Survey respondents also indicated that access to basic care (doctors, nurses, pediatricians, etc.) and midwife/OB/GYN services was a problem along with access to dental care even when health insurance coverage was secured.
- The major barriers and challenges identified in accessing health care were the same in both the survey and focus groups. They were: Having no insurance; problems with insurance - does not cover needed services, medications, providers not accepting it; long waiting times to obtain an appointment; long waiting times at appointments; language and communication issues; costs of care; poor treatment by providers and staff; and inconvenient hours at which care provided.
- Socio-environmental changes are needed to promote healthier lifestyles, information about resources, and services for youth, seniors and special populations.
- A wide range of needed system-wide service improvements were raised by focus group participants including: changes in service delivery; more education for consumers; improved communication; better relationships with health care providers; changes in the structure of facilities; greater access to specialty care;

improved transportation; and more support groups and help addressing insurance problems.

- The need for universal access to care, universal or free/low cost coverage, equal treatment, better hours, more services and more available services, education for consumers, professionalism on the part of providers/staff and a focus on the social factors which impact health were raised by both survey respondents and focus group participants.

Recommendations

The survey and focus group findings from the CHNA highlight the critical need for improved access to health care services and changes needed in the health care system in many communities in North and Central Brooklyn. The following recommendations, which are derived from an analysis of the information gathered from the 722 community residents living in 15 North and Central Brooklyn communities who participated in either the survey or focus groups, are categorized into four categories, which mimic the original goal of the CHNA, namely to uncover residents' perceptions and concerns regarding:

- Health Care Quality
- Access to Care
- Utilization Patterns and Barriers
- System Changes to Improve Primary Care Delivery

Many of the recommendations fall under multiple categories, as noted below. Since the survey and focus groups targeted low-income residents of North and Central Brooklyn, the ensuing recommendations may not be representative of or applicable to the entire population of this region. Nonetheless, these recommendations highlight useful and meaningful ways to improve residents' access to health services and alter the health care delivery system in a manner that improves health outcomes.

Health Care Quality

- Conduct an air quality study to identify triggers in ambient air in Brownsville (11212), Cypress Hills (11208), Bushwick (11237) and Bedford Stuyvesant (11221), which showed the highest prevalence of asthma. Medical care alone cannot ameliorate this condition.
- Consider the basic needs of patients who are waiting for care. Certain health conditions (e.g. diabetes, pregnancy) may make it difficult for consumers to endure long waits at an appointment without food or beverages.

- Improve screening questions to be more inclusive of the needs of diverse populations, including people with disabilities and people who identify as LGBT, and target outreach to. This will provide for better accurate information gathering, hence improving more earnest consumer disclosures and sharing during medical visits.
- Increase the cultural and linguistic competency of health care providers, staff and administrators by providing ongoing staff development and training on communication skills, the needs of special populations and the importance of being sensitive to their unique needs and the importance of patient-centered care.
- Implement customer service training for all levels of health care staff to improve interactions with clients. Many of the participants noted differential treatment by staff by demographic characteristics (e.g. health insurance status, socio-economic status, immigration, race/ethnicity, language, sexual identity).
- Improve the accessibility and readability of essential medical/health care information in written materials, including but not limited to materials that discuss how to choose a health care provider, what insurance covers or does not cover, and out of pocket costs versus covered costs.
- Collaborate with community or health plan enrollers to work with consumers regarding changes in health care coverage to ensure that consumers maintain coverage for their health care services.
- Provide funding to train and educate patient advocates to support consumers by helping them navigate health care facilities and educate them on service availability.

Access to Care

- Increase OB/GYN practitioners in Prospect Heights (11238) and Bedford Stuyvesant (11233).
- Increase pediatrician providers in Bedford-Stuyvesant (11221).
- Extend primary care hours to evenings and weekends to better accommodate the schedules of patients.
- Increase awareness of and access to low cost health services and public health insurance.
- Financially support outreach and education efforts by grass roots community based organizations to promote community resources/services and provide education/assistance that will help facilitate appropriate referrals.
- Increase access to translation and interpretation services and work with consumers to develop delivery systems that will better meet consumer needs.

Health Care Quality & Access to Care

- Establish centralized referral services or information centers where consumers can obtain information on existing health care resources in their community. In addition, increase consumer awareness of grass roots community based organizations which can assist them with meeting their health care needs.
- Increase peer support groups for residents and make residents aware that such groups are available, particularly for special populations.

System Changes to Improve Primary Care Delivery

- Develop a system of care among a coordinated network of health care and social service providers, residents and community based organizations to address various barriers such as; the lack of cultural and linguistic competent information and resources available to community residents; the need for provider resource sharing to address long waiting time for and at appointments; the need for extended office hours/days to also address gaps in care/services and emergency room overuse.
- Develop a process to engage community residents ("community advisory board") to work on some of the community level utilization barriers, such as over-use of emergency rooms. Residents can help in various ways such as the development of messaging at the community level that will encourage use of alternative services and conducting outreach to encourage residents to use primary care and other services. African Americans and persons insured by Medicaid need special focus as they had the highest rates of emergency room use. Communities to pay special attention to are: Bedford Stuyvesant (11221 and 11216), Brownsville/East Flatbush (11212). Funding resources will be needed to engage residents.
- Explore improving or developing health care access and care coordination by linking community pharmaceutical services and hospital care electronic systems.
- Explore improving or developing better electronic systems between community pharmaceutical services and hospitals, which may improve medication compliance.

Access to Care & Utilization Patterns and Barriers

- Focus attention on particular illnesses and communities in order to target services where they are most needed. Our findings indicate that the following health conditions were prevalent and often the reason cited for emergency room visits: Asthma, diabetes, and hypertension. These illnesses were particularly prevalent in the following areas: Bushwick (11237) and Brownsville/East Flatbush (11212), Cypress Hills (11208) and Bedford Stuyvesant (11221). When comprehensive, continuous care is available these conditions can be treated on an outpatient basis
- Increase the availability of quality dental care services in North and Central Brooklyn. Priority should be given to communities reporting greatest problems in

accessing dental care; which are: Bedford Stuyvesant (11221), Bedford Stuyvesant/Ft. Greene (11205), Williamsburg (11206) and Cypress Hills (11208). Many residents travel outside of the borough for such services.
- Increase access to specialty health care services in the community. Participants indicated that they had to travel outside of their community to see specialists.
- Develop working relationship with Access-A-Ride to address consumer concerns with its transportation procedures, costs, and timeliness to increase utilization and access to appointments, particularly for senior citizens and people living with disabilities.

Access to Care, Utilization Patterns and Barriers & System Changes Necessary to Improve Primary Care Delivery

- Develop a coordinated campaign to outreach to and work with primary care practitioners, health clinics and managed care plans to encourage and increase the number of providers who accept public health insurance. While this coordinated campaign should cover North and Central Brooklyn, targeted focus should be on Bedford Stuyvesant (11216 and 11221) and Brownsville/East Flatbush (11212). Similar campaigns have been utilized in the past and can serve as a model - such as the measles epidemic campaign, borough-wide Child Health Plus promotion by facilitated enrollment agencies, and the borough-wide HIV outreach and referral case management campaign. With the introduction of the Affordable Care Act's increase in primary care reimbursement, receptivity to this campaign may be greater.
- Modify the design of health care facilities to make them more accessible, "user friendly" and comfortable. For example, improve wheelchair access, the level of lighting, the font of printed materials, and the comfort of seats in waiting rooms and clinics for pregnant women.
- Extend urgent care center hours in North and Central Brooklyn to offset emergency room use. According to our analysis, participants utilized emergency rooms for immediate problems and when health care offices were closed. Extending hours may have to address the issue of emergency room overuse.
- Use evidence based strategies to help redesign systems for patient scheduling and patient flow to reduce waiting times for and at appointments. For example, technology can be used to help patients schedule their appointments using the internet.
- Increase access to dental and mental health services. Participants indicated that this was a major gap in the current service delivery system in North and Central Brooklyn. One stop care models where these services are added to current facilities, renting space near current facilities, using mobile vans and referrals to training programs in dentistry and clinical and counseling psychology programs/clinics which offer services with reduced and sliding scale fees can be used to address these needs.

- Provide funding to train and educate patient advocates to support consumers by helping them navigate health care facilities and educate them on service availability.

Many of the recommendations from this CHNA are analogous to those made in the New York City Health and Hospital Corporation's Primary Care Initiative Community Health Assessment Final Report, released in 2008, which highlights the barriers residents living in underserved areas of New York City face when seeking primary health care. Similarly, many of the recommendations regarding accessibility; outreach and education strategies; and collaboration with community groups in the CHNA were also presented in the BHIP's study. The overlap between these recommendations symbolizes the urgency for required changes in the health care system. Implementing these recommendations will likely not only improve health outcomes for residents of North and Central Brooklyn but also reduce healthcare costs overall.

"Brooklyn faces daunting population health challenges. High rates of chronic disease are exacting a human and economic toll…Community health care needs and health care resources vary widely by neighborhood. Disparities in health status are also associated with poverty, race and ethnicity."[1]

THE NEED FOR CARING IN NORTH AND CENTRAL BROOKLYN

I. INTRODUCTION

Need for this Study

The study, *The Need for Caring in North and Central Brooklyn* (*The Need for Caring*), is a community health needs assessment (CHNA) utilizing a community based participatory research (CBPR) approach to capture residents' perspectives on their health care needs and the barriers and gaps in access to health care services in their communities. The study focuses on 15 zip codes located in North and Central Brooklyn. The zip codes are: 11201, 11205, 11206, 11207, 11208, 11212, 11213, 11216, 11217, 11221, 11222, 11226, 11233, 11237 and 11238. The study primarily focuses on the following communities: Bedford-Stuyvesant, Bushwick, Brownsville, Crown Heights, Cypress Hills, East Flatbush, East New York, Flatbush, Fort Greene, Prospect Heights and Williamsburg. Other communities included in this study are: Downtown Brooklyn, Gowanus, and Greenpoint.

This study was commissioned by The Brooklyn Hospital Center (TBHC) and Interfaith Medical Center (IMC), endorsed by the Community Health Planning Workgroup (CHPW), an advisory group of Brooklyn-based providers, health planners, and community organizations, and undertaken by community-based organizations to document health needs in the community.[2] Funding was provided by TBHC, the I.M. Foundation of Interfaith Medical Center, and the New York State Department of Health (NYSDOH). At the same time, a national consultant, Navigant, worked on a feasibility study in order to propose recommendations for IMC and TBHC.

The health care system in North and Central Brooklyn is under challenge to change by an official state study recommending hospital mergers, closings, and reductions in beds. These communities have long been recognized as medically underserved, where poverty and illnesses are intertwined. Residents are often medically uninsured or rely on public health insurance coverage to pay for their health care services. This leads to financial challenges for the health care providers serving these communities. Past and current studies have shown difficulties with access to care, gaps in care and services,

and the need for expansion of distinct services identified by community residents in their neighborhoods.

The intent of this research is to directly influence the proposed merger of TBHC and IMC (and any decisions about structural changes to Brooklyn's healthcare system), by highlighting the health needs of the community.

Additionally, *The Need for Caring* can serve as a model for documenting the needs, barriers, and gaps in care and services for similarly challenged communities across the state and the country.

Background

The financial fragility of hospitals in North and Central Brooklyn was acknowledged in 2011 and made the subject of a special task force convened by the New York State Commissioner of Health, Dr. Nirav Shah. The five-member task force – the Medicaid Redesign Team Health Systems Redesign: Brooklyn Work Group (MRT Brooklyn Work Group) – was charged with assessing the strengths and weaknesses of Brooklyn hospitals and their future viability. The MRT Brooklyn Work Group was part of the state-wide Medicaid Redesign Team (MRT) process initiated by Governor Andrew Cuomo in January 2011.[3] The initial (Phase I) goal of the MRT was to make recommendations on how to reduce the state's share of the Medicaid budget by $2.3 billion. The second phase of the work (Phase II) of the MRT was a series of work groups charged with recommending health systems redesign - the MRT Brooklyn Work Group was a part of this phase.

At the same time that the MRT Brooklyn Work Group initiated its work, State Senate Minority Leader John Sampson and Brooklyn Borough President Marty Markowitz formed a Brooklyn-based community Work Group to develop recommendations and to inform the MRT Brooklyn Work Group.[4] The membership of this group included health care providers, unions, community-based organizations, and advocacy groups. Their report, *Creating a Vision for Brooklyn's Health Care System: A Report of the Brooklyn Health Care Working Group* developed an important framework for designing the health system. They recommended the need to:

- Bolster Brooklyn's primary care infrastructure as a first and top priority;
- Formulate an active, coordinated care model to streamline collaboration and partnerships between providers currently existing in Brooklyn;

- Ensure that community-based organizations and the community in general, are integrated into the health care delivery system in Brooklyn, to promote patient wellness and link patients to the appropriate services at the appropriate time. (See Appendix 1)

The MRT Brooklyn Work Group held two public hearings, visited all of the hospitals in Brooklyn, and contracted with experts to analyze financial and other data. Their report *At The Brink of Transformation: Restructuring the Health Care Delivery System in Brooklyn* made sweeping recommendations and raised concerns about continued services in underserved communities. The specific recommendations for the hospitals included:

- Merging IMC and Wyckoff Heights Medical Center (Wyckoff Hospital) with TBHC, with TBHC designated to take the lead;
- Merging Brookdale Hospital Medical Center (Brookdale) with Kingsbrook Jewish Medical Center (Kingsbrook), with Kingsbrook designated to take the lead;
- Closing hospital services at SUNY Downstate Medical Center (SUNY Downstate) and merging these services into Long Island College Hospital (LICH) which had been previously merged with SUNY Downstate;
- Closing Kingsboro Psychiatric Center (Kingsboro) and shifting the patients and services to a hospital in Staten Island;
- Eliminating 1,200 hospital beds in the borough. [5]

In addition, the MRT Brooklyn Work Group report recommended the availability of Health Care Efficiency and Affordability Law for New Yorkers Capital Grant Program (HEAL NY) to assist in accomplishing these actions. HEAL NY dollars are federal and state funds distributed through a competitive process through the New York State Department of Health (NYSDOH), and generally used for capital projects.

These recommendations mobilized community, union, and elected officials to action. One of the outcomes of the MRT Brooklyn Work Group recommendations was the development of a Community Health Planning Workgroup (CHPW) to plan with TBHC, IMC, and Wyckoff Hospital regarding the recommended merger. Wyckoff Hospital, with a new administration, chose not to participate in this planning effort.

The CHPW approach for the planning process to inform the redesign of the health care delivery system was a collaborative one engaging hospital, provider and community sources. At its onset, the CHPW involved community partners, health and social service providers, and other health stakeholders committed to preserving safety-net health services for Brooklyn so that residents receive the care they need.

The membership of the CHPW group includes 18 community-based health organizations. This includes: IMC and TBHC, community health centers, community organizations, representatives of elected officials, and the three partners of *The Need for Caring* – Brooklyn Perinatal Network (BPN), Commission on the Public's Health System (CPHS), and New York Lawyers for the Public Interest (NYLPI).

The charge of the CHPW is to assess community health care needs and to consider the scope of health care resources within the community; develop a framework for a health system in North and Central Brooklyn which will provide the full range of highest quality health care services; develop options for meeting the needs of the community; and help inform the implementation of the HEAL NY 21 proposal submitted for funding by TBHC/IMC/Wyckoff.

The members of the Save Our Safety Net – Campaign (SOS-C),[6] who were also involved in the Brooklyn Health Care Working Group, were invited to join the CHPW. They were asked to help identify community health needs to inform the restructuring plans. In response, a community needs assessment was recommended which would include engaging with community residents in order to identify their needs. Under the leadership of BPN, a proposal for funding was developed and submitted to TBHC to fund the assessment. The community health needs assessment was funded by the NYSDOH, the I.M. Foundation of IMC, and TBHC.

The agreement by the three partners in this assessment – BPN, CPHS, and NYLPI – was to develop a survey instrument, define the zip codes of interest, develop focus groups of populations that would be missed in the survey, and contract with an academic center to assist and advise the partners on ways to make study valid. The CUNY Institute for Health Equity (CIHE), the academic partner in this effort, provided technical and research assistance including compiling and organizing demographic data on the communities; brainstorming outreach strategies to reach the target population; vetting focus group guidelines and procedures; reviewing survey analyses; aiding with the training sessions for staff; helping to code the focus group data and providing feedback on report drafts and recommendations.

II. LITERATURE REVIEW

Community health needs assessment (CHNA) is defined by the National Institute for Clinical Excellence (NICE) as: "a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities."[7] Although some CHNA definitions place more emphasis on the data collection and analysis, while others on the implementation and

policy development – the commonality remains in the emphasis on community engagement in the design, data collection, analysis, and interpretation of the assessment.

To conduct the CHNA, a community based participatory research (CBPR) approach was employed. Community-engaged approaches to research, like CBPR, have the potential to reduce and/or eliminate racial and ethnic health disparities.[8] CBPR can be defined as:

> [A] collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issue being studied, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change.[9]

CBPR can help bridge the gap between researcher and community stakeholders in meaningful ways. For example, CBPR helps to address the lack of trust between researchers and community members. The lack of trust challenge is of particular concern for our study as the literature shows that trust within partnerships is paramount, particularly within the African-American community, which is "more likely than the majority population to believe that health research holds personal risk and that full disclosure is not afforded minority populations."[10] In addition, building trust is also important for reducing health disparities, which can "be addressed [when] culturally relevant, trustworthy approaches are employed."[11]

Part of the impetus for undertaking the CHNA is the concern with the impact of potential closing of safety-net facilities, or the merger of hospitals that leads to reductions of services in medically underserved communities. The three hospitals whose catchment areas are the major focus of this study can all be defined as safety-net hospitals, based on a definition in the MRT Brooklyn Work Group report.[12] According to this report, a safety-net hospital:

1. Is situated in and serve[s] a high need community, often characteristically by poverty, public health challenges, low levels of educational attainment, and other psychological demands, like drug and alcohol abuse and inadequate housing;

2. Fulfills otherwise unmet health care needs in a community;

3. Serves a high volume of Medicaid and medically indigent patients;

4. Serves comparatively few commercially-insured patients;

5. Is typically located in a federally-designated Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA); [and]
6. Principally provides core medical and surgical services, such as obstetrics, pediatrics, and internal medicine, and behavioral health services.[13]

The literature shows that having nearby safety-net resources, like hospital emergency departments and public hospitals, has positive effects on service utilization and access to care for the uninsured.[14] The literature also suggests that although all patients are impacted when safety- net hospitals are closed, Medicaid and uninsured patients may experience a greater impact because it is more difficult for them to find an acceptable alternative facility where they can get care.[15]

To date, the professional literature is inconclusive with regards to the impact of hospital mergers on patient care. The vast majority of the literature focuses on the financial and management impacts of mergers rather than on quality of care.[16] There is very little professional literature that looks at the impact of mergers of safety net facilities in medically underserved communities. There are however, media reports about the merging of all Catholic hospitals in New York City into one management and governance structure, St. Vincent's, in 1999.

The merger, in addition to the flagship St. Vincent's in Manhattan, included: Bayley Seton and St. Vincent's on Staten Island; Mary Immaculate, St. John's and St. Joseph's in Queens; St. Mary's in Bedford Stuyvesant in Brooklyn, and a facility in Westchester.[17] All of these hospitals were sold or closed, and all, except for St. Vincent's in Manhattan, were located in medically underserved communities. St. Mary's Hospital in Bedford Stuyvesant closed in 2004, and was the third of the St. Vincent Catholic Medical Center hospitals to close in one year.[18] The closing also meant the eventual closing of all but one of the seven community health centers the hospital operated along with several WIC centers.

III. THE COMMUNITIES

North and Central Brooklyn has long been recognized as containing several medically underserved communities. The communities are described in profiles presented in Appendix 2 and the map in Appendix 3 outlines the communities targeted for *The Need for Caring*. Available state, city and community level data was culled before the present study was undertaken.

Poverty is concentrated in the North and Central neighborhoods of Brooklyn where in 2000 more than 30% of the population lived in poverty.[19] The area also had the highest mortality rates overall. Up to 41% of the residents in several of the zip codes studied have been told by a medical provider that they have high blood pressure.[20] Residents in three of the Central Brooklyn neighborhoods reported not getting needed medical care in the past year (14.7% - 19.7%). Another poverty indicator is when more than 50% of a population is uninsured or on Medicaid.[21] The following zip codes have uninsured and Medicaid populations exceeding 50%: 11237 (68.5%), 11221 (60.1%), 11233 (60.1%), 11207 (58.3%), 11206 (50.9%), 11216 (60.1%), 11208 (58.3%), and 11222 (50.9%).

A large percentage of the residents of North and Central Brooklyn are people of color and immigrants - a larger percent than the population of New York City as a whole. In New York City, the Black population is 25.1% and the Latino population is 27.5%. In Central Brooklyn, the combined Black and Latino population is close to 80%. The zip codes with the highest percent of residents who are people of color are: 11237, 11221, 11233, 11207, 11212, 11216, 11213, 11208, 11238, and 11205.

Prevention Quality Indicators (PQI) measure inpatient hospital visits that might have been avoided or treated through better preventative care. Communities in the northeast section of Brooklyn have the highest PQI rates.[22] Statewide, four percent of admissions are potentially preventable. In Brooklyn, the following hospitals in 2009 exceeded the four percent mark (in order of highest percent to lowest): Long Island College Hospital (LICH), SUNY Downstate Medical Center, Kingsbrook Jewish Medical Center, Wyckoff Heights Medical Center, and The Brooklyn Hospital Center. Emergency Department (ED) use in Brooklyn is similar to the rest of the city and state for both “non-emergent” visits and the “emergent but primary care treatable” visits.

The Brooklyn Healthcare Improvement Project (B-HIP) provided important information on the use of ED services in North and Central Brooklyn, overlapping many of the same zip codes as used in *The Need for Caring*.[23] *The Need for Caring* study complements the B-HIP study as it interviews residents in the community as opposed to the ED. In the B-HIP study, patients and staff were interviewed in the EDs of the 6 hospitals participating in the project. In addition, canvassers were hired to locate provider sites within the community and to estimate the numbers of health care providers available in the selected zip codes. The B-HIP study concluded that, “There appears to be a shortage of quality, accessible primary care throughout much of the study area coupled with challenges to full utilization of existing PCP’s.”[24] The zip codes identified as having a shortage of Primary Care Full Time Equivalent (FTE) to 1500 population are: 11237, 11221, 11233, 11207, 11206, and 11212.[25]

The B-HIP study also identified communities as "Hot Spots" which are described as being densely populated "with the highest average annual rates of ACSC hospital discharges and ED utilization in the study area along with high incidence of chronic diseases."[26] ACSC is defined as Ambulatory Care Sensitive Conditions that could have been treated on an outpatient basis. The three communities that contain census tracts identified as Hot Spots are: Brownsville/East New York (11212 and 11207), Crown Heights North/Bedford Stuyvesant (11213, 11216, 11233), and Bushwick/Stuyvesant Heights (11221, 11237, and 11206).[27]

The federally designated Health Professional Shortage Areas (HPSA) located in these communities are: Bedford-Stuyvesant, Bushwick, East New York, and Williamsburg.[28] There are also population groups within communities that are HPSA designated: low-income residents in Crown Heights.[29]

The MRT Brooklyn Work Group report identifies the number of visits for Medicaid fee-for-service beneficiaries and managed care enrollees in 2009. The zip codes in which Medicaid patients made the fewest visits (up to 5.5 per year) are identified as: 11216; 11233; 11207; 11212; 11225; 1226; and 11203.[30] The reason(s) for the lower number of visits per person were not identified.

Two studies in 2006 identified Primary Care Shortage areas in the city and the state.[31][32] The entire North Eastern and Central Brooklyn neighborhoods were designated as Physician Shortage Areas. In a ranking of counties in one study, Brooklyn was rated the second worst county in a provider ranking based on a number of variables – only the Bronx was rated worse. In a 2008 report that targeted communities in the city in need of primary care service expansion,[33] telephone surveys were done and street surveying was accomplished by community-based organizations. Eight targeted zip codes in Brooklyn overlapped with the targeted zip codes in *The Need for Caring,* these are: 11206, 11237, and 11221; 11233, 11212, 11207, and 11208; 11226.

The top five barriers identified to seeing a doctor in the respondents' neighborhood, in the 2008 study are very similar to those raised by the people surveyed in this report. They are:

- Had to wait too long in the waiting room
- Needed an appointment sooner than the appointment time offered
- Doctor or nurse did not spend enough time with us
- Doctor or nurse did not listen carefully enough
- Could not afford to pay the bill.[34]

In addition, in the same 2008 study, respondents were asked to name the category of provider they had the most difficulty in accessing in their community. The responses

are consistent with the responses in *The Need for Caring* described throughout this report:

- Dentist
- Doctor or nurse you go to for your basic health care needs
- Pediatrician/baby doctor
- Prenatal care/mid-wife/obstetrician/gynecologist
- Mental health counselor.[35]

IV. ASSESSMENT STUDY APPROACH

A two-pronged approach was used to capture the voices of community residents. First, a community survey was developed and administered to a larger sample of community residents. Second, a series of focus groups was conducted with groups of community residents who were either underrepresented in the survey population and/or represented community residents with special needs. In addition, listening sessions were conducted with different constituents in the community to present the preliminary findings from both the survey responses and the focus groups and to obtain input on whether the findings were in agreement with the experiences of others.

The research protocol was reviewed by an independent research organization which granted the study an IRB exempt status.

Study Strengths and Limitations

Despite the fact that a convenience sampling procedure was used, the socio-demographic characteristics of the sample do match several of the characteristics of North and Central Brooklyn residents in terms of race/ethnicity, gender and type of insurance. The current study used data from multiple sources- surveys, focus groups and listening groups to assess the perceptions and experiences of residents and these aligned with the findings from previous community assessments. The community based participation approach allowed for a collaborative process in which key stakeholders had a role in the study design, data collection, and data interpretation. The process underscored the central role that community based organizations can play in mobilizing communities to address key health issues and inform decision making.

The use of a non-probability based convenience sample limits the generalizability of the findings. Survey data collection was primarily done during the hours of 9 AM to 5 PM and may have excluded those who work during those hours. Only one focus group was conducted with each specific population which may limit generalizability. The survey process did not focus on specific illnesses but asked general questions about health.

The methodology section of the report which follows describes the procedures used to collect data using the surveys and focus groups.

V. METHODOLOGY

A.THE SURVEY

Survey Sample

The survey sample was a non-probability based convenience sample. During the data collection phase, two of the study administrators kept track of the amount of surveys that were completed in each zip code; maps were generated for each of the zip codes which indicated the number of surveys collected and sites which data was collected from. These maps were reviewed on a daily basis and survey collectors were asked to collect additional data from those zip codes that had lower levels of response.

Of the 723 people surveyed, 644 qualified as valid from the 15 North and Central Brooklyn zip codes. In recognition that there are differences among and between the zip codes in this study, each of the zip codes was placed in priority order based on: the percent of Medicaid beneficiaries and uninsured residents; the number of Full Time Equivalent (FTE) primary care providers per 1,500 population,[36] race and ethnicity,[37] and BHIP identified Hot Spots.[38] (Appendix 4)

The Priority 1 zip codes have: a population where over 50% of the residents are on Medicaid and uninsured; the least number of Full Time Equivalent (FTE) primary care providers; the highest percent of African-American and Latino residents; and were identified in the BHIP Hot Spots (see Table 1).

Table 1 – Priority 1 Zip codes

Priority 1 Zip codes (n=274 surveys)		
Zip Code	**Community**	**Number of Residents Surveyed**
11237	Bushwick	49
11221	Bedford-Stuyvesant	40
11233	Bedford-Stuyvesant	27
11207	East New York	50
11206	Williamsburg	55
11212	Brownsville/and East Flatbush	53

The Priority 2 zip codes are similar to Priority 1 zip codes, but with slightly lower indicator levels, and included 6 zip codes (see Table 2):

Table 2 – Priority 2 Zip codes

Priority 2 Zip codes (n= 321 surveys)		
Zip Code	**Community**	**Number of Residents Surveyed**
11216	Bedford-Stuyvesant	38
11213	Crown Heights	55
11208	Cypress Hills/East New York	54
11226	Flatbush	83
11238	Prospect Heights	27
11205	Bedford Stuyvesant, Clinton Hill and Ft. Greene	64

The Priority 3 zip codes exhibited the lowest indicator levels, and included 3 zip codes (see Table 3 and Appendix 4):

Table 3 – Priority 3 Zip codes

Priority 3 Zip codes (n=49 surveys)		
Zip Code	**Community**	**Number of Residents Surveyed**
11201	Downtown Brooklyn	18
11217	Gowanus	28
11222	Greenpoint	3

Data Collection and Methodology

Survey Development

The survey questions and format were developed by BPN and CPHS, distributed by e-mail, then reviewed and approved by the other members of the Community Evaluation Committee (Evaluation Committee) during weekly conference calls. This committee includes BPN, CPHS, NYLPI, the BPN evaluator and CIHE researcher. It had the responsibilities of advising on the selection of partner organizations; guiding evaluation work; ensuring that under-represented populations are identified and included in the study and developing recruitment strategies.

The survey instruments for two former studies that these organizations had been involved with were used as a guide for question development.[39][40] During the training phase, the survey was piloted with high school and college students and a community sample and revised as needed.

Survey Procedures

The hospitals and community health centers participating in the CHPW identified their primary service catchment areas, so that 14 of the targeted zip codes were identified in this way. Our study omitted the 11211 zip code (the Northern part of Williamsburg) as its demographics (higher income, fewer ethnic minorities, more privately insured, etc.) are atypical of the area. In addition, the initial CHNA concept and work plan was presented in its early stages to the Brooklyn Health Care Stakeholders Group of the SOS-C, as it was specifically set-up to address this Brooklyn health care crisis. It was attended by providers, unions, community-based organizations, and community residents. During that meeting, the targeted zip codes were discussed and a strong case was made for the inclusion of one additional not contiguous zip code (11226), with similar populations and health problems as the other targeted zip codes. The final zip code – 11226 in Flatbush – was then incorporated into the study. It should be noted that the Navigant consultant study being prepared under contract with the hospitals, only included the zip codes identified in the hospital catchment areas. There is however much overlap with the zip codes targeted in the BHIP study.[41]

Survey Monkey was used for this survey for easier data collection and analysis. The survey was to be administered on iPads for ease of data input. However, several CBOs opted to administer their surveys on paper out of safety concerns.

With expert assistance from the CUNY Institute for Health Equity (CIHE), targeting within the zip codes was accomplished through recommendations of types of locations

to do the surveying, as well as screening questions that eliminated from consideration populations that were not targeted, e.g., less than 18 years of age; zip code of residence; and income and family size based on the income guidelines developed by the New York City Housing Authority (NYCHA). These income guidelines were used rather than federal poverty levels, because they more accurately reflected the income needed to live in a high cost city such as New York.

Community-based organizations were identified by BPN to do the surveying. These groups were located in community, trusted by the residents, and reflected the composition, language, and culture of the communities in which the surveys were being administered. These community based organizations had previously participated in city and state level community assessments. The community-based organizations that participated in the survey were: Arab American Family Support Center; Brooklyn Perinatal Network; Caribbean Women's Health Association; East New York D&TC; Fort Greene SNAP; Make the Road New York; New Dimensions in Care; New York Communities for Change; Progressive Community Center for Children & Families; and United Jewish Organizations of Williamsburg. This way of surveying has been shown to improve the response and the willingness of participants to share information.

Ethnic minorities and immigrant populations are less likely to engage in research than their white counterparts.[42] This may be in part, due to barriers in reaching linguistically and culturally isolated communities, and also the long-standing mistrust between researchers and minority communities.[43] By partnering with community-based organizations, many studies have seen improved rates of survey participation.[44] Additionally, the findings from community-based organization-led surveys at times identified missing data or provided more thorough findings than standard survey methods.[45]

It is well documented that training and hiring surveyors from the assessed community can achieve the following results: (1) increased participation by potential respondents who are more likely to participate in an interview conducted by someone from the area; (2) enhanced data quality due to greater trust; (3) local interviewers set the time and tone for community-based nature of the research and intervention that would follow; and (4) improved employment opportunities for the community.[46]

Training for the Surveyors

Two training sessions were held for the surveyors on how to administer the survey. Five of the surveyor organizations used iPads for the survey. The other five administered the survey on paper and then transferred the data to Survey Monkey. The organizations that chose to administer the survey on paper identified the need to

protect their staff in high crime areas. During the training sessions, several organizations raised concerns about the wording and the order of the questions. These concerns led to several changes in the survey.

Also, during the training session, the participants were asked to pair up and test the survey with their partner, so one person asked the questions of their partner. This was done to test the understandability of the instrument, the understandability of the questions, and the time needed to complete the survey. For most of the participants the survey took between 15 and 20 minutes to administer. After several adjustments, the survey instrument was pre-tested in the community, and some additional adjustments were made, particularly to the questions in which there were skip patterns.

The surveying organizations were instructed to offer honorariums worth no more than $10 value. The organizations were allowed to choose what those honorariums would be, e.g., $10 in cash or a $10 Metro Card because they better knew the needs of their constituents and community. The person being interviewed was not initially told what the honorarium would be for participating in the survey.

The Survey Instrument

The survey instrument (Appendix 5) contains four screening questions: zip code; age group; number of people living in household; and household income. If a person did not meet the criteria set by the screening questions, they were thanked and did not complete the survey. There are 10 demographic questions in the survey instrument, including: whether the respondent was born in the United States; how long the respondent lived in the neighborhood; the respondent's marital status; how many people live in the respondent's household; the respondent's employment/unemployment status; and the respondent's race and ethnicity.

The next set of 29 questions center around the respondent's health care experience. The three final questions are open-ended, and ask what services are missing from the respondent's neighborhood; if the respondent had the power what changes would they make in the health system; and anything else that the respondent chose to share. The closed questions probed for the satisfaction level of services within the respondents' neighborhood; the reasons for going for care outside their neighborhood; whether, and what kind of, health insurance the respondent and members of their household have; if health services have been used in the last two years; if there were visits to an emergency room in the last two years, and the reason(s) for this visit; the type of health care provider where the respondent receives his/her care; the specific provider; the length of time needed to arrive at their place of care, the mode of transportation; and barriers that they encountered when going for health care services. Many of these

questions contained additional open-ended space to list reasons for their response or their place of care.

A subset of questions asked if the respondent, or any member of his or her household, had particular listed illnesses or disabilities. If they responded affirmatively to any of these questions, they were also asked: if there was a disability, what type of accommodation they received; if they were able to receive care for this disability or illness; what type of provider they went to for this treatment; and if they were satisfied with the care they received.

Coding of the Open-Ended Questions

A grounded theoretical approach was utilized in identifying the core themes of the three-open ended questions. CPHS created a coding scheme based on an independent and in-depth review of each of the initial survey responses. A secondary layer of review was provided by CIHE, who reviewed a random sample of responses during the quality assurance check of the data. CIHE reviewed the codes developed by CPHS and two members of the CIHE team devised a more formalized data analysis code book that was used to inform the coding of data from the focus groups.

Patterns of answers were reviewed, so that appropriate categories of responses could be identified. The categories of responses fell into two major categories: the type of services respondents felt were missing from the community and/or would like to see in the community; and general access and barriers identified.

For question #27, respondents were asked specifically: “Are there any medical or health-related services you think your neighborhood needs more of? If so, what are the services?” Question #28 asked for a more general response of: “If given the power for one day, what changes would you make in the medical care system?” Question #29 was added to ensure that respondents could share concerns that may not have been addressed by the previous questions: “Is there was anything else to tell us about their family’s health care, or health care services in your neighborhood?” In spite of the different thrusts of these questions, the responses to each of the questions fit into the major themes identified.

In addition, the direct quotes from respondents that were typical, poignant, or illustrative of a problem or solution, were identified and will be reported. These quotes will be reported in italics as shown below:

"The struggles and predicaments of low income families and children in poverty is a never ending story. We struggle with bad eating habits, lower birth weight infants. We need farmers markets, whole foods, fruit stands, vitamins, dental care, etc."

B. THE FOCUS GROUPS

Sampling Frame

Surveys were administered in 15 Brooklyn zip-codes which span the North and Central Brooklyn communities of Bedford Stuyvesant, Bushwick, Brownsville, Crown Heights, Ft. Greene, Williamsburg, East New York, Greenpoint, New Lots and Flatbush (i.e., 11201, 11205, 11212, 11217, 11221, 11226, 11238, 11206, 11216, 11213, 11233, 11237, 11207, 11208, and 11222). To remain consistent with the surveys, individuals had to have the same qualifiers to be eligible to be a participant in the focus groups. Hence, participants had to reside in the above zip codes and meet the age and income eligibility guidelines of the New York City Housing Authority (NYCHA).

Focus Group Sample

A review of the socio-demographic characteristics of populations targeted and surveyed was done; groups that were under-represented or not included were considered as priorities to be targeted for focus group participation. Focus groups were also set-up to involve hard-to-reach populations that would not otherwise be part of this assessment. The schedule of focus groups are found in Appendix 6.

Groups that were considered as part of the focus group planning process were:

1. Teens

2. People living with disabilities

3. People living with mental health disabilities

4. Men aged 18- 35

4. Men aged 45-55

6. Senior Citizens

7. Immigrants

An area of interest was community residents who were undocumented and uninsured. After attempts to recruit, the people in the field from our network of providers and particularly those that serve that population advised that people are not self-reporting, though they may be in that category. The experience in the focus groups has been, that people identify once they are in the groups and feel a level of safety and comfort, but will not self-report in the recruitment stages.

During August, September and October 2012, the following focus groups were conducted with:

1. Teens
2. People living with disabilities
3. Spanish-speaking people receiving mental health services
4. Immigrants
5. Men aged 18- 35
6. Men aged 45-55
7. Senior Citizens
8. Pregnant Women
9. Individuals identifying as LGBTQ

Pregnant women were added as the Evaluation Committee determined that members of these groups might provide unique perspectives on the current health care delivery system. The LGBT group was added on by a recommendation from the CHPW.

Measures

Demographic Form

Participants completed a demographic form which asked them for their zip code, age, gender, race/ethnicity, employment status, household composition, annual income, and type of health care coverage. Participants were also asked for their perception of the three biggest problems they had getting health care in their community (See Appendix 6).

Focus Group Protocol

Participants were asked to discuss the major health problems they had indicated in terms of the underlying causes and strategies for resolving them. Next, they were asked to discuss if they or their household members had health insurance, where they usually go for health care, and their reasons for utilizing health care services within or outside of their communities. Participants were also asked about the types of accommodations needed at community facilities, their reasons for using the emergency room and medical or health services needed in the community. Finally, focus group members were asked what changes they would make in the medical system if they were "given power for one day" and for any additional comments about health care. (See Appendix 7).

Procedures

The Project Coordinator had the responsibility for determining, in conjunction with the Evaluation Committee (that is, the "partners" BPN, CPHS and NYLPI), how the focus groups will be conducted. The following methods were used:

- Staff from community organizations were trained in focus groups techniques and in the essentials of the focus group guide – only those that conducted the focus groups were trained.
- Partnered with a trained facilitator.
- BPN was responsible for arranging audio recording for focus groups.
- The focus group facilitator was responsible for transcription of each focus group based on the culture and acceptance of the attendees.
- BPN reported on general outcomes or findings of the focus groups to the Evaluation Committee on a regular basis.

As part of the participant recruitment process, the Project Coordinator reached out to the wider network of providers, community groups and community members if possible to recruit for participants for the focus groups. Community-based organizations or others that were thought to be able to contribute to recruiting or gaining access to various populations were suggested by the CHPW and at community meetings held by the SOS-C.

Recruiters were provided with the criteria, date and time of focus groups and were the responsible contact to confirm participants. Flyers were created and used as part of the recruitment process; sessions were advertised as discussion groups (See Appendix 8).

Ongoing follow up with the Project Coordinator and the recruiters occurred. Once persons were referred, the Project Coordinator and BPN management would review the screening criteria of those referred to ensure that those referred met the criteria required.

Focus group size was aimed at 10 to 12 participants per group. Over sampling was used to ensure that there was an adequate size of participants. Groups were rescheduled if a minimum of 5 participants were not scheduled. Participants were contacted by the recruiter to confirm attendance and to remind them of the time and location of the group. Focus groups were conducted in the daytime, afternoon or evening to best accommodate the schedules of the participants.

Focus groups were scheduled to last for 2 hours and conducted at community sites that were accessible by public transportation. Appropriate food and beverages were served.

Eligibility criteria were verified before the start of the focus groups. Participants completed a demographic sheet and consent form (See Appendix 9) prior to the focus groups and a sheet after the focus group concluded to indicate that they had received their compensation (See Appendix 10).

Focus groups were conducted according to the established protocol (See Appendix 7). Participants were apprised of the purpose of the discussion groups and ground rules for conducting the groups. The groups were audiotaped and notes taken.

All participants received a financial honorarium of $50 at the end of their session along with a letter thanking them for their participation (See Appendix 11).

Focus Group Analyses

Focus group data were analyzed using a set of systematic procedures. Data from each focus group were summarized based on the notes taken during the session as well as the tape recordings. Each summary was read by the researchers present at the focus groups to ensure that all of the key elements were captured. Next, an intra-case analysis of each focus group was conducted; key themes were first abstracted from each group after a careful reading of each summary (Huberman and Miles 1994). A grounded theory approach was used in that the researchers allowed the themes to emerge from the participant's responses to the questions. After this first level of analysis, categories from the open ended analyses of the surveys were used to refine the analysis. After all of these analyses were complete, a cross-case analysis was conducted to identify the themes across all of the focus groups (Huberman and Miles 1994). These cross-cutting themes were charted by theme and focus group and reviewed by a second researcher to ensure coding reliability.

The next section of the report presents the survey and focus group findings.

VI. FINDINGS

A.SURVEY FINDINGS – Drawing a picture of the surveyed population

This section of the report will describe the overall findings from the surveys. The survey instrument was administered by community-based organizations to community residents in 15 zip codes in North and Central Brooklyn.

This process produced 644 valid completed surveys. Seventy nine invalid surveys were eliminated because the person being interviewed did not meet the screening criteria, or because of insufficient information.

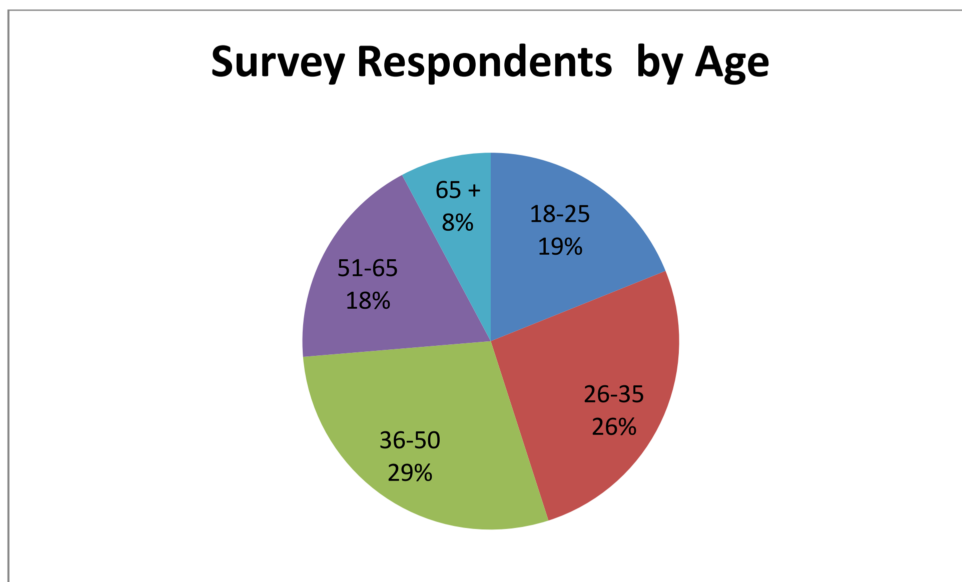
Summary information on the communities based on survey data by zip codes can be found in Appendix 21.

Sample Characteristics

Screening Questions

Age: Survey respondents ranged in age from 18 to over 65 years of age (see Figure 1). A majority of the respondents, 352 or 54.7%, were between the ages of 26 and 50.

Figure 1 – Survey Respondents by Age



Household: The average (mean) household size was three (SD=1.78). A large majority of the respondents, 521 or 80.9%, lived in households with one to four people (see Table 4). The surveyors were instructed to ask the question as households rather than family, in order to ascertain how many people were living in one dwelling. Of the people living in these households, respondents said that 640 were adults and 338 were children.

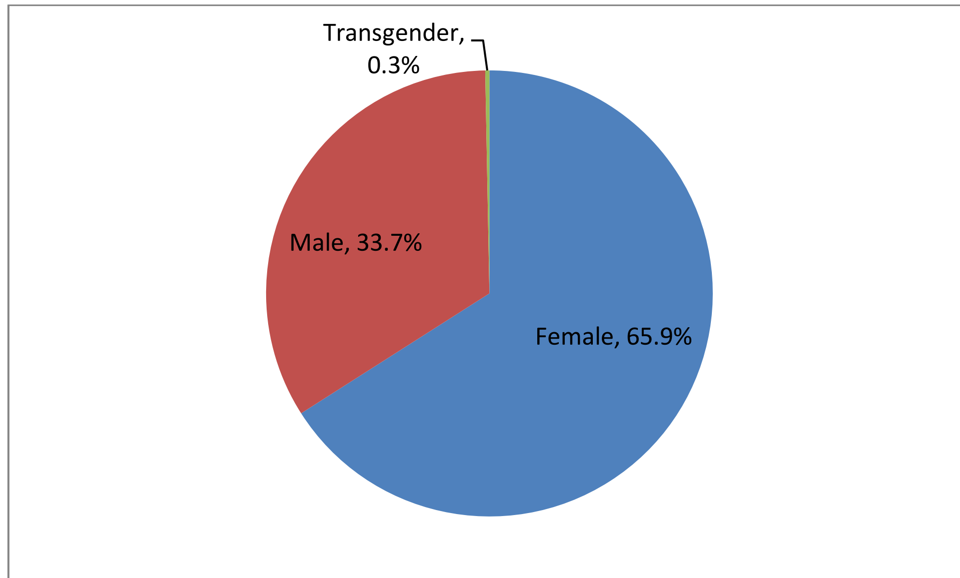
Table 4 – Household Size

Household Size		
Household Size	Number of People	Percent
1 person	120	18.6 %
2 person	141	21.9 %
3 persons	148	23.0 %
4 persons	112	17.4 %
5- 6 persons	93	14.9 %
7-10 persons	27	4.3%

Income. Household income and household size were combined to assess income eligibility requirements for the study (see survey in Appendix 5). Since broad categories were used for reporting income, the data for this question is not precise. Based on a household size of 4 or less, 81% of the respondents indicated an income of $66,400 or less. A more specific question about income was asked of a subset of the respondents who indicated they were working.

Gender: Almost two-thirds of the respondents (424 or 65.9%) identified as women (see Figure 2). Recognizing the need for male voices, two focus groups were organized to gather more information from men.

Figure 2 – Survey Respondents by Gender



Socio-Demographic Characteristics

Race, Ethnicity and Country of Origin

On the survey, respondents were asked two questions related to race and ethnicity. Respondents were first asked about their race/ethnicity and were given specific categories (African American, African, Asian/ Pacific Islander, Arabic/Middle Eastern, Caribbean/ West Indian, Native American, White, Mixed race/ethnicity, Other (specify) and No Answer). Next, respondents were asked if they were of Latino/Hispanic heritage (Yes/No/No Answer). The findings for both of these questions are summarized below and presented in Figures 3 and 4.

Race/Ethnicity**:** The zip codes surveyed are largely communities of color, in Central Brooklyn over 80% of the population is Black, including African-Americans and Caribbean/West Indians**.**

Of the 577 respondents who indicated their race in this survey:

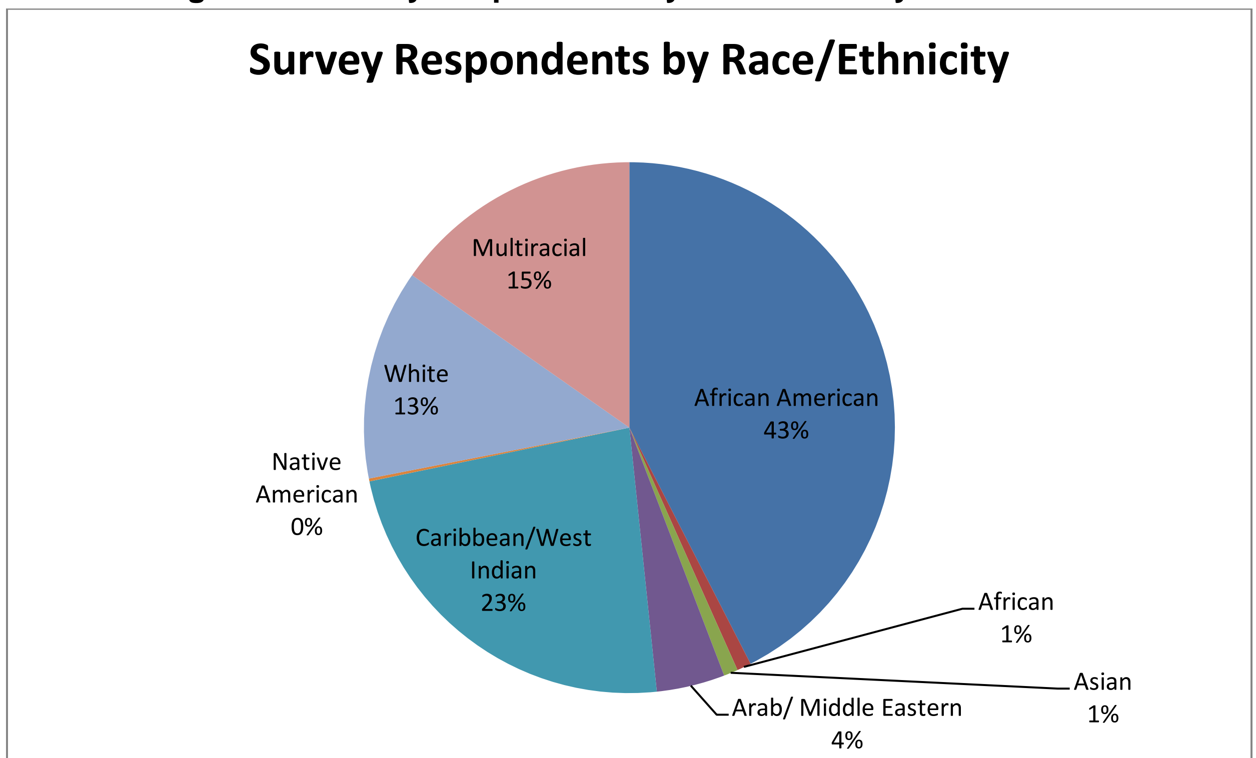
- 245 people (42.5%) self-identified as African-American,
- 135 people (23.4%) self-identified as Caribbean/West Indian,
- 88 people (15.3%) self-identified as Mixed race/ethnicity or checked two or more

racial categories

- 74 people (12.8%) self- identified as White,
- 24 people (4.2%) self-identified as Arab/Middle Eastern,
- 5 people (.9%) self- identified as African,
- 5 people (.9%) self-identified as Asian/Pacific Islander, and
- 1 person (.2%) self-identified as Native American.

Thus, a majority the respondents who indicated race, identified as persons of color. Figure 3 presents the findings from the first question on racial and ethnic background. Latinos could identify as any race; 135 respondents identified as Latino/Hispanic (see Figure 4).

Figure 3 – Survey Respondents by Race/Ethnicity



,

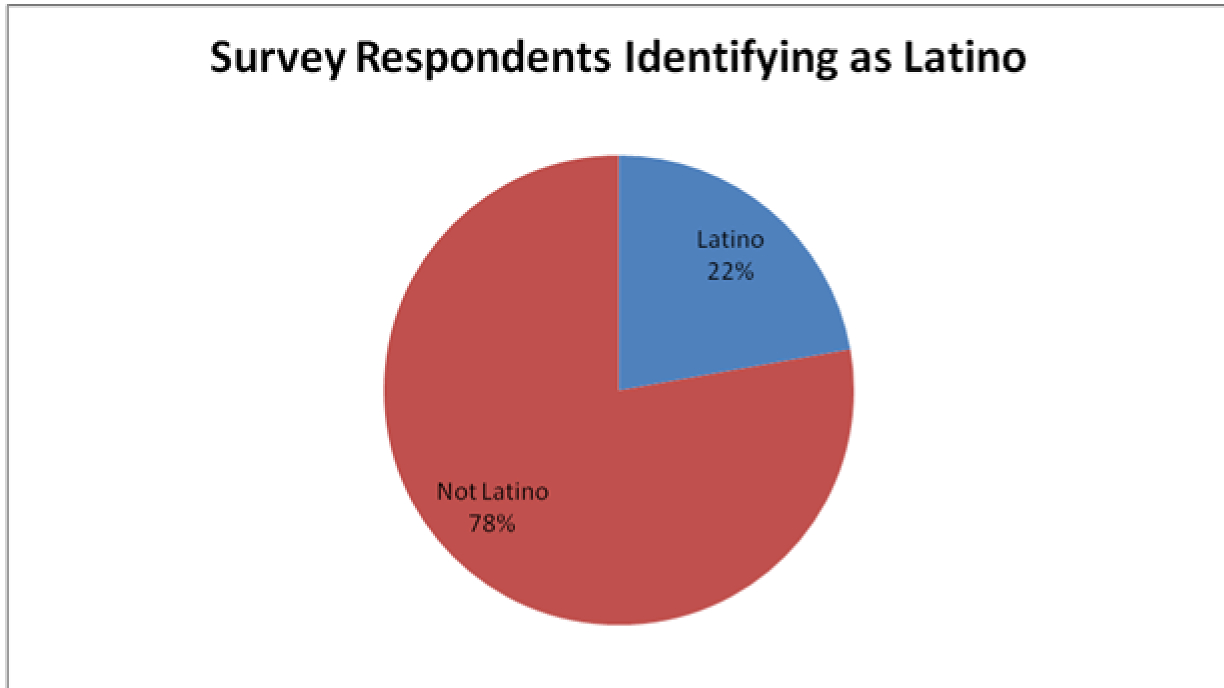
- African-Americans comprised over 50% of the sample in six zip codes: 11216, Bedford-Stuyvesant (70.3%); 11212, Brownsville (68.0%); 11217, Gowanus (63.6%); 11208, Cypress Hills (62.7%); 11207, East New York (55.3%) and 11238, Prospect Heights (53.8%).
- The highest percentages of Caribbean/West Indian respondents who were interviewed were from 11226, Flatbush (66.7% of those who responded from the zip

code); 11233, Bedford-Stuyvesant (40.7%); 11237, Bushwick (37.5%); 11213, Crown Heights (34.6%) and 11207, East New York (25.5%).

- The highest percentages of White respondents who were interviewed were from 11206, Williamsburg (50.9% of those who responded from the zip code); 11205, Fort Greene (44.1%); and 11222, Greenpoint (33.3%).
- Respondents who indicated two or more racial groups were drawn from 11221, Greenpoint (66.7% of those who responded from the zip code); 11221, Bedford-Stuyvesant (47.4%); 11237, Bushwick (37.5%) and 11213, Crown Heights (25.0%).
- Over half (54.2%) of Arab/Middle Eastern respondents who were interviewed resided in 11201, Downtown Brooklyn (comprised 81.2% of those who were interviewed in this zip code) (See Appendix 12)

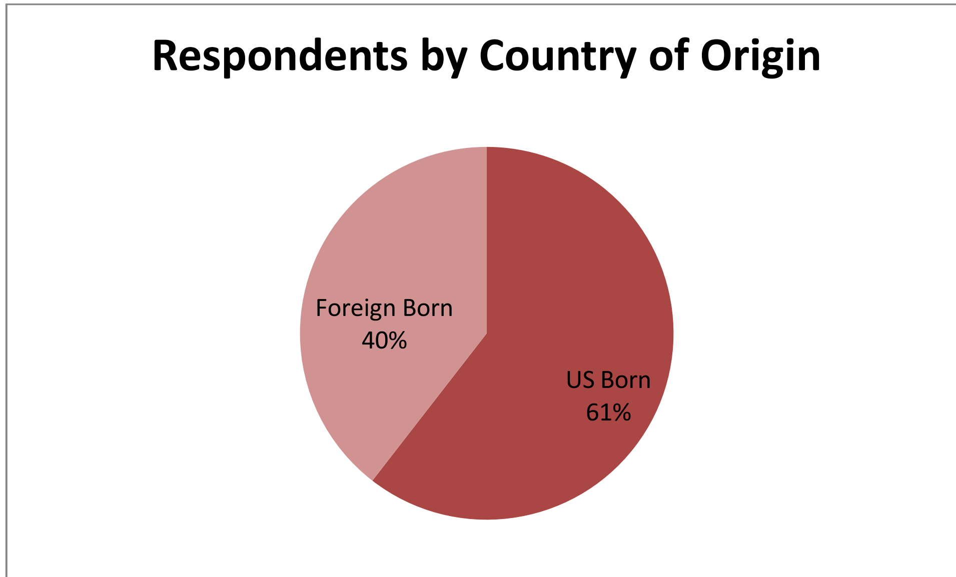
***Latino/Hispanic*:** One hundred thirty five respondents (22%) identified as Latino/Hispanic. Latinos could identify with any race. 54% (73) of the 135 Latinos in the sample indicated a race/ethnic category. Among these 73, 52.1% (38) indicated multiracial; 20.5% (15) indicated Caribbean; 13.7% (10) indicated White; 11% (8) indicated African-American, 1.4% (1) indicated Asian and 1.4% (1) indicated Arab/Middle Eastern. The highest percent of Latinos are found in 11237, Bushwick (95.9% of those interviewed in this zip code) and 11221, Bedford Stuyvesant (83.8%) and are where the highest percent of respondents did not indicate race. Many Latino/Hispanic respondents were interviewed in large numbers in 11222, Greenpoint (33.3%); 11217, Gowanus (32.1%), and 1120, East New York (22.9%). (See Appendix 13)

Figure 4 – Survey Respondents Identifying as Latino



Foreign-born: Two hundred fifty three of the respondents (39.5%) identified as foreign born (see Figure 5). This is consistent with the population of New York City (36%) and the borough of Brooklyn (40%). Two hundred and fifty-one respondents indicated their country of origin. The majority of the respondents indicated that they were born in South America (44.6%), the Caribbean (27.9%), Central America (6.4%), and the Middle East (6.0%). Nine respondents, born in Puerto Rico, identified themselves as foreign born even though they are U.S. citizens. (See Appendix 14)

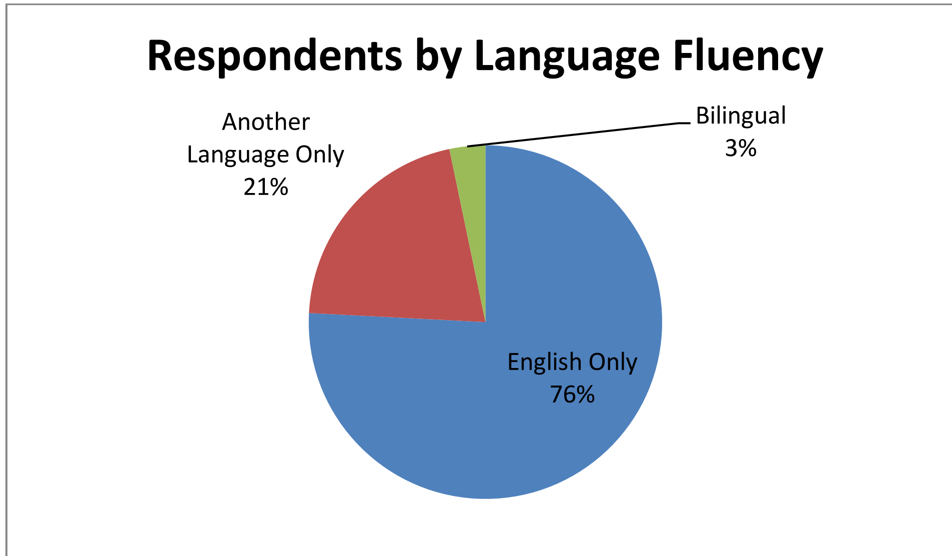
Figure 5 – Respondents by Country of Origin



- The highest percentage of respondents who were born outside of the United States resided in 11237, Bushwick (89.8% of those surveyed from this zip code); 11226; Flatbush (75.6%), 11221, Bedford-Stuyvesant (67.5%) and 11201; Downtown Brooklyn (61.1%).

Language**:** Four hundred eighty six people responded that they were comfortable speaking about their health care in English only; 82 said Spanish only; 21 said Arabic only; 22 said Creole only; 7 said Yiddish only, 1 said French only and 1 said Hungarian. 21 indicated that they were bilingual (7 in English/Yiddish; 6 English/Spanish; 4 Creole/English; 3 French/Creole and 1 Arabic/English). Thus, 134 people in this survey sample are comfortable speaking about their health care only in a language that is different from English (see Figure 6).

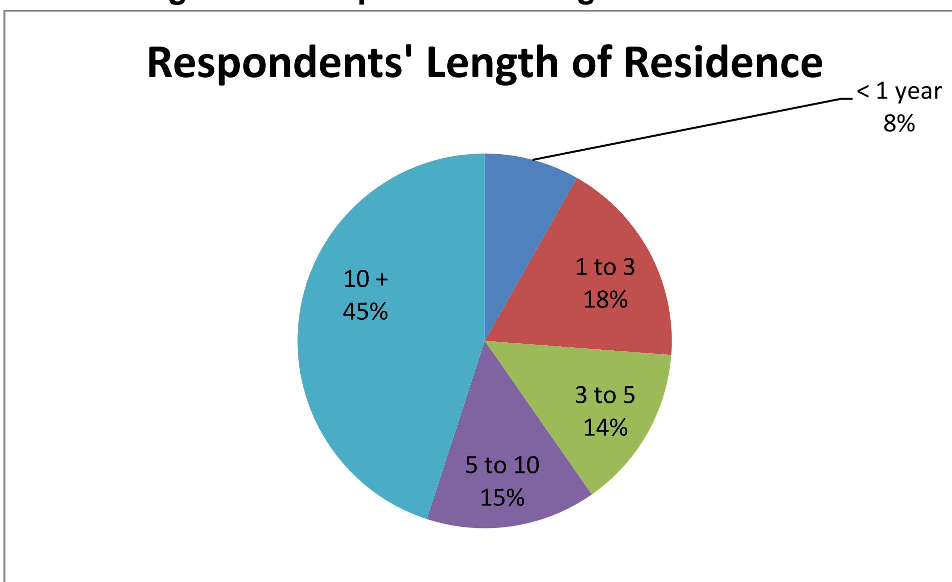
Figure 6 – Respondents by Language Fluency



Other Socio-Demographic Characteristics

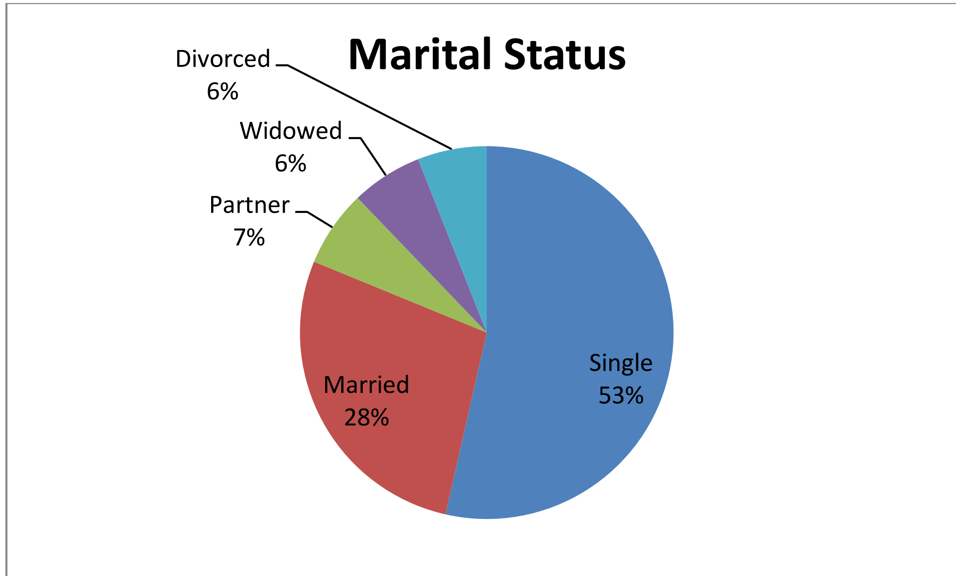
Years in Neighborhood: About seventy percent (69.8%) of the individuals interviewed have lived in their communities for three years or more. 287 respondents (45.0%) have lived in their neighborhood for more than 10 years; 94 (14.7%) have lived there for five to 10 years, and 90 (14.1%) have lived there for three to five years. Although there have been changes in the populations in all of these communities, this sample shows a stable living situation. Length of residence is shown in Figure 7.

Figure 7 – Respondents' Length of Residence



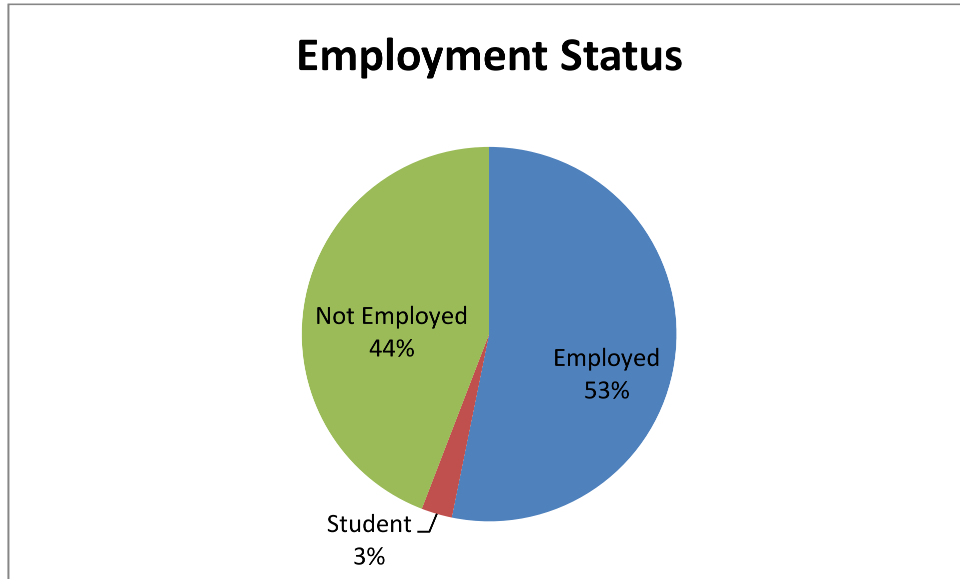
***Marital Status*:** As can be seen in Figure 8, when asked about their marital status, 339 people (53.6%) indicated that they were single and 175 (27.6%) indicated that they are married. Others indicated that they were living with someone (6.6%), widowed (6.2%) or divorced (6.0%).

Figure 8 – Marital Status



***Employment Status*:** When asked about employment status, 53% of the sample (341 respondents) indicated that they were employed and 2.7% (17 respondents) indicated that they were full-time students (see Figure 9). However, 283 participants (44.1%) said they were not currently employed. The zip codes in which over 50% of the respondents indicated that they were not working are: 11201, Downtown Brooklyn (72.2%); 11216, Bedford Stuyvesant (60.5%); 11207, East New York (60.4%); 11208, Cypress Hills (51.9%) and 11212, Brownsville/East Flatbush (50.9%) (See Appendix 15). The high numbers of respondents indicating they are not working could be a function of interviewing during the daytime hours, and finding people who do not work or who are retired.

Figure 9 – Employment Status



***Income/Earnings**:* 309 respondents who indicated that they are working were asked a follow-up question about their earnings. The annual median income was between $20,000 and $29,000. Almost 65 percent (201) of the 309 who responded indicated an income of less than $30,000, and 40.5% had incomes less than $20,000 a year. The incomes in *The Need for Caring* are generally lower than incomes found in the community profiles done by the Center for the Study of Brooklyn (See Appendix 2). The median household incomes ranged from $23,104 (Bushwick 11237) to $56,293 (Downtown Brooklyn 11201).

In interpreting the income data, it is important to keep in mind two caveats. First, reports of income on the community level can be misleading as affluent communities often contain pockets of poverty which are masked by having residents with higher income levels; this is especially true in communities experiencing gentrification. In *The Need for Caring* study, the Downtown Brooklyn (11201) participants who were predominantly Arab American reported incomes lower than the median for this area. Secondly, as a cap on income level was used as an inclusion criteria for the study, it is not surprising that reported income levels are lower than those reported in the community level data.

Health Care Experience

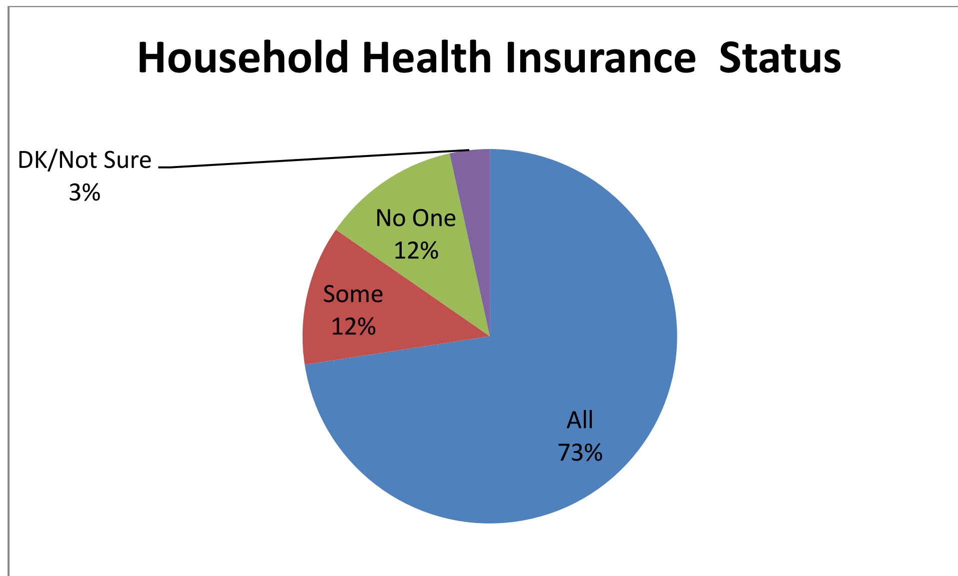
***Health Care Decisions*:** Respondents were asked who in the household makes health care decisions for them and members of their household. Of the 604 responses to this question, 456 (75.5%) respondents said they made the health care decisions for themselves and their households.

***Health Insurance*:** When asked if they and those living in their household had health insurance, including Medicaid, six people did not give an answer.

- Four hundred sixty three (72.6%) said that all members of the household have health insurance,
- 77 (12.0%) said that some have insurance,
- 76 (11.9%) said that no one in the household has health insurance,
- Twenty two people (3.4%) said don't know/not sure.

Figure 10 shows the findings on health insurance for the survey respondents.

Figure 10 – Household Health Insurance Status



- The highest number of respondents who indicated that they or their household members did not have insurance coverage resided in zip codes 11201, Downtown Brooklyn (22.2%), 11217, Gowanus (21.4%); 11207, East New York (16.7%); 11237, Bushwick (16.3%) and 11233, Bedford Stuyvesant (15.4%). (See Appendix 16)

Type of Health Insurance

Next, survey respondents were asked about the specific types of insurance that they and members of their household had. For both questions, respondents could indicate more than one type of insurance so the numbers in the table below indicate the number of responses given for each type of insurance (see Table 5).

Table 5 – Type of Insurance (No. of Responses)

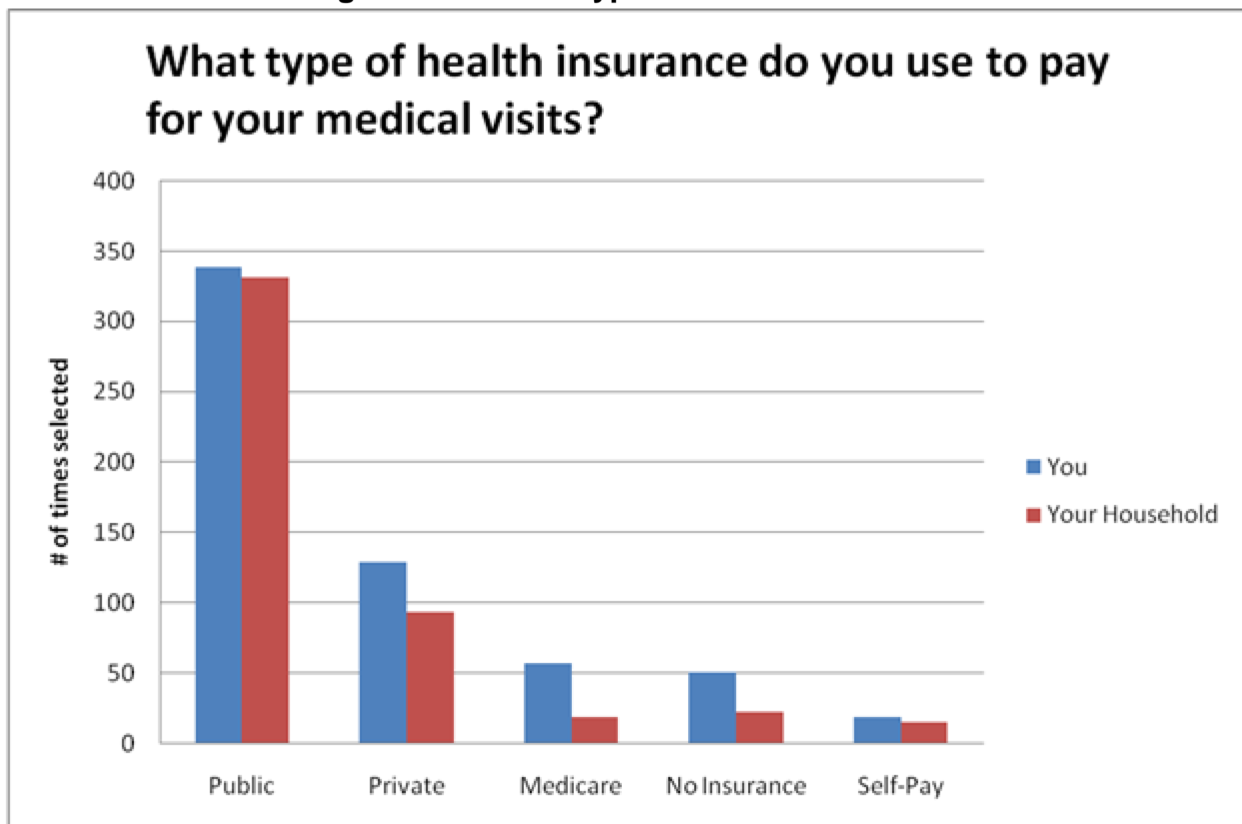
Type of Insurance (Number of Responses)		
	You	**Household**
Public Insurance		
Medicaid	284	210
Child Health Plus	7	58
Family Health Plus	47	33
Other Health Insurance Coverage		
Medicare	57	19
Your Employer	82	48
Someone else's employer	42	41
Plan that someone else buys	5	5
Military/TriCare/VA	3	1
Self-pay	19	15
Do not Have Health Insurance	51	23
Don't Know/Not Sure	17	36
Some Other Source	48	

Note. 40 responses of no answer were received about the individual's insurance and 17 responses of no answer were received for household insurance.

Approximately one million of the 2.5 million Brooklyn residents (or 40%) are covered by public health insurance. As can be seen in the table above, the majority of responses for survey respondents (338 responses or 52.4%), and their household members (301 responses or 46.7%) indicated coverage by income-eligible public health insurance – Medicaid, Child Health Plus, and Family Health Plus. Fourteen percent of the responses on the survey indicated that respondents have no health insurance or identify as self-pay. 129 responses given by respondents cited private coverage (i.e., indicated "your employer", "someone else's employer" or "plan that someone else buys"), and 94 responses indicated that household members have private coverage.

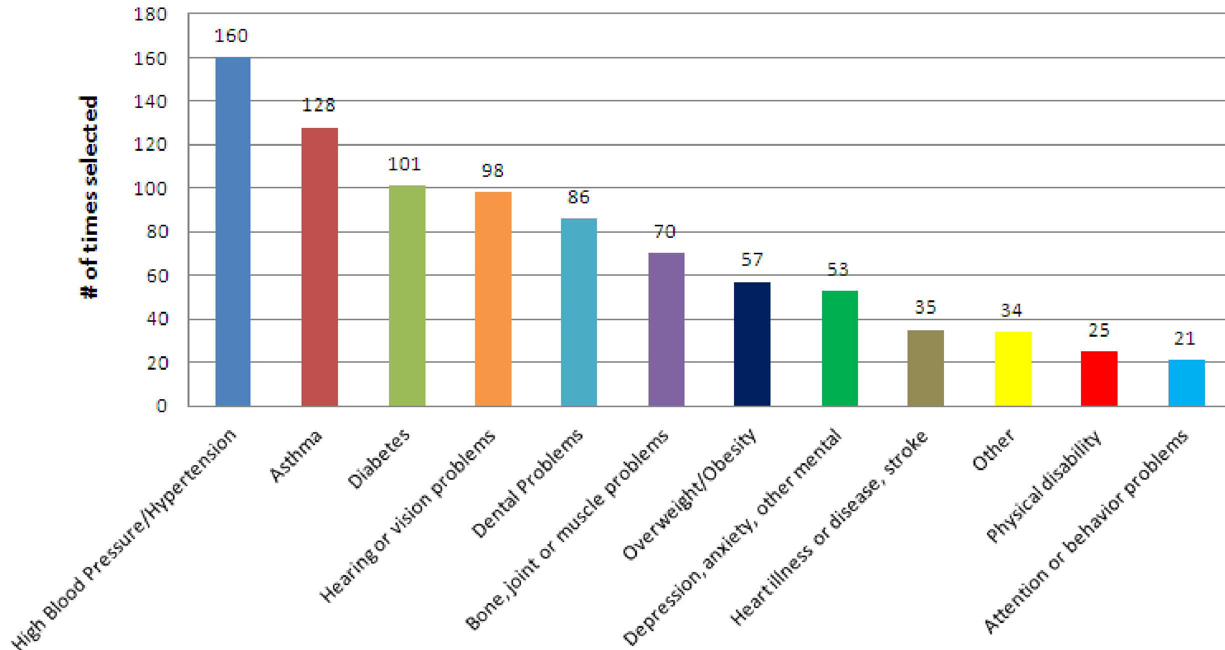
Figure 11 below shows the major types of insurance indicated by survey respondents.

Figure 11 – What Type of Health Insurance



Health Conditions

Figure 12 – Do you or members of your household Have Health Conditions



"Are there any health related services that my community needs more of? Yes of course especially in low income neighborhoods; HIV, STD testing and prevention services more information on how to prevent diseases. Also services preventing cancer health issues as in obesity. More sickle cell foundation treatments for sickle cell patients curse for the sickle cell. Two of my sisters are dealing with the sickle cell disease, they get very sick."

Survey respondents were asked to respond to a list of illnesses or disabilities that they or members of their household may have (check all that apply). Health conditions are portrayed in Table 6.

Table 6 – Health Conditions

Condition	Number of Responses	Percent of Sample
High Blood Pressure	160	24.8%
Asthma	128	19.9%
Diabetes	101	15.7%
Hearing or Vision Problems	98	15.2%
Dental Problems	86	13.4%
Bone, joint or muscle problems	70	10.9%
Overweight/Obesity	57	8.9%
Depression, anxiety, other mental	53	8.2%
Heart illness or disease, stroke	35	5.4%
Other	33	5.3%
Physical disability	25	3.9%
Attention or behavior problems	21	3.3%

Note. 19 responses were no answer.

The most often cited medical conditions are hypertension, asthma, diabetes, and hearing or vision problems, as reported by zip code:

- Asthma was cited most often in: 11212, Brownsville/East Flatbush (39.6% of respondents who live in this zip code); 11222, Greenpoint (33.3%), 11208, Cypress Hills (29.6%); 11237, Bushwick (24.5%) and 11221,Bedford Stuyvesant (22.5%).

- High blood pressure/hypertension was cited most often in: 11212, Brownsville/East Flatbush (39.6%) 11205, Bedford Stuyvesant/ Fort Greene (35.9%); 11217, Gowanus (35.7%); 11237, Bushwick (30.6%) and 11226, Flatbush (28.9%).

- Diabetes was cited most often in: 11212, Brownsville/East Flatbush (30.2%), 11226, Flatbush (22.9%) and 11237, Bushwick (20.4%).

- Hearing or vision problems were cited most often in: 11221, Bedford Stuyvesant (30.0%), and 11237, Bushwick (28.6%).

229 responses (35.6% of the sample) were "none of the above" conditions. The highest percent of this response was found in: 11238, Prospects Heights (51.9%); 11201; Downtown Brooklyn (50.0%); 11233, Bedford Stuyvesant (48.1%); 11213, Crown Heights (47,3%) and 11207, East New York (42.0%).

33 responses indicated other health problems. The major conditions listed included Special Needs/Developmental Delays (4 respondents); Sickle Cell (3 respondents) and Alzheimers, Arthritis, Seizures, Back Problems (2 respondents each).

Subset Questions: Access to Care for Respondents with Health Conditions

Survey respondents who indicated they had one or more health conditions were asked a series of follow-up questions about their access to care. These questions included the types of accommodations made for the disabled, obtaining treatment for all these conditions; where treatment is received; and level of satisfaction with services.

Accommodations for people with disabilities: When asked about accommodations eight respondents put no answer and one indicated a wheel chair. There were seven other responses, including Access – A – Ride, transport to private practice, and physical and occupational therapy.

Obtaining treatment for all of these conditions: 377 people answered this question and 44 people stated "no answer". The majority of the sample with health conditions indicated that they received treatment "all of the time" (155 people or 41.1% of the sample). Others received care "most of the time" 85 (22.5%), sometimes 83 (22.0%), a few times 28 (7.4%), never 26 (6.9%).

Where Treatment is Received: Since individuals could receive care from more than one source, Table 7 below reflects the number of responses.

Table 7 – Location Where Treatment is Received

	Number of Responses	Percent Of Responses
Doctor's Office	201	36.2%
Hospital Clinic	135	24.3%
Health Center	96	17.3%
Emergency Room	70	12.6%
Other	6	1.8%
Did Not Get Treatment	12	2.2%
Do Not Know/Not Sure	35	6.3%

Note. 29 people gave "no answer".

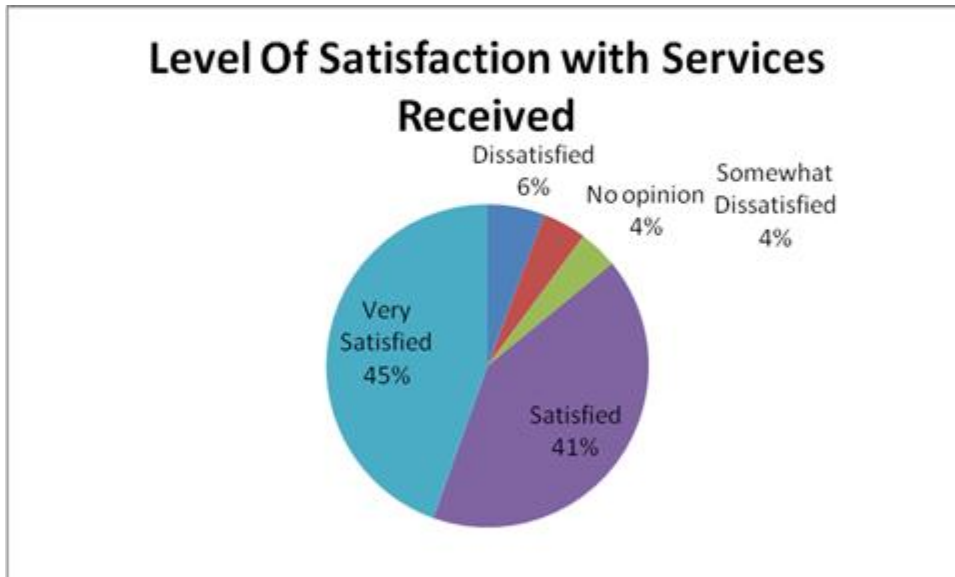
Several reports have suggested that a high percentage of Brooklyn residents travel to Manhattan for their care. Of the **177** respondents who responded to this subset question, only **12** Respondents (8.7%) visited hospitals outside of Brooklyn.

- Three community health centers were named (4 responses)
- Two HHC Diagnostic and Treatment Centers were named (3 responses)
- Private doctors named (23 responses)
- Seven North and Central Brooklyn Hospitals were named (95 responses)
  - Brookdale 9
  - Brooklyn 19
  - Downstate 5
  - Interfaith 7
  - Kings County 14
  - Woodhull 27
  - Wyckoff 14

Level of Satisfaction with Services Received. 394 people responded to this question and no answer was given by 27 people. 10 people (2.5%) were not receiving any care. Of the 384 individuals who indicated their level of satisfaction,

the majority (85.9%) of respondents were satisfied with the care they received (see Figure 13).

Figure 13 – Level of Satisfaction with Services



Thirty seven respondents gave reasons for their lack of satisfaction with services received. Nine respondents indicated a problem with the waiting time; three had health insurance problems; three still felt ill or were in pain, three indicated a poor relationship with the staff in the doctor's office, two indicated lack of services, and two said it was too expensive. Other comments included 'no good doctors'; 'no specialists' and one cited the language barrier. Some of the direct quotes from respondents stand out:

"Son with developmental delays only gets therapy at school and he also needs it at home."

"Because I don't think my child is getting the best treatment for his condition."

"Western medicine is inaccessible to people of lower income."

"Lack of service offered in a low income neighborhood."

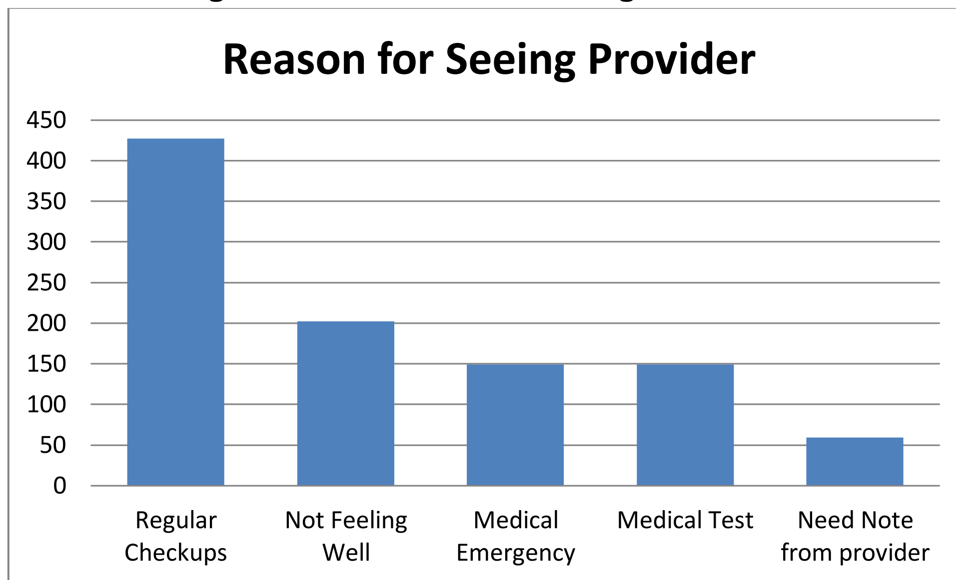
"Sometimes hospital/clinic staff assume we have Medicaid because of our skin color."

Access to Care

The next section of the survey asked questions regarding access to care. First, respondents were asked **"In the last two years, have you or members of your household gone to a health care provider?** (If yes, why? If no, why?)" Of the 640 individuals who answered this question, the majority (88.8% or 568) said yes and 72 (11.2%) said no.

Respondents could give multiple reasons for going to the doctor; these responses are reflected in the Figure 14 below.

Figure 14 – Reason for Seeing a Provider



There were 63 individual responses with reasons when people said no. The major reasons were categorized and are presented in Table 8.

Table 8 – Major Reasons for not going to a doctor

Reason	Number of Responses
Not sick/No need	23
No insurance/cost of care/insurance issues	16
Time issues	4
Belief in natural healing	2

- In three of the15 zip codes, over 20% of those surveyed had not seen a provider in the last two years: 11201, Downtown Brooklyn (27.8%), 11205, Bedford Stuyvesant/Fort Greene and 11217, Gowanus (21.4%). (See Appendix 17).

- Reasons given for visiting a provider in the last two years by zip code were as follows:

  - *Medical emergency* – 11212, Brownsville/East Flatbush (50.9%); 11237, Bushwick (30.6%); 11208, Cypress Hills (29.6 %), and 11207, East New York (26.0%).
  - *Needed a medical test* – 11212, Brownsville/East Flatbush (43.4%); 11221, Bedford Stuyvesant (35.0%) and 11206, Williamsburg(32.7%).
  - *Didn't feel well* – 11212, Brownsville/East Flatbush (56.6%); 11213, Crown Heights (45.5%); 11207, East New York (40%); 11226, Flatbush (39.8%); 11206, Williamsburg (32.7%) and 11238, Prospect Heights (30.6%).
  - *Regular Check-up* – all zip codes above 47%. (See Appendix 18)

Next respondents were asked **"Have you and your household members been able to get regular check-ups when you are healthy?"** Six hundred and twenty three respondents gave an answer. The majority of respondents (536 respondents or 86.0%) said yes; 87 respondents (14.0%) said no.

The next section of the survey asked respondents to describe their access to care both within and outside of their community.

Care in the Neighborhood

"More affordable clinic put more clinics in our neighborhood. Low income communities need more educational services, preventing obesity because obesity is affecting our communities."

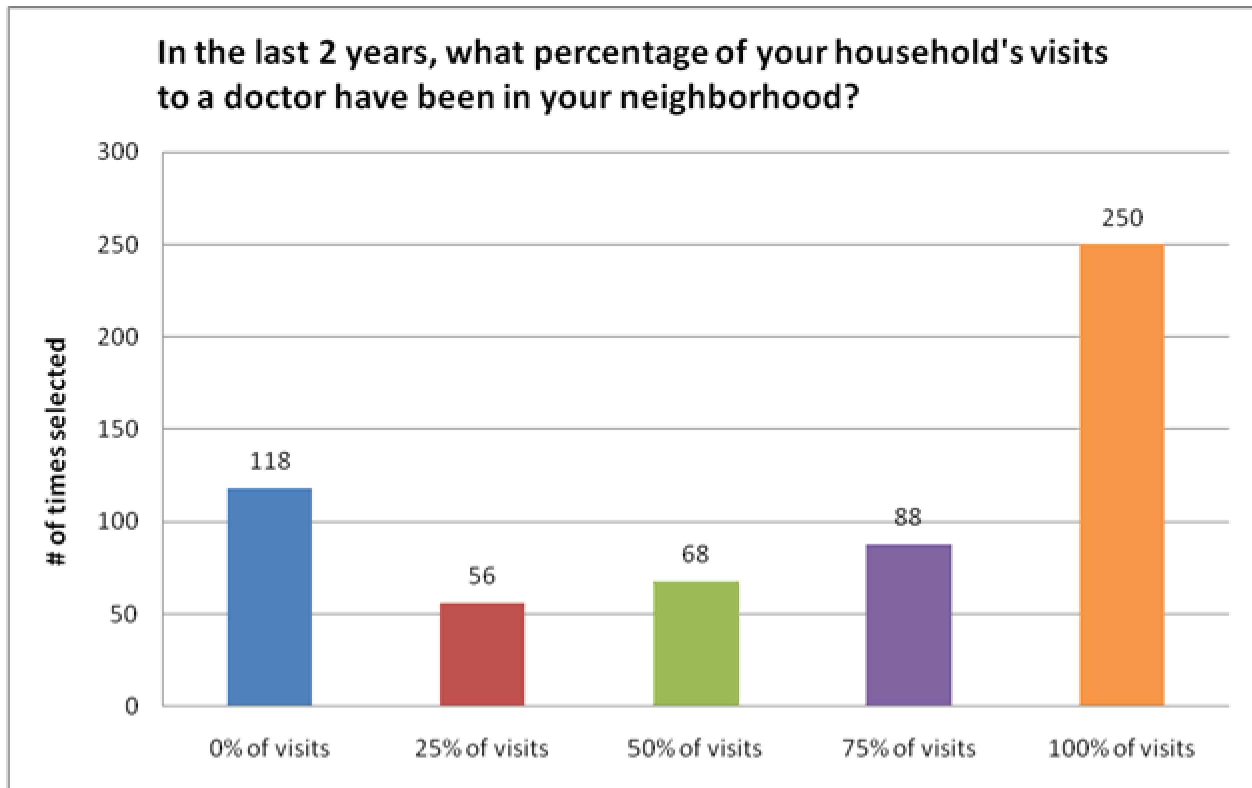
"There needs to be more of everything so you don't have to go out of the neighborhood."

"The neighborhood needs a community low income based clinic for the under privileged (sic) with working hours between Monday and Saturday."

"Put a health clinic in 11223, more pharmacies. I would re-open St. Mary's."

Care in the Neighborhood

Figure 15 – Care in the Neighborhood



In the last two years, have you and your household members' visits to a doctor or nurse been in your neighborhood? This question was included because there have been concerns raised about a lack of services in many of the North and Central Brooklyn communities. Almost 20% of all of respondents made all visits outside their neighborhood (see Figure 15) . Slightly less than 40% of respondents had all visits in their neighborhood and 32% of respondents' visits were, in part, in their neighborhood (see Table 9).

Table 9 – Health Care Provider Visits in Community

Health Care Provider Visits in the Community		
Visits	**Frequency**	**Valid Percent**
None (0%)	118	18.7%
25%	56	8.8%
50%	68	10.8%
75%	88	13.9%
All (100%)	250	39.6%
Not been to a doctor	25	4.0%
Do Not Know/Not sure	26	4.1%

Note. Thirteen respondents did not answer this question.

- Of the 118 respondents who indicated that *none* of their visits had been to a provider in their neighborhood in the last two years, the zip codes with the highest percent of respondents not using services in their neighborhood are: 11201, Downtown Brooklyn (50.0%); 11217, Gowanus (46.2%); 11233, Bedford Stuyvesant (37.0%); 11238, Prospect Heights (29.6% and 11207, East New York (26.5%).

For the 118 respondents who did not seek care in their community, the next three questions were skipped because they specifically queried about access to care in the respondents' neighborhood.

First respondents who sought care in their neighborhood were asked to describe the type of facility that they accessed. Since, respondents could indicate more than one source of care, Table 10 below reflects the number of responses.

Table 10 – Types of Facilities where care is sought

Type of Facility in the Community Where Respondents Sought Care		
Type of Facility	**Number of Responses**	**Percent**
Doctors or Nurses office	241	37.4%
Hospital clinic	171	26.6%
Community health center	153	23.8%
Emergency Room	77	12.0%
Traditional Healer	5	.8%
Another kind of place	3	.5%
Don't know	6	.9%

Note. 34 responses were "no answer".

- In zip code 11222 (Greenpoint) 66.7% of the respondents get their care in a hospital clinic; in zip code 11237(Bushwick) , 63.3% receive their care in a hospital clinic; 42.5% in zip code 11221 (Bedford Stuyvesant); and 43.6% in 11213 (Crown Heights).
- In zip code 11212 (Brownsville/East Flatbush), 32.1% of respondents indicated they get their care in a hospital emergency room.
- The respondents in the following zip codes indicated high usage of community health centers/clinics: 11222, Greenpoint (66.7%); 11212, Brownsville/East Flatbush (47.2%); 11208, Cypress Hills (35.2%) and 11216, Bedford Stuyvesant (47.2%).
- The respondents in the following zip codes indicated high usage of private doctors' offices: 11206, Williamsburg (60.0%); 11226, Flatbush (51.8%); 11238, Prospect Heights (40.7%), and 11212, Brownsville/East Flatbush (39.6%). (See Appendix 19).

When asked to provide a specific name of the facility in their community where they sought care**,** not all of the named facilities cited were located in North and Central Brooklyn.

- Five hospitals outside of Brooklyn (7 responses)
- Six community health centers in Brooklyn (17 responses)
- One HHC Diagnostic and Treatment Center (4 responses)
- Private doctor (31 responses)

- Other types of providers (22 responses)
- Seven North and Central Brooklyn Hospitals (150 responses)
    - Brookdale (37 responses)
    - Brooklyn (27)
    - Downstate (6)
    - Interfaith (16)
    - Kings County(16)
    - Woodhull (31)
    - Wyckoff (17)

Next, respondents were asked the length of time it took for them and members of their household to get to care in their neighborhood**.** Four hundred nine of the 528 responses (82.8%) to this question traveled for 30 minutes or less to get to care in their neighborhood (see Table 11).

Table 11 – Length of Travel Time to Access Care

Length of Travel Time to Access Care in the Community		
Travel Time	**Frequency**	**Valid Percent**
Less than 10 minutes	148	30.0%
10 to 30 minutes	261	52.8%
30 to 60 minutes	59	11.9%
Over an hour	11	2.2%
Do not know/not sure	15	3.0%

Note. 34 respondents did not answer this question.

Finally, respondents were asked how they travelled to access care. Since respondents could give more than one response, Table 12 reflects this.

Table 12 – Mode of Travel to Access Care

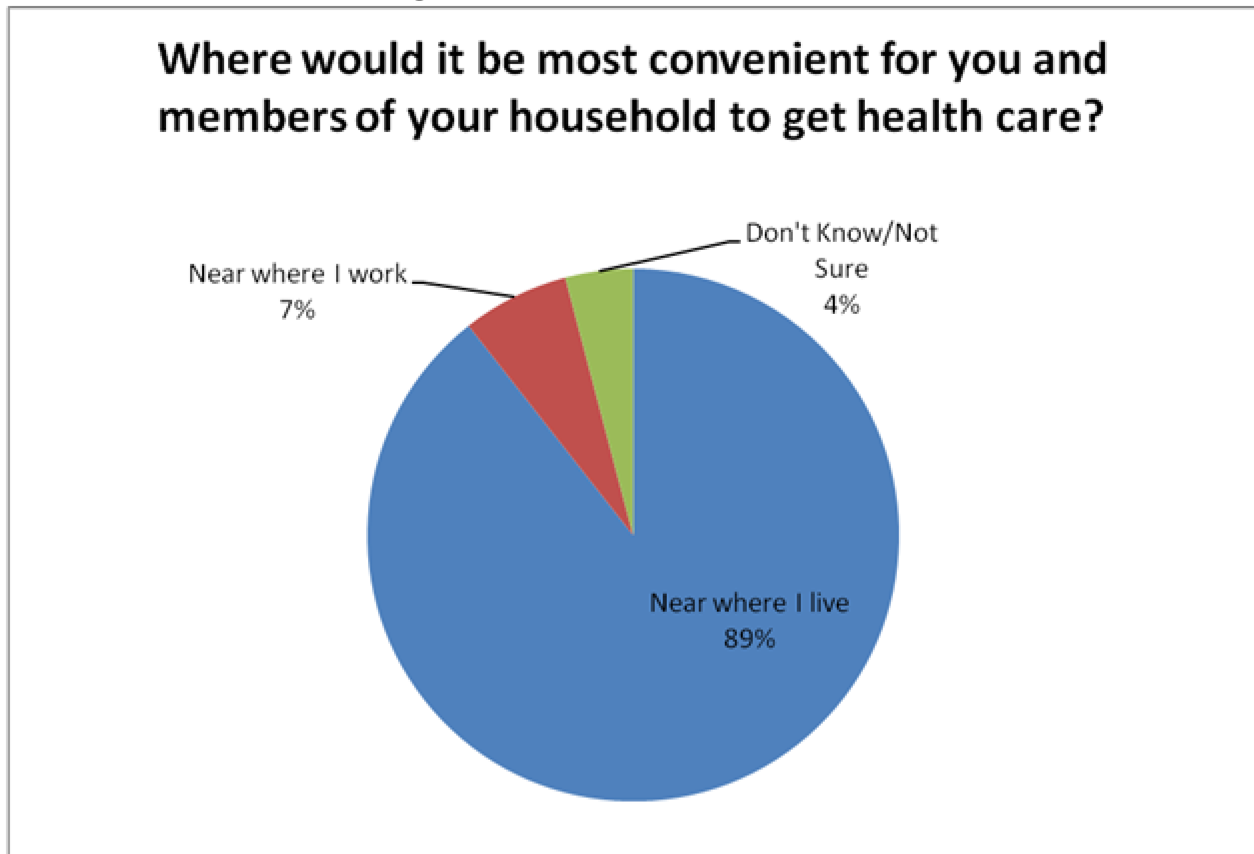
Mode of Travel to Access Care in the Community		
Mode of Travel	**Number of Responses**	**Percent of Responses**
Walk	244	35.2%
Bus	191	27.6%
Subway	78	11.3%
Cab	67	9.7%
Drive	65	9.4%
Other	24	3.4%
Car Service	23	3.3%

Note. 36 responses were "no answer".

The 24 other sources of transportation included 11 by ambulance, 4 by Access-A-Ride, 4 by ambulate, 2 by bike, one by wheel chair, and one by motorcycle.

Convenience of Care

Figure 16 - Convenience of Care



“I wish I have a clinic close to my home because I have three little children I travel with all of them to the doctor office.”

When asked where would be the most convenient place for them and members of their household to obtain care, 613 individuals gave a response**.** Of the 613 responses, 89.4% preferred to receive care near where they lived, 6.5% wanted care near where they worked and 4.1% did not know or were not sure (see Figure 16). Thirty four respondents described another place they would like to seek care; five of these respondents stressed the importance of receiving health care in a place that was clean, safe and comfortable.

- The zip codes in which more than 90% of the respondents indicated their preference for receiving care in their neighborhood included: 11201, Downtown Brooklyn (100%); 11233, Bedford Stuyvesant (95.8%); and 11205, Bedford Stuyvesant/Fort Greene (93.7%).
- The zip codes in which the lowest number of respondents indicated a preference for care in their neighborhood include: 11238, Prospect Heights (77.8%) and 11217, Gowanus (64.3%).

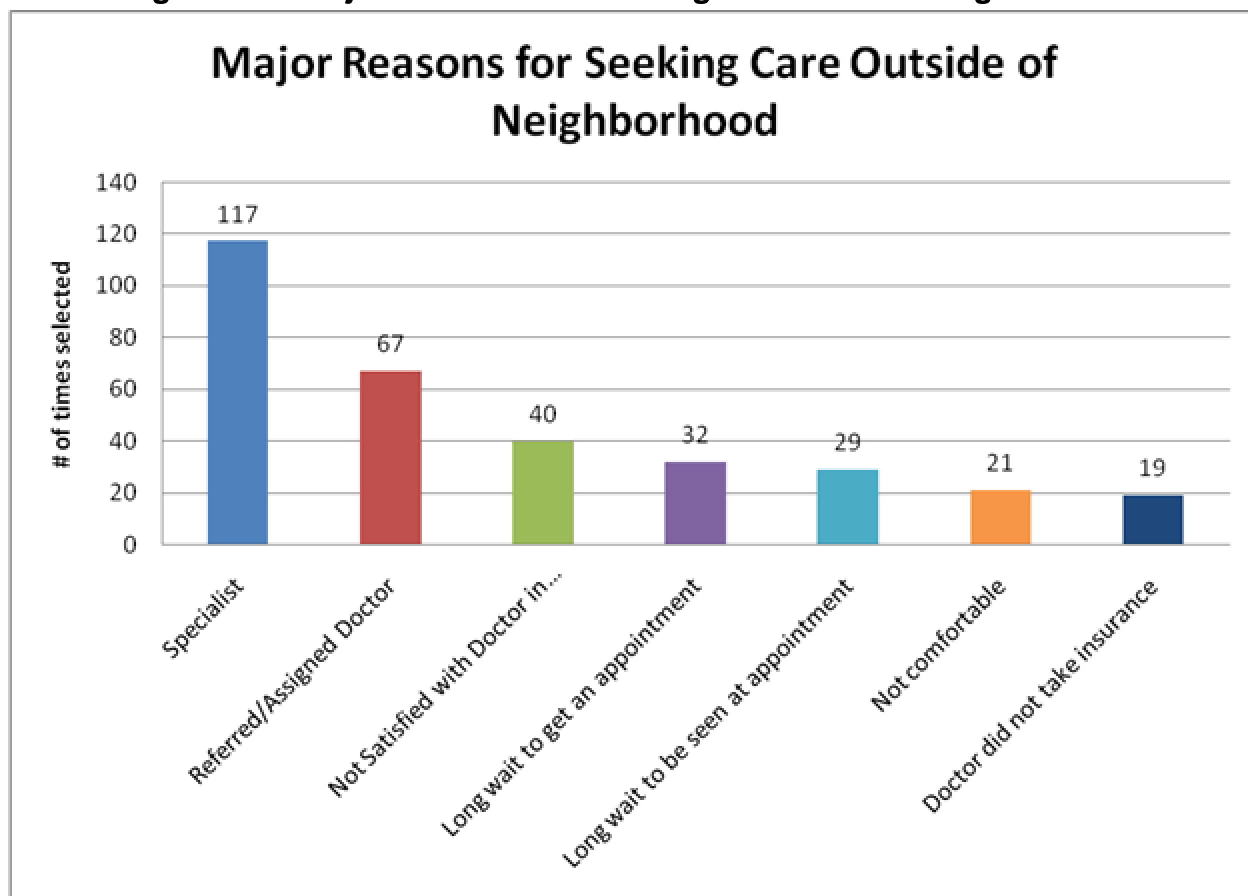
Care outside the Neighborhood

“I have to travel with my children to get medical care because I don’t speak English.”

“I feel so depressed now, no job, no health insurance, no medication, and there is no mental health doctor who will understand me and help me in this area.”

“I am very happy with the health care that my children receive, but I would like to have that kind of services in my neighborhood.”

Figure 17 – Major Reasons for Seeking Care outside Neighborhood



Respondents who indicated that they sought any percentage of their health care outside of the neighborhood were read a list and asked to identify any reason that they or members of their household went to a doctor or nurse outside their neighborhood (see Figure 17 and Table 13). The most frequently cited reasons for going outside the neighborhood are: specialist outside neighborhood (25.7% of responses) which indicates a choice, and referred or assigned doctor in another neighborhood (14.7%) which suggests there was no choice.

Table 13 – Responses for Seeking Care outside Community

Reason for Seeking Care Outside of the Community		
Reason	**Number of Responses**	**Percent of Responses**
Specialist	117	25.7%
Referred/Assigned Doctor	67	14.7%
Not Satisfied with Doctor in Neighborhood	40	8.8%
Long wait to get an appointment	32	7.0%
Long wait to be seen at appointment	29	6.4%
Not comfortable	21	4.6%
Doctor did not take insurance	19	4.2%
Could not afford a doctor or nurse found in neighborhood	15	3.3%
Schedule conflict between myself and doctor	13	2.9%
Does not speak my language	6	1.3%
Facility could not accommodate my disability	5	1.1%
Other	74	16.2%
Do not know/Not Sure	17	3.7%

Note. 69 responses (25.4%) were "no answer"

There were **74 other** responses. Reported are those where there is more than one similar response:

- Going there before I moved 10
- Emergency 5
- Veteran that goes to the V.A. 4

- Didn't go to any doctor 4
- Go to private doctor 3
- Customer service poor 2
- Doctor in another neighborhood 2
- Go near to work 2

For respondents that answered they saw specialists outside their neighborhood, we asked them to state the kind of specialist. The most often-cited specialists are: obstetricians/gynecologists, dentists, general doctors, and cardiologists:

- Allergist 1
- Asthma treatment 1
- Cardiologist 8
- Dental 12
- Dermatologist 1
- Eye doctor 8
- Endocrinologist 5
- Eye doctor 6
- Gastroenterologist 4
- General doctor 11
- Gynecologist/OB 19
- Dermatologist 7
- Neurologist 6
- Orthopedist 6
- Pediatrician 5
- Physical therapy 2
- Podiatrist 7
- Psychiatry/Psychology/Counseling 7
- Rheumatologist 3
- Surgeon 3
- Urologist 5

- The break-down by zip code of highest number of reasons given for going for care outside of the neighborhood were:
    - *I get care from a specialist outside my neighborhood* – 11206, Williamsburg (34.5% of responses); 11216, Bedford Stuyvesant (26.3%), and 11233, Bedford Stuyvesant (22.2%).
    - *Was referred or assigned a doctor in another neighborhood* – 11216,

Bedford Stuyvesant (18.4%); Williamsburg, 11206 (16, 4%) and 11233 Bedford Stuyvesant (14.8%)

- *Not satisfied with doctor found in my neighborhood* – 11208, Cypress Hills (13.0%); 11205, Bedford Stuyvesant/Fort Greene (12.5%), 11206, Williamsburg (10.9%) and 11216, Bedford Stuyvesant (10.5%)
- *Had to wait too long to get an appointment* – 11216, Bedford Stuyvesant (10, 5%), and 11237, Bushwick (8.2%)
- *Had to wait too long to be seen at an appointment* – 11216, Bedford Stuyvesant (10.5%), and 11237, Bushwick (8.2%)

When asked the type of place that they received care outside of their neighborhood, 265 respondents gave valid answers and 45 did not give an answer. The highest percent of responses were private doctor (116 or 43.8% of responses) and hospital clinic (72 or 27.2%). See Table 14.

Table 14 – Type of Place Where Care is sought outside Community

Type of Place Where Care is Sought Outside of the Community		
Type of Place	**Number of Responses**	**Percent of Responses**
Private Doctor's Office	116	43.8%
Clinic in a hospital	72	27.2%
Community health clinic or health center	43	16.2%
Emergency Room	19	7.2%
Another kind of place	7	2.6%
Traditional Healer	1	.4%
Do not know/not sure	7	2.6%

Note. 45 responses were "no answer".

- Please provide a specific name of the facility where you go for your care – 125
  - Ten hospitals outside of Brooklyn (21 responses)
  - One community health center in Brooklyn (1 response)
  - Private doctor (19 responses)
  - Other types of providers (20 responses)
  - Three other hospitals in Brooklyn (6 responses)
  - Eight North and Central Brooklyn Hospitals (26 responses)
    - Brookdale (1 response)
    - Brooklyn (11)
    - Downstate (3)
    - Interfaith (3)
    - Kings County (4)
    - Kingsbrook (1)
    - Woodhull (1)
    - Wyckoff (2)

- Of the respondents who visited the ten hospitals outside of Brooklyn**:** 3 were from 11205, 1 was from 11206, 2 were from 11207, 1 was from 11208, 2 were from 11212, 1 was from 11213, 1 was from 11216, 3 was from 11217, 1 was from 11221, 2 were from 11226, and 3 were from 11237.

When asked how long they travelled to obtain care from a provider outside of their neighborhood, 256 individuals gave valid responses and 46 individuals did not answer the question. As can be seen in Table 15, unlike the travel time in the respondents' neighborhood, the travel took longer for respondents who receive care outside of their neighborhoods. 53.9% of respondents said it took from 30 minutes to an hour.

Table 15 – Length of Travel Time to Access Care outside Community

Length of Travel Time to Access Care Outside of the Community		
Travel Time	**Frequency**	**Valid Percent**
Less than 30 minutes	77	30.1%
30 minutes to 1 hour	138	53.9%
1 to 2 hours	38	14.8%
Over 2 hours	3	1.2%

Note. 46 individuals gave no answer.

Finally, respondents were asked how they travelled to access care outside of their community. Since respondents could give more than one response, Table 16 reflects this.

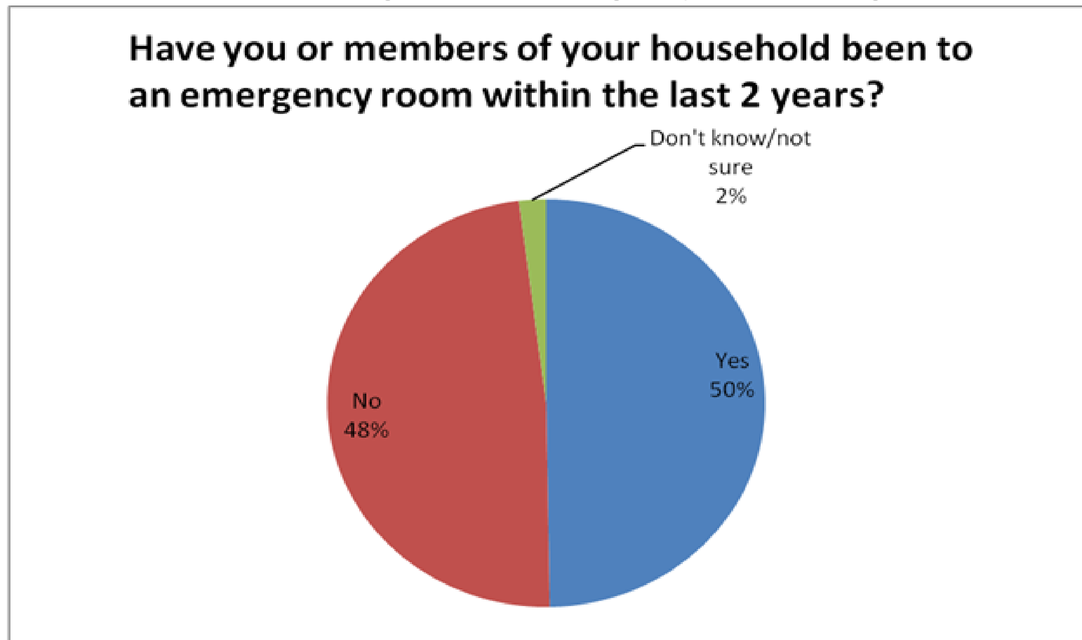
Table 16 – Mode of Travel to Access Care outside Community

Mode of Travel to Access Care Outside of the Community		
Mode of Travel	**Number of Responses**	**Percent of Responses**
Subway	130	33.8%
Bus	91	23.7%
Drive	58	15.1%
Cab	36	9.4%
Walk	30	7.8%
Car Service	26	6.8%
Other	13	3.4%

Note. 42 responses were no "answer"

Emergency Room Usage

Figure 18 – Emergency Room Usage



"More emergency rooms; they are closing many local hospitals. We also need a dental emergency room."

"To keep open the remaining hospitals in the neighborhood."

As can be seen in Figure 18 and Table 17, when asked if they or members of their household had been to an Emergency Room within the last two years, half of the respondents (49.7%) indicated yes.

Table 17 – Emergency Room Use

Emergency Room Use		
Response	**Frequency**	**Valid Percent**
Yes	301	49.7%
No	292	48.2%
Do Not Know/Not Sure	13	2.1%

Note. 38 individuals did not answer this question.

About 60% or more of the respondents in 11221, Bedford Stuyvesant (72.7%); 11212, Brownsville/East Flatbush (65.4%) and 11216, Bedford Stuyvesant (59.5%) indicated emergency room use in the past two years.

Of the 301 respondents who had visited the emergency room in the last two years, 210 respondents identified how often they had used the emergency room. Fifteen answers were difficult to interpret and one person could not remember; thus there were a total of 194 responses which could be evaluated. The majority of people (71.1%) made 1 or 2 visits to the emergency room.

When asked for the reason that they or their family went to the Emergency Room, 348 responses cited the highest number of visits for asthma (28.9%) and high blood pressure (27.6%). Both of these conditions can often be treated on an outpatient basis if care is available in the community.

Type of health insurance coverage appears to have an impact on ER usage. Of the 301 respondents who indicated they had used the emergency room in the last two years, the highest percent usage of ER visits by insurance coverage was: Medicaid (49.5% for self, 37.9% household), insurance by employer (13.6% self; 9.6% household), Medicare (9.6% self, 4.0% household), and no health insurance/self-pay (7.3% self, 3.7% household).

Of all of the people with different race and ethnicity cited, African-Americans had the highest number and percent of persons using the Emergency Room in the last two

years, 130, which was 56.5% of the African-American respondents and 47.1% of those who indicated that they used the emergency room.

- African Americans who lived in 11212, Brownsville/East Flatbush (18.5%); 11216, Bedford Stuyvesant (11.5%) and 11216, Bedford Stuyvesant (11.5%) used the emergency room more.

- 83 (63.8%) of the African American emergency room users were female; 46 (35.4%) were male. Over half (52.7%) of the African American emergency users were between 26 and 50 years of age. 64% (83 people) were single and 16.3% (21 people) were married. Forty-seven percent were employed, 52% were not employed and 2% were students. Ninety-five percent had insurance and 48% received all of their care in their community.

- African-Americans who used the emergency room reported problems with asthma (31.5%), high blood pressure (28.5%), hearing or vision problems (18.5%); bone. joint or muscle problems (13.8%) and mental illness (12.3%).

Caribbean Americans constituted 20.3% (n=56) of those who indicated that they used the emergency room.

- Emergency room use was highest for Caribbean Americans who lived in 11226, Flatbush (39.3%), 11237; Bushwick (12.5%) and 11207, East New York (12.5%).

- Almost three-quarters (73.2%) of the Caribbean American emergency room users were female; 15 (28.8%) were male. Over half (53.5%) of the Caribbean American emergency users were between 26 and 50 years of age. 50% (28 people) were single and 35.7% (20 people) were married. Forty-six percent were employed, 48.2% were not employed and 2% were students. Eighty-nine percent had insurance and 30 % received all of their care in their community.

- Caribbean Americans who used the emergency room reported problems with high blood pressure (33.9%), asthma (28.6%), hearing or vision problems (23.2%); and diabetes (21.4%).

63 or 52.5% who indicated that they were Latino used the emergency room in the last two years.

- Latinos who lived in 11237, Bushwick (39.7%) and 11221, Bedford Stuyvesant (23.8%), used the emergency room more.

- 49 (77.8%) of the Latino emergency room users were female; 14 (22.2%) were male. Over half (58.7%) of the Latino emergency users were between 26 and 50 years of age. 41 % (25 people) were married and 38 % (23 people) were single. Fifty-four percent were employed and 46% were not employed. Eighty-four percent had insurance and 27% received all of their care in their community.

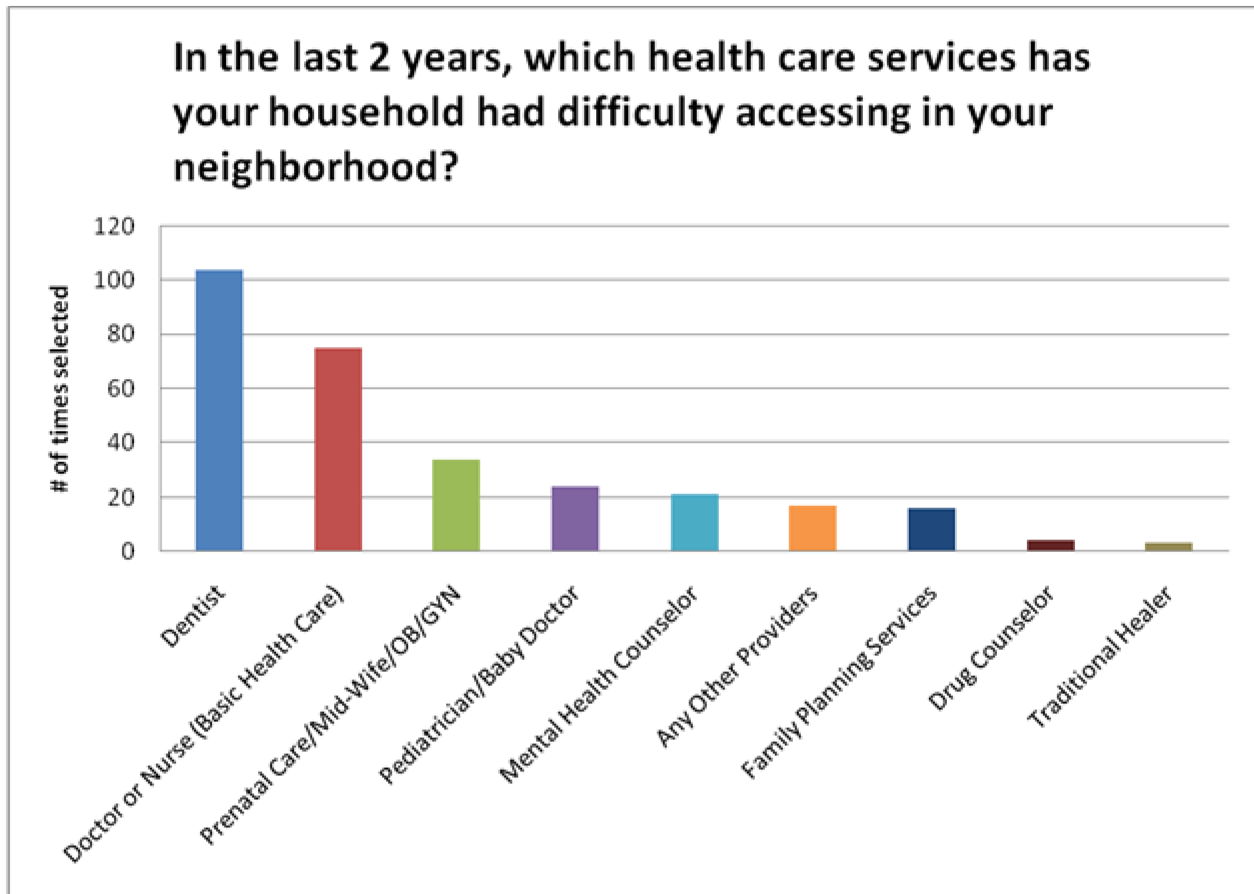
- Latinos who used the emergency room reported problems with asthma (31.7%), high blood pressure (28.6%), hearing or vision problems (23.8%); diabetes (27.0%) and overweight/obesity (20.6%). (See Appendix 20).

Barriers to Care

"More clinics to avoid emergency room"

"More clinics to cut down on wait time."

Figure 19 – Barriers to Care



The last section of the survey addressed barriers to care. Respondents were first asked in the last 2 years, if they or any of your family ever had difficulty getting access to any of the following health care providers in your neighborhood**.** They were read a list and asked to identify all that apply.

248 respondents (43.1) % indicated that they had no difficulty getting access to providers in their neighborhood. But the most often cited access problems as reflected in the graph above and table below were dental care, seeing a doctor for basic care, and prenatal care/seeing a Mid-wife/OB/GYN (see Figure 19 and Table 18).

Table 18 – Difficulty Accessing Health Care Providers

Difficulty Accessing Health Care Providers		
Provider	**Number of Responses**	**Percent Based on Responses**
Dentist	104	34.9 %
Doctor or Nurse (Basic Health Care)	75	25.2%
Prenatal Care/Mid-Wife/OB/GYN	34	11.4%
Pediatrician/Baby Doctor	24	8.0%
Mental Health Counselor	21	7.0%
Any Other Providers	17	5.7%
Family Planning Services	16	5.3%
Drug Counselor	4	1.3%
Traditional Healer	3	1.0%

Note. 99 Responses were “no answer”

“If I was given the power for day the changes I would make would be focusing on good mental health. It helps us enjoy life and cope with problems. It offers a feeling of well-being and inner strength. It determines how we take care of our bodies by eating right and exercising.”

- The types of services which respondents had difficulty accessing by zip code are:
  - *A doctor or nurse* – 11201, Downtown Brooklyn (27.8%) and 11226, Flatbush (25.3%).
  - *Dentist* – 11222, Greenpoint (33.3%); 11206, Williamsburg (29.1%), 11208,
  - Cypress Hills (27.8%); 11217, Gowanus (25.0%); 11221, Bedford Stuyvesant (25.0%)
  - *Prenatal Care* – 11238, Prospect Heights (18.5%); 11233, Bedford Stuyvesant (14.8%)
  - *Pediatrics* – 11221, Bedford Stuyvesant (17.5%) (See Appendix 17)

- If respondents indicated they had encountered difficulties in accessing care, they were asked to describe what happened; 141 responses were obtained. Those cited by more than one person are presented in the table below.

No insurance	12
The don't take my insurance	8
Needed dental care	5
Did not have car fare	3
Don't have health problems	5
Hours of service	6
Can't get care right away	2
Not enough special needs doctors	2
No services in area	2
Went without care	2
Not comfortable with available services	2

Dental Problems and Access to Dental Care

About 13.4% (86 people) of the sample indicated that they had dental problems and 16.1% (104 people) indicated that they had trouble accessing dental care.

Women were more likely to report dental problems (69.8% or 60 people) than men (30.2% or 26). Sixty three percent of those who indicated dental problems were younger than 50 years of age.

Individuals with dental problems were significantly more likely to report health problems. On average, they reported about 3 problems (Mean=3.22, SD=1.93) compared to the two health problems (Mean=1.81, SD= 1.16) reported by those without dental issues ($t(102)= 6.461, p<.001$)). The major health problems reported by those with dental problems were hearing and vision problems (41.9%), high blood pressure (36.0%),

asthma (29.1%), bone/joint problems (26.7%, weight problems (23.3%) and diabetes (22.1%).

Thirty five percent of those who reported having dental problems also reported having problems accessing dental care.

Women were more likely to report problems accessing dental care (73.1% or 76 people) than men (26.9% or 28 people). Seventy-six percent of those who indicated that they had trouble accessing dental care were younger than 50 years of age.

Among the 301 individuals who said they used the emergency room in the past 2 years, 13.6% indicated that they had dental problems. 58 respondents (19.3%) who used the emergency room indicated that they had trouble accessing dental care.

Issues that Might Limit Ability to Access Health Care

Next respondents were read a list of issues that might have limited their ability to secure health care or caused them to wait before they or their household member went to the doctor or nurse in their neighborhood**.** Since, respondents could check all that apply, the table below reflects responses. 182 respondents (30.1%) indicated that they had no barriers in access to care based on this list. 112 respondents (18.5%) have not had limits in accessing a doctor or nurse. Thus, almost half of the respondents (48.6%) have not had limited ability to secure health care services. Table 19 summarizes the 777 responses that were indicated by survey respondents

Table 19 – Issues that Might Limit Ability to Access Care

Issues that Might Limit Ability to Access Health Care		
Issue	**Number of Responses**	**Percent Based on Responses**
Had to wait too long to get an appointment	105	13. 5%
No health insurance	95	12.2%
Had to wait too long at the appointment	75	9.6%
Could not afford the bill	71	9.1%
Insurance did not pay for what was needed	59	7.6%

Health plan problem	48	6.2%
Could not find a doctor that took your insurance	41	5.3%
Cannot miss work or school	31	4.0%
Other	31	4.0%
Did not make me feel comfortable	28	3.6%
Did not like the care received	27	3.5%
They did not return your phone call	24	3.1%
Hours of service are a problem	24	3.1%
Did not speak my language	21	2.7%
They were hard to reach by phone	20	2.6%
Did not know how to make an appointment	16	2.1%
Transportation problems	13	1.7%
Did not know how to find a doctor or a nurse	12	1.5%
Couldn't find a doctor or translator spoke language	10	1.3%
Did not know where to go	9	1.2%
Did not have a doctor or nurses phone number	6	0.8%
The facility was not accessible	6	0.8%
Took too long to get there	5	0.6%

"There are health services in my area. Long Island College Hospital is not too far, but I have no health insurance to use it."

"Waiting period is too long, more staff, always short staffed."

"Health clinic for myself and my children with Arabic speaking doctors; travel far with my children."

"The doctors need to care about the patients. Speak to them personally and the office staff should be polite."

"Accessible rides to doctors and visiting service. Make services more affordable for the working class and don't discriminate when they don't have co-payments. They still need health services done."

Barriers by zip code

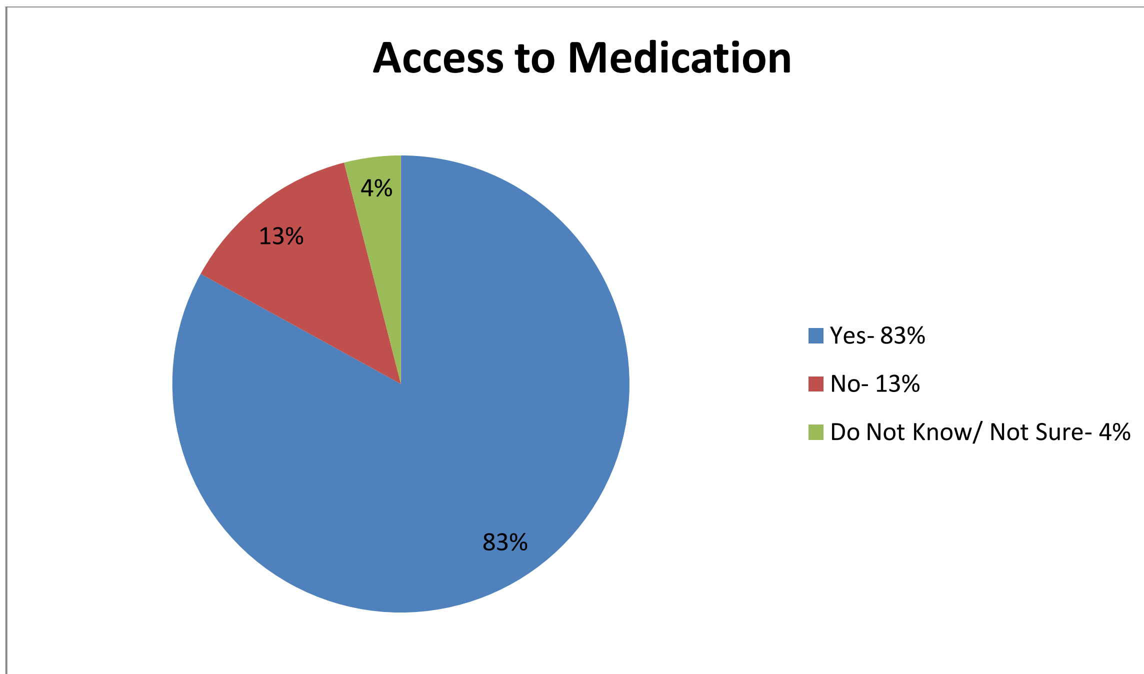
- Had to wait too long to get an appointment by zip code – 11221, Bedford Stuyvesant (50.0%); 11237, Bushwick (42.9%); 11222, Greenpoint (33.3%),
- No health insurance by zip code – 11201, Downtown Brooklyn (33.3%); 11233, Bedford Stuyvesant (29.6%); 11238, Prospect Heights (22.2%)
- Had to wait too long at the appointment by zip code – 11237, Bushwick (36.7%); 11221, Bedford Stuyvesant (27.5%); and 11238, Prospect Heights (18.5%).
- Could not afford the bill by zip code – 11238, Prospect Heights (33.3%); 11201, Downtown Brooklyn (22.2%)
- Insurance did not pay for what was needed- 11222, Greenpoint (33.3%)
- Have not had limits accessing doctor or nurse by zip code – 11213, Crown Heights; (49.1%); 11217, Gowanus (35.7%); 11213, Crown Heights (49.1%) and 11206, Williamsburg (29.1%). (See Appendix 18)

Access to medications

The final two close ended questions on the survey asked about access to medications. Respondents were asked if in ***"*****the last 12 months, have you or your family members been able to receive all of the prescription medications needed?"**

31 individuals indicated that they did not need any medication and 20 individuals did not answer. Of the 585 people who gave applicable responses, the majority (83.1%) were able to obtain needed medications (see Figure 20).

Figure 20 – Access to Medications



- Those who indicated that they had not received all the needed prescription medications were given a list of potential reasons. Since they could check all that apply, Table 20 reflects multiple responses. 134 responses were obtained. The most frequent responses were lack of health insurance (32.1% of responses), costs too much (31.0%), and health plan problems (17.9%).

Table 20 – Barriers to Accessing Prescription Medications

Barriers to Accessing Prescription Medications		
Reason	**Number of Responses**	**Percent Based on Responses**
No health insurance	43	32.1%
Costs too much	41	31.0%
Health plan problems	24	17.9%
Can't find doctor who accepts health insurance	7	5.2%

Not available in area	6	4.5%
Cannot miss work	5	3.7%
Not like the service	3	2.2%
Not know where to go	3	2.2%
Hours of service	2	1.5%

Note. 28 responses were "no answer".

Open-Ended Qualitative Questions on the Survey

This survey contains three open-ended questions that are not tied to another question and do not request an explanation of additional information about that question. In other surveys, at times the picture drawn by respondents is rosy and that everything is okay, however when asked directly for their opinion, problems are more likely to be expressed. [47] This survey asks the respondent many times to respond in their own words, so that the answers to the questions below appear to corroborate the other responses.

The responses from these three questions were used in two ways: to identify direct quotes that contribute to the overall information provided in this survey; and to categorize the responses so that there is also a count of the prevalence of similar responses. The categories chosen were identified based on the purpose of the survey: a community health needs assessment of the North and Central Brooklyn communities to gather information from residents about what they think of health services in their neighborhoods and what they perceive is missing or more is needed. After a careful review process of the responses to these questions, the categories selected were: Access, Barriers, Culture/language, Travel time, Waiting time for appointments and at appointment, Insurance Coverage, Type of Service needed, Problems/Attitude, Costs, and Lack of Information.

 # 27. Are there any medical or health-related services you think your neighborhood needs more of? If so, what are the services?

Community Health: Some of the quotes from respondents address the overall need for services and for changes in the neighborhood that promote healthier living.

"Convenient physical access to grocery stores and other retailers that sell a variety of foods. More clinics/dental offices."

"Better time service and more organized clinic appointed visits for patients and staff members that are knowledgeable."

"More parks and pools to swim."

"More mother father classes for young men and woman with children."

"Every service that provides for the communities general health needs."

"Need youth health programs; get youth off of the corner and into a productive environment."

On specific services:

"Dental services that accepts more different types of Medicaid, drug services that could provide addicts rehab and also more clinics for youth treatment."

"Wish there were more options for men."

"More services for children with special needs."

The most frequently mentioned services needed in the community include: dental care (86), more doctors and clinics (76), pediatricians (35), OB/GYN (38), mental health (32), and geriatric services (18). As well, the theme of the need for more of these services was repeated in the other two open-ended questions.

The specialty care services mentioned most frequently as needed in the community are: general specialists (44), eye doctor (14), cardiologist (10), and orthopedist. The need for services for special populations was identified ten times. The need for recreation and preventive services was identified by eight people.

Barriers to care that were identified included: culture and language (8), hours of service (8), problems with attitude of providers (8), and waiting time (7).

Additional issues that were raised included: costs (32), insurance problems (21), quality (16), and lack of information (12).

"Better communication between patient and doctor (language barriers)."

"More doctors because I have to wait too long to be seen."

"More convenient for seniors that don't have access to ambulant."

"More services to educate people about access to medical care."

"Medical transportation by local organizations that the community trusts. This would also create jobs."

#28 If you were given the power for one day, what changes would you make in the medical care system that you feel would make it work better for you, your family, and for people in your community?

"Allow uninsured to receive health care, never denied."

"A better system to expedite visits."

"Easier to obtain health, more system communications between doctors and files."

"No distortion of the diagnosis that will inhibit recovery for possible quality of life."

"Hire doctors too crowded."

"I live in Bed-Stuy and they do not make you feel comfortable. You have to wait too long. The doctors treat you as if you are just another number."

"I don't have health insurance. I think the uninsured should be seen and not made to feel inferior."

"Bring services closer to your home and more readily available and have appointments dates set up to accommodate the client needs at time of need instead if months down the year. Waiting time should not take a half a day."

"Cover everything: eliminate co-pays; all services under one roof; reduce wait times. Better customer service; more time with patients; clearer explanation of diagnoses, illnesses, procedures."

"Reduce infant mortality, make schools healthier. I'll get rid of all drugs or any harmful narcotic. Better food less hybrid. Eliminate all fast food restaurants."

The above quotes are the types of statements that respondents expressed in response to this question. Access and coverage statements were predominant.

The responses to this question were more related to issues of access and barriers than the responses to question #27. However, there was also indication of the need for particular kinds of services, including: more doctors and clinics (54), dental care (13), and geriatric services (13).

Barriers to care and access concerns were identified by more than half of the respondents to this survey. Some of the barriers included: waiting time (31), culture and language differences (23), attitude problems (23), and hours of service (9). Other related problems include: costs (26), quality (22), insurance problems (14), and lack of information (14). In addition, systems change issues (17) got attention, along with the need to do more to teach/educate (16), and focus on the social determinants of health (10), including access to healthy food and recreation.

Access to care and coverage was most often cited in response to this question. The responses included:

- Care more accessible and available 81
- Universal access to health care 40
- Free universal coverage 52
- Free care 47
- Equal treatment 10

There are many quotes from respondents that cover these issues; just a few of them will be listed here:

“Faster doctor visits, less wait times.”

“For doctors to make house call and come see you as needed.”

“Make services more cleaner and more professional also more organized. Try to get more people in better healthy by building organizations to get more people medical care on track.”

“Late hours for working people. Doctors should look at the whole person, not only what you tell them. They should ask questions. Maybe there are other issues. Make mandatory to remind patients of needed exams and vaccinations for children.”

“Bring services closer to home. Doctors should spend enough time with patient to really understand the problem.”

“Increase the allowed income for middle class to be eligible for Medicaid.”

“I will give everyone a good health service and will make everybody can qualify for Medicaid.”

“I make the services more readily available for everyone including people without immigration status.”

“I will bring more Spanish doctors from Latin America! They know us better and we would have a better communication and understanding!”

#29 Is there anything you would like to tell us about you and your family’s health care, or health care services in your neighborhood? (For example: Do your children get good medical care? If not, what are the reasons?)

The responses to this question were mostly more personal and/or general. A large number of respondents (70) indicated that they were satisfied with their health care, but this applied mainly to the care received by their children. The wording of the example in

this question directed people toward talking about their children's medical care. It is not clear if respondents would have answered the same way in talking about their own care.

There were again many negative comments about care in the community.

"The health care services are garbage. There should be more home visits by doctors."

"More language access for those doesn't speak English or more Hispanic doctors."

"People in my neighborhood do not know there are resources, and we cannot find private practices, only clinics and facilities, and there we cannot get personal care."

"Better doctor office so individual groups like my 19 year older brother can go and be comfortable."

"My child has good medical care but mines isn't really too good, once I got a certain age my Medicaid was shut off. I am still trying to build it back up."

"We need environmental testing in the area. There have been lots of contaminations in the area and residential buildings were built on top of them. Kids are being diagnosed with cancer and asthma, etc., at a higher rate as a result."

"Doctors office hours are limited it is very difficult for my daughter to help me with my wife."

"I spent all day at the doctor office and it create problem with my job."

"Not too bad, could be a little better. They're closing hospitals in our area. They're closing Downstate and we don't want that at all."

"Our community has a lot of health issues because we do not have good doctors and don't get a proper diagnosis, etc. Doctors don't spend much time with patients therefore missing important facts regarding the health of patients."

“Providers should bring service in my community based on our needs.”

“The area is not safe or healthy for our children.”

“The care we get is alright but would like to see the same doctor all the time.”

There is concern expressed in response to this question for more doctors/clinics (17) and dental care (8).

Most of the access and barrier question responses reflect the answers to the other open-ended questions. Under barriers: culture/language (8), waiting time (12), and attitude problems (10). Also cited in these responses are: insurance problems (15), costs (19), quality (31), and lack of information (14).

Summary and Important Findings from the Surveys

The goal of this survey was to target, screen, and interview community residents in an effort to, as closely as possible; reflect the low income diverse population in the 15 zip codes in North and Central Brooklyn communities. The demographic profile of the survey respondents came close to that of the North and Central Brooklyn profile. For example, the percent of foreign-born respondents in this survey (40%) is similar to the 40 % rate of Brooklyn residents. The Central Brooklyn population is 80% Black. Sixty-six percent of survey respondents identified as Black (African-American and Caribbean/West Indian); 21% as Latino and 15.3% as multiracial. Twelve percent of the respondents indicated that they or their household members have no health insurance. Over 52 % of the respondents are covered by income-eligible public health insurance, that is, Medicaid, Family Health Plus, and Child Health Plus.

This study targeted respondents with lower incomes based on family size, using the New York City Housing Authority (NYCHA) guidelines. Therefore the income of respondents in this study, who are working, appears to be lower than the median income in the identified zip codes. As explained in the methodology section, before the study was undertaken available data on the community was pulled. According to available community data on the zip codes included in the study, the lowest median income is found in 11237, Bushwick ($23,104) and the highest median incomes are found in 11201, Downtown Brooklyn ($56,293) and 11217, Gowanus ($49,567). In *The Need for Caring*, 65 percent (201 of the 309 working respondents) indicated an income less than $30,000 per year. As stated earlier in this report, it is important to keep in mind

that community level data can mask the urgent needs of residents with lower income levels.

The overall goal of *The Need for Caring* was to document health care needs, gaps in services and barriers to care.

The most often reported illnesses/health conditions were high blood pressure/hypertension (24.8%); asthma (19.9%); diabetes (15.7%); and hearing or vision problems (15.2%). All of the conditions are amenable to preventive and primary care services, when these services are available. These illnesses were not evenly distributed among the different zip codes. For example, 11237, Bushwick showed high prevalence of all four of the health conditions and 11212, Brownsville/East Flatbush showed a high prevalence for three of the conditions – asthma, high blood pressure and diabetes.

Care outside the neighborhood is of major concern. Since an overwhelming majority of respondents (89%) said that it would be more convenient to receive care in their neighborhood. However, 32% received care both within and outside of their community and 18.3% received all of their health care outside of their community of residence. The major reasons for seeking care outside of the community were the need to see a specialist, being referred or assigned to a doctor in another neighborhood, lack of satisfaction with services in the neighborhood and time issues (waiting too long to get an appointment or waiting too long to be seen at an appointment). These reasons varied by zip code. For example, in 11216, Bedford Stuyvesant, all five reasons were prevalent.

In addition, access to health care was not always available within all of the zip codes studied. Respondents were asked, and shared the types of services they felt were missing from their community. Doctors and nurses who provide basic health care and dentists were the most frequently named providers that are needed. The availability of different types of health care providers varied by zip code.

In the open-ended questions on the survey, the same types of services were identified as needed in the community: Dental care (86), more doctors and clinics (76), pediatricians (35), OB/GYN (38), mental health (32), and geriatric services (18), were the most frequently mentioned as services needed in the community. A 2008 study by the City Council, prepared by the Health and Hospitals Corporation in conjunction with a community task force, in which respondents were surveyed in some of the same zip codes, listed the same services as needed in the community.[48]

Specialty care services that were mentioned frequently as needed in the community are: general specialists (44), eye doctors (14), cardiologists (10), and orthopedists.

The need for services for special populations was identified ten times. The need for recreation and preventive services was identified by eight people.

Although, almost half (48.6%) of the respondents said that they did not have limited ability to secure health care services; barriers were indicated by other respondents in both the close ended and open ended responses on the survey. When specifically asked, respondents indicated that the major barriers which limit access to health care were having to wait too long to get an appointment, lacking health insurance, waiting too long at appointments and the cost of care. In two of the three open-ended questions, barriers to care were frequently raised, and the responses were more qualitative in nature than found in the rest of the survey responses. Concerns that were not captured in the closed-ended questions were noted in these responses. It is not unusual for respondents to disclose more information when not constricted by multiple choice questions. Barriers that were often raised in response to these open-ended questions were costs, insurance problems, quality, and lack of information. In addition, other important barriers that were raised by respondents included culture and language differences, hours of service, problems with attitude of providers, and waiting times. Respondents indicated the need for:

"*Late hours for working people.*"[49]

"Doctors office that can open long hours for working people."

"Health services even if you cannot pay."

Emergency room use is an important component of the health care delivery system in medically underserved communities. There are many health conditions that could be treated on an outpatient basis in the community if there is access to services. This study is complementary to a study prepared by the Brooklyn Health Improvement Project (B-HIP), in which residents from almost the same zip codes were interviewed in the emergency room. Another important aspect of the B-HIP study was the identification of what is labeled "Hot Spots" in the neighborhoods.[50] Using SPARCS data, the project was able to identify problems of health care usage in three distinct areas that had the highest number of hospital discharges for conditions that could be treated in the community (ACSC).[51] The top "Hot Spots", reported in census tracts, are located in Brownsville/East New York (11212, 11207); Crown Heights/North Bedford Stuyvesant (11213); and Bushwick/Stuyvesant Heights (11237, 11233). There is some overlap with our study, in that the zip codes with the heaviest usage of the ER are: 11221, Bedford Stuyvesant; 11212, Brownsville/East Flatbush and 11216, Bedford Stuyvesant.

Of the 644 respondents to the survey, 301 (49.7%) indicated that they or a member of their household had been to an emergency room in the last two years. The majority (71%) had made 1 or 2 visits. Asthma and high blood pressure were key reasons for visiting the emergency room; acute phases of these chronic conditions need urgent treatment, but preventive and ongoing, continuous, comprehensive care can mitigate the need for emergency treatment.

Type of health insurance coverage appears to have an impact on ER usage. Typically, it is believed that the uninsured heavily use ER for services. In this study, of the 301 respondents who indicated they had used the ER in the last two years, the highest percentage usage of ER visits by insurance coverage was: Medicaid (49.5% for self, 37.9% household), insurance by employer (13.6% self; 9.6% household), Medicare (9.6% self, 4.0% household), and no health insurance/self-pay (7.3% self, 3.7% household).

Patterns of emergency room use were explored more in depth for African-Americans who had the highest number and percent of persons using the Emergency Room in the last two years (130 or 56.5% of the African-American respondents), Caribbean Americans (56 or 41.5% of the Caribbean respondents) and Latinos (63 respondents or 52.5% indicated that they used the emergency room in the last two years).

Finally, individuals who reported dental care needs were also more likely to report more health problems including issues with hearing and vision, hypertension, asthma, bones and joints, weight and diabetes.

B. FOCUS GROUP FINDINGS

Focus Group Participants

A total of 78 individuals participated in the focus groups. Focus groups ranged in size from 5 to 12 participants with an average (median) size of 8 participants. Focus group sites included: The Brooklyn Center for the Independence of the Disabled, the Caribbean Women's Health Association, Central Economic Development Corp, Brooklyn Borough Hall, RAICES, Inc., the Brownsville Public Library and the Brooklyn Community Pride Center.

Participant Characteristics

Participants in the focus groups resided in 13 of the targeted zip codes; only 11237 and 11222 were not represented. Efforts were made to outreach to all zip codes, however, we were not effective in reaching these two communities for focus groups. As can be seen in Table 1, the focus group participants represented a diverse group.

Overall, participants ranged in age from 13 to 88 years with an average age of 44 years. Over sixty percent were woman and two-thirds were Black. Twelve participants (16%) of the sample did not indicate their income. Of those who responded, the annual median income was $20,000 or less. Thirty-six percent had an income of less than $10,000, 34 % had an income of $10,000- $20,000, 14% had an income of $20,000- $30,000, 9% had an income of $30,000- $40,000, 3% had an income of $50,000- $60,000 and 3% had an income of $60,000 or over. Only one in six participants were employed. About seven in ten participants had insurance.

<u>Individuals Living with Physical and Sensory Disabilities</u> (this group did not include any people living with mental disabilities)

On August 9, 2012 a discussion group was conducted at the Brooklyn Center for the Independence of the Disabled at 27 Smith Street in Brooklyn, New York at 1 PM. Prior to the asking the focus group questions, the facilitator asked about the proper terminology to use to describe the group. The participants responded that they are considered, "Individuals living with physical and sensory disabilities or conditions".

There were a total of 13 participants, two of whom left early and two of whom left and returned to fully take part in the discussion. These participants included people with physical disabilities, visual impairments and hearing impairments. A total of 11 participants actively participated in the discussion, including 5 males and 6 females. The ages ranged from 40 years old to 70 years old. Participants resided in seven different zip codes including 11201, 11205, 11207, 11208, 11212, 11213, and 11226.

Six of the participants identified themselves as Black or African-American, one identified as Indian American and three identified themselves as White. Two reported that they were currently employed and the remaining participants were either retired or not employed. They all reported an income of $20,000 or less a year.

The three biggest problems participants faced in getting health care in their community included not having the right documentation (immigration issues), being unable to afford to pay out of pocket when providers did not accept their insurance (Medicaid or Medicare) , and not being able to understand the medical jargon.

All except one participant had health insurance coverage. The participant who did not have health insurance coverage stated that he does not receive health insurance because of his undocumented immigrant status. While that is true, he has benefitted from Health and Hospital Corporations (HHC) Options, a program that allows people to

access care at reduced costs, at more than one of the HHC facilities. All other participants have secured Medicare or Medicaid, with at least 50% receiving both Medicare and Medicaid.

When asked to identify some of the barriers/challenges with their health coverage, the participant who was undocumented, had a physical disability, and was diagnosed with Lupus, said that he clearly felt "I do not get all the services, I believe that I need".

Others indicated that not all insurance plans cover all the services that they need to help with their conditions. Specifically, when they are diagnosed with additional illnesses, they find themselves being dropped by their physician or unable to continue to receive care with the same physician because their insurance does not cover their new health condition. In many cases, participants are finding it difficult to get medical attention because doctors are not easily accepting Medicare or Medicaid. Participants complained about yearly fluctuations in formularies- at one point in time they can get medicine, but in the next year they can no longer receive the same medications as a result of formulary changes. One participant stated that because of the costs of medication, she went a year without taking many of her prescribed medicines. She had been diagnosed with a chronic illness and received a referral to a specialist to confirm her illness. The illness was confirmed by the specialist, but she could not stay with that physician because they did not take Medicaid/Medicare. Another participant who lives in the Brownsville section of Brooklyn prefers staying close to her neighborhood hospital for easy access and knowledge of the community. She is visually impaired; hence her walking is challenged sometimes because she very rarely uses her cane. She needs surgery, but because the local hospital does not take her insurance and she does not feel comfortable going to any other hospital, she is waiting for about 6 months until she can change her insurance plans. Most of the participants enrolled in -Managed Care Plans agreed that having such a small window to change their enrollment (and having the 1 year waiting period if they failed to make a change within that period) was a barrier to care. Another participant viewed Medicare changes as a challenge. For example, the participant received approximately 40 visits for 90 days and after the 90 days would have to get re-evaluated by his doctor for the next 90 days. The doctor wrote the prescription for care that he needs for walking but the physical therapist stated that he now has to wait 6 months; in the interim his legs atrophied and his ability to get around has weakened. Because the participants are low-income, they feel that the care they receive is substandard and the wait for services (4-5 hours) is associated with the type of insurance they have.

Most participants do not change their provider or insurance plans because they feel that while one plan may cover new services they may need, it will not cover the other types

of care they need, so they see health insurance not covering everything as a major barrier.

When asked about their health insurance coverage, all, but one participant was not completely satisfied. They understood from providers that the reimbursement rate was too low for the doctors and that many providers no longer accepted Medicare or Medicaid because of the length of time it took for the providers to be reimbursed. Only one of the participants is receiving fee-for-service Medicaid, all of the other participants are receiving managed care. Participants called their health insurance “low end”. When probed further, they not only felt that it is for those that have low income but that they receive substandard care because they are looked down on. A few compared their Medicare Part B, which is primarily used for their private doctors, as a different level of care.

When asked about their health care utilization, most participants go to their primary care provider and/or particular specialists. They utilize multiple physicians for their multiple health needs. They go to the emergency room when their physician is not in office, during holidays. Some receive care at a hospital setting.

Most of the participants stated that they go to more than one place for care and that most are those places are outside of their community. Most physicians do not take their insurance for all services; one participant goes to an HHC facility in his community because it offers the specialty care needed, but will not go there for his routine visits, because the wait is too long once there.

Most of the participants are enrolled in Access-A-Ride, but do not use it because it is not as accessible. Many participants reported taking the bus or train instead. Identified problems with Access-A-Ride included: whenever there is a last minute change – Access-A-Ride won’t take the change; when participants have to cancel, they must provide notice 3-4 hours in advance or run the risk of losing the service. In addition, arrangements must be made 24 hours in advance to reserve pick-up. Usually, participants use Access-A-Ride to travel to new locations, far locations and unfamiliar locations.

Many of the participants who use facilities outside of their community indicated that these facilities do not provide accessibility for wheelchair bound patients. Others noted that locations need to have bright lighting for the visually impaired, and large print materials for the visually impaired/legally blind. Participants mentioned that the bells to get into the buildings are often too small for persons with visual impairment.

When asked about the types of accommodations that are needed at these facilities, participants noted

- Wheelchair accessibility
- American Sign Language proficiency
- Large print materials
- Brighter lights in facilities

Participants mentioned that they used emergency rooms at night time, weekends and holidays when doctor's offices are usually closed. This also includes religious holidays of the doctors. Additionally, participants have used the ER because they felt it was quicker than going to the doctor's office and that they would be seen more quickly. When they have a condition that requires immediate attention, participants use the ER; an example shared was that of a diabetic patient who goes directly to the ER when he or she is in crisis because of the quick triage. Participants also indicated using the ER when the doctor refers the patient to the nearest hospital (rather than seeing the patient at the doctor's office). The reason is because the situation is going to warrant additional service that the doctor cannot handle.

Participants felt that their community needed additional:

- GYN services
- Women's Wellness (health and wellness groups)
- Prostrate care and information and education, including more urologists in the community
- Diabetic and high blood pressure education
- Wheel chair clinics
- Podiatrists that works with diabetes and know how to conduct proper foot care
- 24 hour urgent care unit
- Follow up care for persons living with Lupus

Participants indicated that if they were given the power for one day, the changes they would like make were as follows:

- Socialized medicine would be instituted; promoted voting in November to keep Obamacare;

- Homeopathic medications be incorporated with nutritional medicine;
- Information should be straight forward
- Universal health care;
- Medicaid should cover everything instead of having to go from one insurance to another or having to skip around from doctor to doctor because not all insurance plans cover all needs;
- Change waiting time to see the doctors;
- Bigger push on nutrition; and
- To get optimal health care

Noteworthy of this group, is that many of the HHC hospitals were mentioned and mentioned as providing good care.

Summary Key Themes

Health insurance does not cover all needs especially when other medical conditions are present

Need more accommodations at facilities

Reliance on public transportation because of problems with Access-A-Ride

<u>Teens</u>

On August 16, 2012, a discussion group was conducted at 4 PM at the Central Economic Development Corp located at 444 Thomas Boyland Street in Brooklyn, New York.

A total of 7 participants actively participated in the discussion, including 4 males and 3 females. The ages ranged from 13 years old to 22 years old. All participants were English speaking with one being bi-lingual (African dialect). All of the participants lived in the designated zip codes which include: 11221, 11233, 11203, 11212, 11226 and 11213. Six of the participants identified themselves as Black or African-American, one identified as Black/African-American and American Indian, Alaskan Native American. None of the teens/young adults were currently employed. Four of the individuals reported income under $20,000 and three reported household income of $30,000-$40,000.

The three biggest problems in getting health care included not having the right documentation; the length of time it takes to get health insurance and difficulty finding out where to go and that people do not want to pay for health insurance until they get hurt.

All participants had health insurance, three who we learned were brothers had private insurance (probably through their parent's employment), the others had Medicaid and the youngest participant did not know what type of insurance she had. The teens were not able to answer questions regarding problems with the health insurance and how to change providers if needed.

The participants who had private insurance stated they had no problems and that they liked their providers. Participants with private insurance plans or private doctors went outside of their neighborhood for care. One participant noted that there is split care in his household; as the older sibling he sees a private doctor outside of the neighborhood; his sibling will switch from the neighborhood clinic to a private doctor when he gets older. He believes that his care is different than that of his sibling who has Medicaid. He feels and others confirmed that in getting care in hospitals and clinics, providers very often act like "they don't want to be there, have very bad attitudes and that they don't treat patients friendly". They felt this type of treatment was totally different when they go to their private doctors, where people there were much nicer. Participants who received care in a clinic tended to go within their neighborhood. Participants who travelled outside of their neighborhood stated that it took 30- 60 minutes to get to the doctor, but that they did not consider it a long travel or hardship. Many of the students commute outside of their neighborhood to school; hence traveling outside of their neighborhood was not an unusual activity for them. Additionally, most felt that better care occurs outside of their neighborhood and the majority of the participants have been going to the same provider for most of their lives.

The youngest participant who was 13 years old could not easily differentiate whether she attends a private office or a clinic. After further discussion and description, it appeared as though she attends a specialist sports clinic. She takes gymnastics and stated that all of the other patients treated at the clinic had sports injuries.

The majority of the participants stated that they and most of their friends would not go to the doctor unless they were sick and their parents made them. The two participants in their 20's understood the importance of prevention and that was the reasons that they went for care. They were more likely to blame community for some of the illnesses because they felt people have health insurance but "don't go though they have insurance and wait until it's too late." A lively discussion ensued between the participants; the younger participants left with a change of mindset, per verbal

admission and were more aware of the importance of prevention and more appreciative of their parent's insistence. An example was given by one of the participants who explained that he plays basketball and had an hand injury but did not consider going to the doctor, until his mother took him anyway stating "it is better to be safe than sorry" and "if you don't go to get examined you may have problems later on." Again, once they learned of their communities' health status they were happy that their parents made them go to the doctor and wanted to be advocates for their peers.

Participants who attended private doctors felt that they were seen right away, while the participants who attended clinics reported a different experience. All of the participants referred back to how one is treated in a clinic versus a private doctor or having private insurance. The participants attributed the long wait time at clinics to persons that worked at these places. "We see them talking and walking around or acting like they don't want to be there and take it out on the clients; that's some of the reasons why you have to wait long."

The majority of the participants viewed the emergency room as inappropriate for regular use and that their first choice was going to a doctor's office. One youth stated "who would use the emergency room unless you have an emergency." Another commented "that would be a waste of money, that's why you have insurance." Only one participant admitted that she used the emergency room for other reasons; she had used the ER to receive follow-up for care after a car accident.

When asked if there were any medical or health-related services that the participants thought their neighborhood needed more of, participants identified social problems that needed to be addressed in their neighborhoods. The areas that were of most importance were:

- Violence including random murders, domestic violence
- Poverty
- No jobs
- Low/poor education
- Obesity

Changes that participants would make in the health care system if given power for one day included:

- Having health care places that focus on young people only
- Eliminating health care expenses so people would be more inclined to go

Summary Key Themes

Differential treatment by insurance

Need to address social issues in the community

Spanish-Speakers Receiving Mental Health Services

On August 31, 2012 a discussion group was conducted at the RAICES, Inc offices located at 10 Hanover Pl, Brooklyn, NY 11201. The focus group brought together people with mental illness to share their experiences and viewpoints on accessing health care and barriers to receiving care. The discussion was held in Spanish. The focus group notes and recordings were later translated into English to make analysis easier.

All participants resided in the designated zip codes identified for this study; three lived in Priority 1 zip codes; 2 in Priority 2 zip codes, and 3 in Priority 3 zip codes. The participants' ages ranged from 47 – 66. 7 females and 1 male were present. All 8 participants identified as Latino/Hispanic.

All participants were currently unemployed; 4 participants had annual household incomes of less than $10,000, 2 had incomes between $10,000 and $20,000, and 1 had an income between $20,000 – $30,000. 1 participant gave no response.

All participants indicated that they had health insurance. When asked what type of health insurance, 5 participants indicated HealthPlus/Amerigroup, 2 participants indicated Medicaid and 1 participant indicated Medicaid and Medicare.

Participants saw the major health problems in their community as involving four major issues: accessing prescription medications, obtaining referrals to specialists, language access and lack of transportation to hospitals. Three participants identified issues with accessing prescription medications in their written evaluation and others in the group also had similar problems. One participant shared her experience losing medication coverage after her Medicaid insurance company, HealthPlus, merged with Amerigroup. Others indicated that insurance providers asked them if they really needed the medication prescribed before approving coverage. Although it was not an issue for them (for example, one participant could afford the 6 dollar co-pay and another could obtain medication free from her community clinic), the group agreed that unaffordable co-pays are sometimes a "hardship" for people in their communities. When asked what people in their communities do if they can't afford their medications, participants responded that they knew people who buy medications in the street/black market, and others that do without their medications.

The group also emphasized the need for more community education about medications, citing that many people do not know the names of their medication – this may be in part due to language barriers. For instance, the group spoke about the difficulty in understanding the paperwork that comes with prescriptions, especially when it is only in English.

Participants voiced their desire to have more health centers with specialty care capacity so that comprehensive care could be attained in a single setting. Participants saw Medicaid as a major reason for having difficulty gaining access to specialty care. One participant waited six months for an appointment with an oral surgeon. The participant was refused care from several locations and when the participant called her Medicaid insurer to explain the difficulty, the representative said, "This is what happens when you live off the government." The participant then went on to explain that when she finally was in the appointment, the doctor ran into the room and screamed, "She didn't pay for the laughing gas!" right as it was about to be administered. Instead, the doctor just gave her local anesthetic and she had incredible pain. This was at a private doctor's office – the group agreed that Medicaid patients are often treated unfairly and given less than adequate care.

The group agreed that more interpretation and translation services were needed. A lot of written communication is only in English, making it difficult to understand. Bilingual participants indicated that they themselves had sometimes been asked to interpret in health care settings. Others had seen custodial workers pulled into medical settings to interpret. The point was made that speaking a language does not qualify you to interpret or translate and the group agreed. They want more people that speak their language in the health profession.

The group agreed that lack of transportation to hospitals was a problem. One participant shared her difficulty in going up and down the stairs to the subway. She used to have transportation through Medicaid, but the service was dropped. Now, she has to walk a long way to get to the doctor.

The group agreed that there are a lot of people with disabilities who need transportation help and do not get it.

Specific comments included:

- "Understanding doctors in English; we need more people that speak our language."
- "Lack of transportation to the different hospitals and clinics"

- “Letters are mostly written in English making it very difficult for Spanish readers to understand”
- “Pharmacies lack some medicines or insurance doesn’t pay for them”
- “More health centers with x-rays, mental health, physical therapy”
- “When HealthPlus merged with Amerigroup I lost coverage for some prescription medications”
- “I have problems with medications – Medicaid doesn’t cover them.”

All participants have health insurance; 7 participants are on Medicaid and 1 is on both Medicaid and Medicare. The participants did not have issues paying for medical bills – most have affordable co-pays or go to clinics with affordable services. All but one participant indicated that everyone in his or her family also had health coverage. The participant who had a family member without coverage says that the uninsured family member does not get care and instead uses natural medicine when feeling ill.

The participants went to a mix of health clinics and hospitals in their community and private doctors’ offices depending on the type of care they needed. The participants also all received mental health services at RAICES – a licensed, outpatient mental health clinic.

All of the participants but two receive care in their neighborhoods. Participants that get care in their neighborhoods emphasized proximity as one of the reasons they stay in their neighborhood – all can get to the doctor’s office within 20 minutes, and two are within a 5-minute walk. One participant who gets care in her neighborhood stays because the clinic near her has everything – dentist, allergists, GYN, etc. – and she is able to get comprehensive care there and does not need to leave. Another participant shared her story of being assaulted and raped – she emphasizes that her current doctor shows sensitivity and concern for her situation and that is why she goes to that doctor.

One of the participants who travels outside of her community said it takes her about 30-45 minutes to get to the hospital and she goes because she grew up in the Wyckoff area and is used to the care there. She also likes that the people are good to her and do not have bad attitudes. The other participant travels because she has diabetes and was referred to a specialist outside of her neighborhood.

The participants were displeased with long wait times. One participant with a cardiology appointment at Brooklyn Hospital waited 2 hours in the waiting room and then another

hour in the exam room until a doctor attended to her. Another waited 4 hours to see a doctor.

Participants also did not like when their doctors always changed; the participants said that you get used to a particular doctor and then out of the blue you have a new doctor. One participant said that in one year she had five different doctors and had to keep repeating her life story to each new doctor. She also had to repeat exams because of this.

Participants were also displeased with the level of professionalism of the personnel in their doctor's offices. They say that the staff often talks about personal information in front of other patients.

The group as a whole did not have much experience going to the ER for care. They agreed that they only go when they believed that they were in real danger – one participant went when she started to have anxiety attacks and she didn't know what was happening to her and that "she doesn't go for dumb reasons. "

The group had trouble identifying particular services that were needed, but did agree on the need for more mental health in their neighborhoods.

Changes participants would you make in the medical care system included:

- Immediate access to doctors - "I'd have a sign that says 'Need a Check Up?' and if you needed one I'd say follow me and take you to a doctor."
- "I would change the secretaries that work for my doctor – they are so rude." This elicited a lot of agreement about the lack of professionalism within medical staff.
- "I would have more people that speak the language that we do." This too, had a lot of agreement. Language services are clearly a priority with this group.
- "More communication"
- "Free services"
- "People could go to the doctor without being afraid that they can't pay."
- "Educate our community" so that we are more informed and have more power.
- "I want the leaders to know that the doctors think that Medicaid won't pay the doctors. I went to get a root canal and my tooth fell out, and have been living with pain for a year. Now, I am afraid to get care with my Medicaid because people treat us like animals. I have to get another root canal and I'd rather suffer, save my money, and go to a private doctor."

- “We need equal rights.”

Summary Key Themes

Culturally competent and linguistically competent care. Need for more qualified interpreters or medical professionals that speak their language so that there is better communication.

Being on Medicaid gets you a lower quality of care. When participants couldn’t access specialists, had long wait times, or received inadequate care, they often identified being on Medicaid as the reason for such inequities.

Lack of Respect – the group agreed that staff can sometimes be rude and they were treated disrespectfully. The customer service aspect of the health care experience plays a role in their overall satisfaction.

Immigrants

On September 18, 2012 at 4 PM a discussion group was conducted at the Caribbean Women’s Health Association located at 3512 Church Avenue in Brooklyn, New York. The purpose of this group was to get the communities feedback on their experience and barriers with health care from the immigrant perspective.

There were a total of 17 participants who arrived, 5 were ineligible to participate because they resided outside of the targeted zip codes and were excused. A total of 12 participants engaged in the focus group (10 females and 2 males). All participants were English speaking, with three people speaking the following additional languages, Spanish, French/Creole and Tamil. The ages ranged from 18 years old to 61 years old. All of the participants lived in the designated zip codes which included: 11207, 11221, 11226, and 11212. Nine of the participants identified themselves as Caribbean/African-Americans, one Latino and two as Asians. Seven identified that they were not employed and four of the individuals reported income less than $10,000, three between $10,000 and$20,000, two between $20,000 and$30,000, two between $30,000 and $40,000 and one at $60,000.

The major problem areas identified included insurance that covered only hospitals, rather than necessary doctors; specialists who do not work on weekends; high co-payments with insurance; and problems obtaining insurance. More than one participant had been told at the hospital he or she attended that since he or she did not have health

insurance he or she could not be seen. One participant noted “if you don’t have children, you can’t get insurance because the poverty line is too low, you may only be a few hundred dollars over and you won’t qualify.”

Many felt that Obama Care was a solution to all people being able to get insurance and having a reduced co-pay. At least one participant stated that she has seen changes since August 1. Also, her friend had back problems and this was the first time that she had what she considered thorough care with more focus on prevention. Other suggestions for changing the problems identified included:

- Raising the poverty line – with food, clothing, rent, there is not enough to cover for paying for health insurance;
- Goals of health insurance should not be considered a privilege but it should be automatic for everyone;

- One participant cited that the quality of health care varies by community. The hospital in the Brownsville community, where she is located, treats people differently than Methodist which is in a primarily White community. One of the elements considered good quality of care for this group is the quickness of being seen and released thereafter. This is recommended for all hospitals.

- Another point of discussion was that when the participants had to come back to a community hospital, they were treated “like a dog”. They felt that some of the White medical students are just going through the motions until they complete their rounds, knowing they will eventually go to work in the Manhattan hospitals. Another participant stated that local clinics also treat people like “crap” and they are often from the same ethnic background. The participants do not feel that the staff likes the job and cares.

- Staff needs to improve on their caring and bedside manner was the general recommendation for staff improvements.

Participants received services at the hospitals, clinics and some utilized available free services.

Four of the 12 participants go outside of their neighborhood for health care. When one participant was really sick, she had to wait hours when she went to a facility in her neighborhood; she then went to a hospital in the City (Manhattan). Another participant received fast service at the same HHC hospital and was told that she was going to get all of the services needed; when the hospital staff found out she did not have insurance they then said she was fine and sent her home. Another person goes outside of the neighborhood to a hospital in Manhattan, and she felt that the nursing staff was at her beck and call, they checked with her every minute to make sure she was okay. Another

participant commented that her nursing friends state that some of the persons of color have to take on two to three work responsibilities. Because of their workload, they do not have time to give as much personal attention to the patients.

When asked if they utilized free services, one woman indicated that she uses Breast Care services; another participant believed that free services were not necessarily the best places to receive care because they were not clean or sanitized. One participant does not have health insurance so she pays out- of pocket. The younger participants (all students) stated that they use their school insurance and go only when they are sick; one of the three stated she receives dental care at NYU.

Participants commented on what is needed in community facilities. Participants stated that it takes a long time to get a wheelchair and it also takes a long time before you get a bed (room in the hospital). One participant, who is uninsured and undocumented, stated that she went to a facility in her neighborhood. Her teeth were broke again after having seen a dentist. Her doctor stated that because of the type of health insurance she had, she had to wait, hence her teeth became worst. She feels that in spite of the coverage, everyone should have equal health care. Another participant stated that the idea of health insurance being considered a privilege versus a need is a problem; care should not be "about how much you make but about your illness."

Participants stated that if they were dying, felt very ill or considered it a dire need, they would use the emergency room. One participant stated and others agreed, that she tries to use home remedies first; many were fearful that immigration will get you if you seek care. As we discussed the fearfulness of many immigrants about seeking care because of immigration repercussions, a recommendation that received the consensus of the group was to spread the word and educate people that they will not get reported if they seek care.

Another issue that came up in discussing why people do not rush to the emergency room is the fear that the hospitals use too much drugs and that safe medication use is not practiced; almost all of the participants felt that they use too much experimental medications. Other reasons for not going readily to the emergency room is that medicines used to cure, they are not like "yesteryear". In the Caribbean, they have free health and they are not used to the United States system. Additionally, one participant stated that staff does not pay attention to you when you are explaining your problems.

Medical or health-related services the neighborhood needed more of included:

- Better understanding of the patients and how to talk with them;
- People that really care;

- The older doctors use to tell us everything now the newer ones don't have the same knowledge;
- Better/flexible hours, give incentives for doctors that work in the evening or weekends;
- There needs to be more compassionate doctors and nurses. An example was provided using home care where the mom had to clean her son's wounds. The mom had some health care knowledge, but felt concerned about cleaning up her son's wound. The staff provided no assistance; sometimes parents may not have the capacity to do some of the follow-up needed once they go back home, but they do need to have at least good instructions and some hands-on instruction.
- It needs to be about prevention again, medicine is not any longer.

Another participant stated that she had a child who had an extensive lung disease. They would change the doctor every week and because of the change, she felt that there was a lack of communication between the doctors. She had to tell each doctor about her son's condition: "What about if I wasn't there, what would happen, or if I wasn't intelligent enough to communicate? The doctor should be telling me what to do, not me telling the doctor, this needs to be improved".

Changes participants would make in the medical care system were as follows:

- Change the system, incorporate natural health
- Equal care for everyone based on necessity; health care is not currently visualized as a necessity/universal care not based on money. One participant noted "we should not be a bank account for doctors – equal care required."
- Add more staff to reduce wait time
- Providers should be more informative when it comes to care
- Send doctors back to school to get more education to improve their bedside manner
- More caring for people/compassionate
- More preventive care by doctors
- See people as more educated and that each person gets equal opportunity for good care, people need to learn to love one another

- Want health care providers to love what they are doing and pay attention to what they are doing
- See staff be more accountable and perform at a higher standard
- More education/seminars/classes to educate young people to take care of themselves
- Would like to see more groups such as this for the community.

Summary Key Themes

Discussed fears immigrants have in seeking care

A few participants had very distinct experiences that they felt occurs more in their communities than in others - not necessarily because they were immigrants but rather because they were people of color, living in poorer neighborhoods.

Concerns about medications

Young Men Aged 18- 30

This group was convened on September 18, 2012 and held at the Brownsville Public Library at 6 PM. Seven young men aged 18 to 25 years old were in attendance. The men resided in zip codes 11206, 11207, 11216 and 11218. Six of the men indicated that they were African-American and one indicated other. Only one of the participants indicated that he was currently employed. Three of the participants indicated that their income was less than $10,000 and four participants did not answer the question.

When asked about the major issues with health care, the young men indicated that their major issues involved health insurance, accessing health care services and lack of information about available resources. Two participants mentioned not receiving care in the hospital emergency room because of a lack of insurance. Others indicated that although they had insurance, it did not cover all of their health care needs including medications or other treatments. One participant noted that his friend was unable to obtain a HIV test because “he did not have symptoms”.

When asked about the types of health care insurance they had, three participants indicated private insurance, two said “no insurance”, one said Medicaid and one was not certain.

Those who had insurance noted that their major problems involved difficulties in understanding deductibles and co-payments and the fact that all services were not covered by their insurance. Two participants indicated that they had been sent bills for services that were covered by their insurance. Two others noted that dental care, transportation by ambulance to the emergency room, medications and treatment for special health conditions were not covered by their insurance plan. Another commented that his mother had advised him to stay with Medicaid even though it is associated with poverty because it affords wider coverage than some private insurance plans.

Those without insurance commented that they felt they had been treated differently in the emergency room in their community because they lacked insurance. One noted that “doctors just do the minimum”. Another added that he felt “placed to the side” and “like an illegal immigrant”. Those without insurance felt that they were better off taking care of their own health as “there was a low chance of getting help at the hospital”. They mentioned using home remedies like herbal teas and taking care of their health at certain times of the year. One noted that he “could not afford to get sick”.

When asked where they go for health care, four indicated their primary care providers; primary care providers were located in clinics or in private offices and family members were the most frequently sited source for how they found their current provider. Others noted that they used the emergency room if they could not handle the health problem on their own or if they perceived the problem as severe. One participant noted that he also used the pharmacy.

Participants indicated that quality of health care was dependent on location. Long waiting times of 5 hours or more was common in community facilities but facilities in Manhattan were quite different. Participants noted that they were “in and out of the ER as if it were a drive through” and that they were treated in the ER as if they had an appointment; they were seen right away. Another noted that he left the emergency room located in his community hospital without being treated because of the long wait. He commented that he thought that he would receive “top care since he came in an ambulance but they just sat him in a chair in the ER”. Another reflected that when he was a child his mother used to tell him when they went to the emergency room to say that he could not breathe. He now understands that waiting times in emergency rooms are long unless you have heart condition or are bleeding, that is “you have to be dying to be served.”

Others noted that there were better hours in facilities outside of their communities. For example, the clinic in Manhattan stays open till 8:00 p.m. rather than closing at 6:00 p.m.; one noted that in community hospitals, “you have to catch them on their time.

They (the staff) don't work on our schedule. They are not open on certain days or on the weekend".

Participants also spoke about differences in health care providers. One commented that more seasoned doctors "tell you what to do" and offer "more wisdom than medications". Another noted that he "did not like students in training" and since he was paying for his health care he "did not want inexperienced staff. Don't test on me." One participant without insurance commented "let them take care of a non-insurance person like me". Another participant noted that people he knew often go to clinics that train students because of the lower cost of care but another participant added that he would not want to take the risk. One commented that doctors often asked for unnecessary tests in order to increase their revenue.

Interestingly, one participant noted that the hospital in his community was like a "Ghost hospital", you never see any activity or anyone going in or out". Several noted that the health care in their community was poor and that facilities had bad reputations. One noted that the hospital in his community was known as "Killer Hall".

Participants spoke eloquently about socio-economic issues that they felt impacted their health care including race, limited income, and lack of employment and job training opportunities. They noted that their geographical region was impacted by a lack of wealth as it influenced who was willing to reside in their community as well as the type of health care services that were available; one noted that "it was hard to build up hospitals in poor areas". Several commented that increasing gentrification was changing the community. One noted that this change would "increase the number of doctors and care available". Others noted that gentrification was increasing housing and parking costs. One participant noted that his community was overpopulated with liquor, 99 cents and pawn shops (cash for gold) which did not offer real job opportunities. Others noted that it was unfair that they had to go outside their community to find employment. One noted that the problems were complex as the educational system was poor and ill prepared students for employment.

When asked what they would want to change if they had the power, participants indicated the following:

- Free clinics that offer discount health care, for example $20 for exams.
- Making health care free
- Health insurance that is accepted anywhere
- Treating everyone the same regardless of health insurance status
- Using taxes to cover the salaries of health care providers
- Government should cover the salaries of providers like they do in other countries

- Doctors making home visits in cases of emergency
- More health care programs
- Make health care and health insurance more understandable so that individuals avoid paying unnecessary fees
- Incentives for taking care of personal health. (One participant noted that his job offered monetary incentives for signing up for a health care spending account and for vaccinations)
- Stiff penalties for health care fraud on the part of providers and insurance companies. One noted that there were major efforts to uncover fraud in the community but not among providers.

Summary Key Themes

Lack of health care insurance/inadequate health care insurance

Social factors which impact the lives of community residents

<u>Older Men 45-55</u>

Eight men participated in this group which was held at a Community Center in Brownsville on September 21 at 6 PM. All of the participants were African-American. Participants resided in three of the targeted zip codes - 11206, 11207 and 11221 and ranged in age from 46 to 52 years. Only one of the participants indicated that he was currently employed. Four of the men indicated that their income was $10,000 or less, one indicated that it was $10,000-$20,000; one indicated that it was $20,000-$30,000 and one indicated that it was $50,000-$60,000.

When asked about the health issues that they noticed, the men indicated economics (lack of jobs and money), access to health care and resources, communication, race and lack of information. One noted that increases in the cost of basic needs like food makes it difficult to cover health care costs.   Participants noted that jobs were hard to find; some individuals did not have access to information that would help them with finding employment and that the jobs often came with no or inadequate medical insurance. Another man noted that he has to wait for six months before his health insurance associated with is new job will begin. Changes in health care coverage were also an issue. One man noted that he is no longer able to obtain vitamins and other medications that were previously covered by his insurance. Another noted that insurance does not even cover “half of his medical care needs”.

Others noted that there was differential treatment for health care depending upon health insurance coverage, race and social class. One noted that he was sent home with a hip bone problem that was left untreated because he lacked insurance. Another noted that the care provided at his community hospital was different from the care provided at a hospital facility located in a predominantly white area; he noted that at this facility care was more immediate. Another noted that the staff at community hospitals “talks about clients like they are dogs” and that they “just go through the motions”. One noted that many medical students are funded and that they “should be willing to give back to the community”. Another noted that clinics located in the community also treat clients poorly and he felt that race and social class were the underlying causes. Two of the men thought that immigration status also played a role in poor treatment. Three of the men commented that they travelled to a hospital located in a mixed racial community because “care was fast” and “they speak when you come in the door”. One man summarized it as you go where “you feel you are going to be treated best”.

Another felt that there was need for less use of medical jargon and improved communication in conveying health information. Another commented that there was a need to highlight the side effects of medications and the need for larger print on labels; patients need to understand what “their medications do and do not do so that they can make an informed decision”. This led into an involved discussion of medication side effect and the need to prescribe “actual” medications rather than generic drugs. Many felt that they were receiving a lowered standard of care when they were dispensed generic drugs.

Several participants noted that people with financial resources get better care. Another disagreed, noted that race is still a factor in how you are perceived and treated. However, he later advocated that people “needed to speak up” to get treatment in response to an individual who relayed that he waited 12 hours in an ER waiting room to be seen.

When asked if they had health care coverage, only two of the participants did not have coverage. One participant had private health care insurance and several had Medicaid in combination with other insurance plans.

Problems with obtaining health insurance were a key theme that emerged. One commented that health care providers do not provide enough information on health services such as where to obtain health insurance. Another participant commented that he had children and was finding it difficult to cover bills as well as health care costs. Another noted that he had insurance but also had high co-payments especially if he had more than one health care provider to see. One noted that he could only go for health care when he was really ill. Two other participants noted that the requirements for

health insurance were problematic; insurance is based on salary but if you have a part time job where the salary varies weekly you might be deemed ineligible for insurance although in some weeks you do meet the standards. They are currently in the process of reapplying for medical coverage. One also noted that the poverty line is too low; $100 can mean the difference between qualifying or not. One participant noted that all providers do not take his insurance and that he walked a distance once day seeking a provider who would take his insurance.

Five of the participant's men indicated that they went outside the community for care to avoid long waits. Others went outside for care because care was more available on an as needed basis. One noted that even going outside of the community it was difficult to see specialists because of their limited hours; some are only available three days a week.

Most of the participants indicated that they had good relationships with their providers and that they were receiving needed screening exams.

When asked what they would like to see in clinics and facilities in their communities, the participants noted:

- Shorter ER waiting times
- Improved access to health insurance
- Need for health care providers that speak English to improve communication
- One medical chart so that information can be shared across different providers
- Health plans that coincide with accessible care
- Transportation to and from hospitals that use the shortest available routes
- The cost of Access-A-Ride is prohibitive for those on a limited budget

Changes that participants would like to see included:

- State health insurance
- Free health care
- Take generic medications off the shelf
- Shorter ER waiting times
- Prescriptions that are good at all pharmacies

When asked for additional comments, one participant noted that the poverty line should be raised; health care is not a privilege and should be taken care of. One man noted that he had seen a change since ObamaCare was enacted; he received a more through back exam and there was a greater focus on preventative care.

Summary Key Themes

Need for better health care coverage

Need for information health care insurance

Concern about medication side effects

Senior Citizens

This session was held on Thursday, September 27 in the Brooklyn Borough Hall Conference Room from 9 to 11 AM. Ten women were in attendance. Participants lived in eight of the targeted zip codes including 11201, 11203, 11205, 11206, 11208, 11211, 11225, 11226 and 11238. Nine of the ten participants indicated that they were African-American and one participant noted that she was multi-racial. One participant indicated an income of $10,000 or less, five indicated an income of $10,000-$20,000, two indicated an income of $20,000-$30,000 and two did not indicate their income.

The key health issues indicated by the participants were allergic reactions to medications, too much information about health issues that was not explained clearly, the lack of health clinics and lack of information about resources. For example, one senior noted that when she first retired she felt that there were a lot of issues about her health care coverage that were hard to understand.

All of the seniors had health care insurance including combinations of Medicare and other plans (Empire Blue Cross Blue Shield, Cigna, Health First, Elder Plan, Well Care, United Health Care, HIP and Medicaid (unspecified)). Seniors noted that changes in the health care system crated an added burden. Understanding Medicaid Part D, co-payments for prescriptions and selecting among plans were issues that were complex for seniors. One noted that her insurance covered provider visits but not prescription costs. Another noted that she found that she had lower co-payments when her plan was changed so that was beneficial.

Seniors were willing to travel outside of the community to see health care providers; some travelled anywhere for 30 minutes to 90 minutes. Some travelled to other boroughs to see providers who had treated them for years and others travelled because of the quality of care they received. They noted that they "could see doctors faster", "it was more pleasant even though the waiting room was crowded", "there was no cursing or yelling", and that "the provider was patient and thorough". One noted that she took her friend to an emergency room in Manhattan and she was pleasantly surprised that there was "only a two minute wait". One noted that things "move quickly" at a private

hospital in the Bronx. Seniors qualified that in cases of emergency, they used the emergency room facilities in their community.

Those who went for services in the community liked the fact that they could walk to their health care clinic or travel a short distance for care. Some went for services both within and outside of the community. Although their primary care physician was located within the community, they had to travel outside to see specialists.

Interestingly, most seniors used public transportation to travel to medical appointments. Two seniors who used Access-A-Ride noted that they had several problems including late pick-ups (up to 3 hours or more) and unwillingness to come to certain neighborhoods. Cost was also an issue for seniors on fixed incomes; although the ride is $2.00 one-way, four trips a week can add up. One senior noted that she used a car service but that was expensive.

When asked about the care in their community, seniors noted that they had witnessed changes in the quality of care over time. One noted that the hospital in her community had recently undergone modifications to make it more modern but that it had not improved services. She wanted the hospital to “be the way it used to be” as it is in walking distance from her home. Seniors were very cognizant of the reputations of hospitals in their community. One commented that the hospital emergency in their community was excellent but that there was a long wait. A few noted that they “would never go” to one hospital. One noted that there was one hospital located in a nearby more well-to-do community where “doctors take their time, make referrals, and have clean uncluttered offices” and the people in the waiting room are “non-argumentative”. She concluded that “you can see a difference in the quality of life” and that “people want to go there”. One senior noted that the emergency room in her community moved fast considering the amount of patients waiting to be seen; she noted that people were inpatient, cursing and rowdy but she recognized that the staff was trying to accommodate everyone. Another noted that she had a heart attack at work, was taken to a community hospital, and received a quadruple bypass which “saved her life”. Another noted that she had two bad personal experiences at a community hospital (they lost eyeglasses when she was there for surgery and she could not see and she also could not see her provider; when her husband was in the hospital they could not find a wheelchair and she had a heated argument with a social worker who wanted to place her husband in a nursing home) and she would never go back.

When asked if they were health related services that were needed in their community, seniors noted the following:

- More compassion, respect and professionalism among staff

- A suggestion box for consumers
- Using triage in crowded emergency rooms. Patients with diabetes and hypertension should be seen as priorities because long waits can impact their health. Food should be available for them as well.

When asked what they would change about the medical care systems, seniors noted the following:

- Better bedside manner among providers
- Nurses should be more professional. They should not “wear their uniform all over the place” but change when they get to work. She noted that this could account for some of the germs that are present in hospitals.
- Need to separate adult and pediatric services in emergency waiting rooms
- Providers should take the time to explain to the patient and family members if need be about the patient’s diagnosis and treatment. Rounds are made in the morning when family members are not there; they may need to be available in the afternoon or evening.
- Need a more humanistic approach to health care. Need to conduct assessments in a private place to look at the overall picture- food and clothing needs, substance use/addiction/abuse.
- More patience with impaired individuals who need health care; some seniors have poor hearing or vision
- Stagger appointment hours
- Have medications ready for pick-up at hospital pharmacies
- Doctors and nurses are overworked and hospitals are short-staffed which lead to poor communication. Other staff is not qualified to provide care and this need to be addressed.

Summary Key Themes

Need for information about health insurance plans

Poor quality of care at community facilities- accommodations that are needed for seniors

Improvements needed in provider-patient relationships

Pregnant Women

Nine women attended the group which was held at 6 PM on Friday, October 12 at a Community Center in Brownsville. Three participants resided in 11208, two in 11233 and the others in 11207, 11212, 11221 and 11238. Participants ranged in age from 15 to 42 years old. The participants were a racially diverse group; five were African-American, two were Latino; one was Asian American and one was Native American. Only one of the women was currently employed. Four indicated that their income was less than $10,000; two indicated that it was $10,000-$20,000; one indicated that it was $20,000-$30,000 and two did not give a response.

The key health problems raised by the participants were a lack of health care providers, waiting time during appointment, not knowing where to go when seeking health information and the need for support groups. Participants noted that they felt that they had limited choice of doctors and that they often saw different doctors at each health care visit. One participant noted that she had a difficult time finding doctors on her insurance plan who worked at the clinics that she was utilizing for prenatal care. A majority of the participants agreed that waiting times during appointments was a major issue; one commented that staff "scheduled early appointments but doctors come later". Another noted that she "had an appointment at 10 AM, was registered (placed in the system) at 11:15 AM and was seen by the doctor at 3:30 PM" making it "an all-day process". Another noted that appointment centers were "frustrating" because people are "handled like cattle". Lack of access to food during waiting times was also raised as an issue; one participant advised that it was best to walk with food. Two of the participants who were pregnant for the first time, noted that they had many questions and were relying on the internet and the library to obtain answers. One noted that she had just heard about the WIC program and planned to ask her doctor about the program on her next visit. One of the first time mothers also noted that there was a lack of support groups for pregnant women and this was especially needed for first pregnancies. A mother of four noted that she had her oldest child over 20 years ago but she also needed support groups because "things have changed".

When asked if they felt comfortable asking their health providers questions, one participant commented that visiting the doctor "should not be a speed date" and that she makes certain to remember to ask her provider all of her questions before she leaves the clinic. She also calls her insurance firm to ask questions. Another participant recommended making a list of questions before the visit

The majority of participants had Medicaid plus another insurance plan and one young mother was covered by her father's private insurance. One participant commented that

she preferred public insurance over her job's insurance plan because she did not have to get referrals for dentists or other specialists; this was often a problem with her employer's plan. One participant noted that her coverage had changed and that she now had co-pays for medication that was once free. Another participant spoke of the challenges she faced because she is taking liquid vitamins because of a present medical condition but her insurance will not cover this cost; they will cover the cost of pills

Participants indicated that they traveled anywhere from 45 minutes to 90 minutes (median= 75 minutes) to obtain health care in facilities located in Manhattan or in other areas of Brooklyn. The major reason for seeking care outside of the community included the positive experiences of family and friends at these facilities or the negative experiences of relatives at facilities in the community. Other reasons included having prior deliveries at the facilities and having a health care provider who was affiliated with the facility. Participants commented that these facilities were "cleaner", "more comfortable", "were quick", and "less crowded" and provided refreshments while patients were waiting to see the doctor. One participant noted that staff made sure "that you have what you need" and that you "are treated like royalty". Others commented on the quality of care provided by the doctors and the pediatric department One participant said that she would have sought care outside of the community but was receiving care locally because she was on bed rest as a result of a high risk pregnancy. Another participant noted that she was receiving care locally but that she had changed from one hospital to another. She found that the first hospital was scheduling prenatal visits two months apart and she felt that she was not receiving enough information on her child's development. The staff at her current hospital kept her informed about the health of her child and she found that beneficial.

The three participants who received care at community facilities were asked to discuss what they liked and disliked. They liked the shorter travel time, being in a familiar place (that is, they had a prior delivery at the site), feeling comfortable with the staff and knowing other women who were utilizing services. One participant commented that women in the waiting area were like "an extended family" and that the other mothers were "open to sharing struggles and food". Another noted that it was like "a focus group at the doctor's office". They all concurred that the waiting time to see a doctor was the greatest drawback.

Participants used the emergency room when events occurred that needed immediate attention and they stressed the long waiting time to receive care. They noted that care was "slowest at night" and that "you have to wait". One participant who was having a

high risk pregnancy was seen quicker only when she pointed out that her throat was closing up due to an allergic reaction to a bee sting. Another explained that she had two bad experiences at one community hospital where she waited about eight hours and did not leave until 3 or 4 in the morning; both times she was in severe pain and felt "desperate". The third time she was in Manhattan and she was seen in "30 minutes". Another participant noted that she had a similar experience when she sprained her back- she was in pain and crying but was not seen for a long time and the staff "had her walk rather than use a wheelchair". Another participant who was expecting twins had fallen during her pregnancy spent six hours in the emergency room; she was seen after a five hour wait. When asked if other family members used the emergency room, one participant commented that she felt that the children's emergency room at one community hospital was better; children were seen "in a timely fashion; not fast but less than three hours, maximum four hours" but "adults wait".

When asked about needed accommodations at community facilities, participants indicated:

- Food (light fare, sandwiches) and beverages (water, juice). They noted that not all women could afford food, that they were concerned that if they left the waiting area and were called they would have a longer wait and that food could lessen aggravations and prevent conflicts.
- Entertainment. Television could distract patients from long waiting times.
- Better chairs with cushioned seats and wider seats to accommodate pregnant women. They noted that benches were uncomfortable and crowded.
- Having books for first time mothers.
- Better separation of women classified as a high risk pregnancy from others receiving OBY/GYN care (other pregnant women, general care appointments).

One participant pointed out that although the hospital had designated days for high risk pregnancies, other woman were present as well making for longer waits.
Services participants wanted to see in their community included:

- Faster delivery of services
- More support groups for first time moms to learn about pregnancy and other health issues. One participant commented that hospitals and clinics should have groups once or twice a month for first time moms so that doctors could explain what moms could expect; she currently relied on information from the internet.

Another noted that during medical visits staff tries "as fast as they can to get you out" and that it was difficult to ask questions.

- Lamaze Groups
- Support Groups for all moms

- Wider networks for information. One participant noted that she wanted someone with whom she could get a second opinion about prescribed medications because she "did not want to take the wrong thing."
- More health care providers. One participant noted that staff explained that long waiting times were due to the fact that there "was only one doctor working".
- Better continuity of care. One participant noted that she was uncomfortable seeing different providers at each visit.

Participants suggested the following changes to the health care delivery system:

- Health insurance coverage for all without regard to status (e.g., immigration status)
- No co-payments or co-payments on a sliding fee based on income. One participant noted that seniors "had paid their dues" and should not have to pay for care. Another noted that patients may not be able to pay for needed medications.
- Funding for hospitals. One participant noted that medicine was expensive and that staff worked hard.
- Better review of the quality of hospital services by Boards of Health. Inspections and site visits should be made to ensure standards and better care. One participant commented that you "go into the hospital, get more sick and bring that back to your house".
- More access to doctors and nurses.
- More support groups.

Summary Key Themes

Need for support especially for first time moms

Long waiting times are a problem; food and beverages seen as important

<u>Lesbian Gay Bisexual Transgender Queer/Questioning (LGBTQ)</u>

This session was held on Friday, October 26, 2012 from 4:00 – 6:00 PM in the Brooklyn Community Pride Center. Five participants who ranged in age from 25 to 47 years old were in attendance. Two of the participants resided in 11216 and the other participants resided in 11217, 11226 and 11233. Four of the participants were African-American and one participant was Caucasian. Three of the participants were male, one was female and one participant checked female and trans male to female. When asked how

they identified themselves two of the male participants said “gay’, one male participant said “MSM”, one female participant said “lesbian” and the last participant indicated “trans male to female heterosexual”. One participant was currently employed. One participant indicated that their income was less than $10,000, one indicated that it was $10,000-$20,000, one indicated that it was $30,000-$40,000, one indicated that it was $50,000-$60,000 and one participant indicated that it was over $60.000.

The key health challenges raised by the group included the lack of health care providers who were sensitive to the issues of the LGBTQ community, problems with insurance, treatment by providers, stigma, and lack of information and immigration status.

Participants noted that many health care facilities in Brooklyn were not “trans-sensitive” or “trans-affirming”; one participant commented that she and her other transgender friends travel “to Manhattan for care rather than Brooklyn.” Participants spoke about the lack of gender neutral bathrooms; forms that did not include other choices for gender; and improper use of pronouns even after staff were informed about the patient’s preference. Several participants explained that asking patients about their gender identity and how they wished to be called was important in building rapport. One participant commented that it helped him feel “that he would not be judged” and made it ‘more likely that he would disclose other things”. He added that health care providers “never ask questions but make assumptions about a person’s relationship status using terms like your girlfriend or boyfriend”. Other participants noted that even though Brooklyn was an urban area, health care providers including the health leadership received “no training about how to speak properly to the LGBTQ community; they do not know what to say and what not to say”. Another reiterated that individuals who identify as LGBTQ “travel to Manhattan or do not go at all”; another added that “he lives and works in Brooklyn but has not gone to a doctor in Brooklyn.” Finally, one participant commented that providers are not aware of issues related to the transgender community like “changes in gender markers” but they “are the gatekeepers and should be making life easier”.

Another participant who disclosed that he was HIV positive explained how the lack of cultural sensitivity was a problem. When he was viewed as a “married black man” he was not sent for an HIV test because they did not fit the perceived risk categories; doctors “did not want to test him”. Now that his status is noted in his chart, having an HIV test is the first thing that health providers ask him even if he is just presenting with a cold. He noted that “all people should be tested for all things’. He also noted the stigma that is associated with his HIV status; he is placed in a room apart from other patients and “isolated as if contagious” and health care providers make sure to use gloves. He stated “I am more at risk because I can be infected” and noted that the lack of knowledge and information on the part of health care providers who “should know better

but don't". He concluded that "doctors should be willing and committed to treat new populations."

Currently, four participants had insurance and one did not. One participant who has had both public and private insurance noted that he felt both were problematic. Medicaid meant restricted access to providers and all day waits in hospitals; private insurance entailed high co-payments. He noted that free clinics often had limited hours and patients sometimes needed more. He currently has full coverage since he was a student but his coverage will end in two months upon graduation; he felt that his co-pay was high and wanted less expensive coverage.

The second participant stated that he always had private insurance but had trouble understanding the benefits even after doing internet research. He noted that when he had changed jobs, he had a 90 day wait before his new insurance began and he was uncertain what to do as he could not afford the COBRA coverage offered by his old job. He was satisfied with his current private insurance which was covered by his job without any deductions and noted that it provided for 10 mental health care visits and had reasonable co-pays for health care visits and prescriptions.

The third participant stated that her mental health care needs were not being met because of the type of insurance that she had. She has a health care provider whom she did not respect and has been without a doctor for awhile; she mentioned that she has progressive health issues that need to be addressed. She is depressed and anxious and has been trying to treat herself. She also noted that many trans-specialists do not take Medicaid. She explained that many of her transgender friends suffer from isolation, anxiety and a lack of social support systems. The lack of support was echoed by other participants in the group who noted that they were often cut off from their family members. They raised the question of "who will be there to make a decision" in health emergencies. One noted that estranged family members might "wipe away a person's identity" in the absence of a living will.

The fourth participant lauded his managed health care plan which provided preventive care like a gym membership as well as transportation to the doctor's office; he found out about this plan from his health care provider. He also noted that he found a brochure in his doctor's office which explained about health items (toothpaste, band aids) he could receive in the mail.

The last participant who was not insured said she used self-medications from her local pharmacy including "all the teas". She noted that she had just missed the cutoff for remaining on her parent's insurance; there was a recent change in her job and she needs to apply for insurance.

One participant noted that immigration status is another issue. He noted that undocumented individuals who presented at a state hospital in Brooklyn were sent to another health care clinic for care. He noted that they received free treatment but were unaware that there rights had been violated. He added that it was “very rare to find patients’ rights posted in Brooklyn” so that people know they are “entitled to x,y,z”.

When asked about travel outside of the community for care, participants noted that it took about 45 minutes to travel to Manhattan. One noted that when they were very sick they went for care at a Brooklyn Hospital and that it was okay. Another noted that they see a private doctor who has a practice in Brooklyn. One noted that they had not been to a doctor in the six months that they had been in Brooklyn; he and other participant noted that they are relying on over the counter medications from the pharmacy to stay healthy.

One participant noted that in his previous state, he posted an inquiry on Facebook to find gay friendly doctors and dentists that were accessible by transit. He asked individuals where they went for care. He explained “it is nice to feel comfortable… there is something about connecting. I can disclose what I am actually feeling. It makes me more likely to follow. I don’t listen to a doctor if I feel he didn’t listen to me”.

Poor treatment in emergency rooms was raised early in the focus group by the transgender participant who noted that there was “gawking” and “improper use of pronouns” on the part of staff. When asked to discuss emergency rooms, another participant noted that “you need a sleeping bag” because of the long waiting times. Another agreed that “you are in for hours”. Another commented that “you need a book and food” but that going in an ambulance rather than walking in gives you faster service. Still another noted that he “tells them his chest is tight”. One noted that they were in a local hospital all night. One person noted that the problem with emergency rooms is that you “have to tell the same story to seven different people even though they could read the problem right off the chart”. One commented that in his former city (New Orleans), you could get a list of the waiting times in emergency rooms via your cell phone and you could decide which one to go to.

Participants also spoke about existing biases among local community residents. One participant noted that it ”sucks in Brooklyn” and you “need to cross the bridge” to find support. One participant noted that there are cultural barriers to discussing certain issues because of fear of judgment; certain topics like the use of condoms, circumcision, etc. are taboo. He commented that people make assumptions when he says that he is MSM- they have “millions of questions” and assume “he is on the down low or turning tricks”. He concluded “they make assumptions because of a lack of knowledge. They want to reclassify me..., they want to slap a label on me rather than

letting me say”. He noted that he attends a men’s support group in Manhattan to discuss mental health issues; in Brooklyn you had to register with the facility in order to attend. He also talked about the changes in mental health services that had occurred in Brooklyn and noted that one facility could not handle all of the patients in need of mental health services. The transgender participant agreed with the lack of community support; she noted that she found it easier to connect with white transgender individuals because there was greater acceptance.

When asked about accommodations for the LGBTQ community, participants noted the following:

- Research on HIV medications. One participant noted that his current regimen had side effects. He also added that insurance is not covering treatment for the fat deposits produced by some of the meds.
- Health care providers need to assess needs that go beyond health care including housing, social service needs, and mental health needs. He noted that there seems to be a “disconnect between physical health and mental health and social issues”.
- Greater awareness and sensitivity on the part of health care providers of the role of social media in the lives of the LGBTQ community.
- LGBTQ Health Expo to raise awareness of health care providers, local pharmacies, urgent care facilities, and community based organizations (provide emotional and social support) who are friendly to the community. Pharmaceutical companies could cover the costs.
- Places in Brooklyn where health care providers could provide low cost and free physical, mental and social services. This “one-stop shopping model” would be beneficial to individuals who have difficulties keeping multiple health care appointments on different days. One person noted that because of anxiety she found it easier to adhere to appointments when they were all on one day. This one stop-shopping-model should offer appointments on the same day regardless of status.
- Use social media to increase awareness of the unique needs of the community.

This is a way to educate health care providers who can subscribe to an e-mail list to receive information.

- Providers may not know where to refer people to so there is need for a referral center.
- Participants noted that lack of a public list of providers which are sensitive to community needs. There is need for a list of providers which includes specialists

like dentists, ophthalmologists, endocrinologists etc. as well as other health care providers.

- Mental health support as “everyone needs a good therapist” but “no one knows where to go”. There is need for a focus on wellness and social support; “we don’t want medications, we just want to talk”.

When asked for changes that they would like to see, participants recommended:

- Mandatory Training or Recertification for health care providers on LGBTQ. One noted that you could take away license if health care providers did not comply; others felt that health care providers could be given perks or benefits.
- Symbol displayed in the office that indicates that the provider understands and cares about the unique needs of LGBTQ. Provide a checklist or rating system that people could access that rates the level of cultural competency.
- Opt in directory for providers. The directory should specifically address questions like types of insurance accepted rather than using phrases like “most insurances accepted”.
- Need a “Road map to Health” for the LGBTQ community which would provide information about what to expect at different ages so that the individual can take preventive measures to improve their health.
- Provide incentives (e,g. a gift card) for patients who keep their health appointments.
- “New York City has a large LGBTQ population and ads posted in health facilities should reflect this diversity.” She noted that modifying the ads to show “different types of families” would show “that we are welcome in this space”. She added that this should be done for the large posters and not just brochures. She also noted that since we are waiting with other patients, showing acceptance through the use of “eclectic visuals” would decrease bullying.
- Having magazines in waiting rooms to show acceptance- for example, the *Advocate. Arise, Positively Aware.* “People spend hours at the hospital and take in information subconsciously”
- Since “doctors are expensive” having staff at health care facilities who can help patients with preventive care. Also, have advocates who can educate about health care issues.
- Have mobile devices which are loaded with an e-library that can provide individuals with up-to-date health care information. One participant noted that this strategy worked well with youth at a school based clinic.

The group concluded with the comment that Brooklyn is “not sensitive to sexual preferences and gender identity”.

Summary Key Themes

Lack of awareness and knowledge among health care providers about LGBTQ issues which not only hampers communication and good relationships with providers but also compliance. Brooklyn is not seen as a good place to seek care.

Mental health needs are not being addressed.

Existing stigmas and perceptions makes it difficult to seek care.

Lack of awareness among community residents about LGBTQ issues.

Lack of insurance or awareness of insurance benefits also is a barrier to care.

Summary of Focus Group Findings

Chart 1 presents a summary of the major themes across the focus groups.

Chart 1 Summary of Major Themes

	Disabilities	Youth	Mental Health	Immigrant	Men 18-30	Men 45+	Seniors	Pregnant	LGBTQ
Major Health Issues									
Accessing services					*	*			
Acessing prescription meds			*						
Allergic to meds							*		
Finances	*			*		*			
Health Insurance	*	*		*	*				*
Health issues not fully explained							*		
Immigration	*	*							*
Lack of access to care/resources		*			*	*	*	*	*
Lack of clinics							*		
Lack of cultural competency(provider)									*
Lack of providers									
Lack of transportation								*	
Language as a barrier			*						
Need for support groups								*	
Race						*			
Referrals to specialists			*	*					
Waiting time during appointments								*	
Quality of Care									
Depends on facility location				*					
Depends on race						*			
Depends on social class				*		*			
Depends on type of insurance	*	*	*		*	*		*	*
Generic meds given not brand name						*			
Lack of consistency in providers			*	*				*	
Lack of cultural competency									*
Lack of professionalism (providers)		*	*	*	*		*		*
Lack of professionalism (staff)			*	*			*		*
Transportation									
Problems with Access-A-Ride	*					*	*		
Lack of transportation to hospital			*						
Cost of Care									
Cannt afford co-payments					*	*		*	*
Canot afford out-of-pocket costs	*				*				
Cannot afford medications	*		*						
Pays out-of-pocket				*					
Access									
Go for care only when ill					*	*			
Use self-treatment because of lack of coverage	*		*	*	*				*
Use pharmacy for care					*	*			*
Use street/black market for meds				*					
Emergency Room Use									
Immediate problem	*	*	*	*	*			*	
Provider not available	*								
Fear of medication prescribed				*					
For follow-up care		*							
To obtain quicker service	*								

	Disabilities	Youth	Mental Health	Immigrant	Men 18-30	Men 45+	Seniors	Pregnant	LGBTQ
Insurance									
Changes in med coverge	*		*		*	*	*	*	*
Clients do not pay till needed		*							
Difficulty in selecting plan	*					*	*		
Difficulty in understanding deductables/co-pays					*		*		*
Does not cover all health needs	*		*		*	*	*	*	*
Does not cover dental					*			*	
Does not cover emergency room					*				
Does not cover new conditions/ speciality treatment	*				*				
Does not cover medical test					*				
Does not cover mental health									*
Does not cover transportation					*				
Income eligibility requirements			*	*		*			
None/inadequate				*		*			
Not accepted by providers	*					*		*	
Problem with job change						*			*
Restricted access to providers									*
Time to acquire/access		*				*			
Use school insurance				*					*
Time									
Long waiting times	*		*	*	*	*	*	*	*
Waiting time depends on insurance	*								
Lack of access to food								*	
Barrier to asking questions								*	

	Disabilities	Youth	Mental Health	Immigrant	Men 18-30	Men 45+	Seniors	Pregnant	LGBTQ
Social/Economic Factors									
Food/nutrition						*			
Gentrification					*				
Lack of job training/preparation/					*				
Lack of information about jobs					*				
Poor education		*			*				
Poverty		*			*				
Race					*				
Unemployment		*			*	*			
Violence		*							

	Disabilities	Youth	Mental Health	Immigrant	Men 18-30	Men 45+	Seniors	Pregnant	LGBTQ
Access care in community									
Close location			*				*	*	
Could not travel out of community because of medical condition								*	
In cases of emergency								*	*
Familiar place								*	
Good relationship with providers		*	*					*	
Know other patiemts								*	
Receive speciality care	*								
Access care outside of community									
Better hours					*	*			
Cleaner facility							*	*	
Good treatment by providers/staff			*	*	*		*		*
Health care provider affiliation								*	
Less crowded							*	*	
Make referrals							*		
More pleasant/comfortable							*	*	
Positive experience of family/friends							*	*	
Prior use of facility								*	
Provided refreshments								*	
Receive speciality care			*		*		*		
Quality of care received			*		*	*	*	*	
Quicker services					*	*	*	*	

The four major health-related issues cited by participants were a lack of information about where to access health care services and resources (raised by 6 of the 9 groups); problem with health insurance (5 of the 9 groups); problems with immigration (3 of the 9 groups) and problems with finances/costs of care (3 of the 9 groups).

The quality of care received was primarily dependent on the type of insurance one had (7 of the 9 groups), lack of professionalism on the part of providers (6 of the 9 groups), and lack of professionalism on the part of staff (4 of the 9 groups).

Eight of the 9 groups (with the exception of youth) mentioned long waiting times to receive care in clinics and emergency rooms.

Three of the 9 groups mentioned problems with Access-A-Ride including being late for appointments, fees for individuals living on a fixed income and routes that are not direct and time consuming.

Seven of the 9 groups mentioned the cost of care as a barrier to access.

Seven of the 9 groups mentioned that their insurance did not cover all of their needs adequately. Needs that were unmet included coverage for new conditions, specialists, dental care, mental health care, medical tests and transportation. Changes in coverage (especially for medications) were cited as a problem by five groups. Three groups mentioned that they had difficulty finding providers who accepted their insurance. Three groups also mentioned difficulties in selecting a managed care plan. Finally, three groups mentioned difficulties in understanding the fine points of their plans including what was covered, deductibles and co-payments.

Participants in 5 of the 9 groups discussed self-treatment because of a lack of insurance coverage.

The major reasons why health care was sought outside of the community were perceptions that the quality of care was better (5 of the 9 groups), there was better treatment by providers and staff (5 of the 9 groups), and that there was quicker provision of services (4 of the 9 groups).

The major reasons why health care was utilized at community facilities included perceptions that the facilities were close to home (3 out of 9 groups) and that they had a good relationship with their health care provider (3 out of 9 groups).

Participants in 6 of the 9 groups reported that they used the emergency room only for immediate and urgent health care needs.

Social factors that impact health included unemployment (3 groups), poverty (2 groups) and poor education (2 groups).

Accommodations and needs varied across the groups and underscored the range of issues that need to be addressed in meeting the needs of community residents. Key themes included improvements in service delivery (6 out of 9 groups), communication (4 out of 9 groups), information/education (4 out of 9 groups), time (3 out of 9 groups), the need to address social issues (3 out of 9 groups) and the need for support groups (3 out of 9 groups).

Participants had excellent recommendations for improving the health care service delivery system. Common themes included universal/free or low cost insurance (6 of the 9 groups), more compassionate care (5 of the 9 groups), the need for equal treatment regardless of patient status (4 of the 9 groups), health education for consumers (5 of the 9 groups), higher standards of care (3 of the 9 groups) and increasing the amount of staff (3 of the 9 groups).

Special Findings

- Individuals Living with Physical and Sensory Disabilities noted that health insurance does not cover all needs especially when other medical conditions are present, the need more accommodations at facilities and that they relied on public transportation because of problems with Access-A-Ride.
- Teens reported that treatment at health care facilities differed by the type of insurance individuals had and that it was important to address social issues in the community including violence, poverty, lack of employment opportunities, and low/.poor education and obesity.
- Spanish-Speakers Receiving Mental Health Services focused on the need for culturally competent and linguistically competent care including the need for more qualified interpreters or medical professionals that speak their language in order to improve communication. They also noted that being on Medicaid resulted in a lower quality of care including difficulties accessing specialists, long wait times and inadequate Finally, the group agreed that staff can sometimes be rude and treat them in a disrespectful manner and that this affected their overall satisfaction
- Immigrants discussed fears immigrants have in seeking care and the need for more caring and compassionate health care. A few had very distinct adverse

experiences that they felt occurs more in their communities than others. However, they attributed these experiences more to being people of color, living in poorer neighborhoods than to immigrant status. They were also concerned about the side effects of medications prescribed for conditions.

- Young Men 18-30 were most concerned about the lack of health care that resulted from having no or inadequate health care insurance as well as the types of health care facilities that were available in their communities.. They spoke about social factors which impact the lives of community residents including race, limited income, lack of employment and job training opportunities and poor education.

- Older Men 45- 55 stressed the need for better health care coverage, the need for information about health care insurance, and better communication with health care providers. They noted that health care treatment varied by race, social class and type of insurance and also voiced concerns about medication side effects

- Seniors focused on the need for information about health insurance plans, the poor quality of care provided at community facilities, the accommodations that are needed for seniors at facilities, the costs and other problems associated with using Access-A-Ride, A key issue was the lack of professionalism of providers and staff and the need for improvements in provider-patient relationships

- Pregnant Women stressed the need for support especially for first time moms and were concerned about the long waiting times to see a doctor during scheduled appointments. They noted that accommodations that would enhance care for pregnant women included comfortable chairs, food and beverages and better triage.

- LGBTQ noted that the lack of awareness and knowledge among health care providers about LGBTQ issues not only hampers communication and good relationships with providers but also lessens compliance. They also noted that mental health needs are not being addressed, that existing stigmas and perceptions makes it difficult to seek care, that there is a lack of awareness among community residents about LGBTQ issues and that lack of insurance or awareness of insurance benefits also is a barrier to care.

The next section discusses the assessment study findings.

VII. DISCUSSION

The Need for Caring Study was aimed at gathering information to inform changes in the health service delivery system in Brooklyn communities. Two strategies were used to capture the voices of residents in 15 targeted zip codes. Six hundred and forty-four respondents completed surveys and 78 residents participated in focus groups. Similar age, income and zip code inclusion criteria were used for both samples; additionally, demographics on survey participants were used to inform the types of focus group participants that were needed to create a more representative sample.

Similar to the survey respondents, about two-thirds of the focus group participants were female. The majority of survey respondents and focus group participants were African-American and Caribbean/West Indian American. The average age (median) of focus group participants was about six years older than survey respondents. A higher percentage of survey group respondents reported that they were currently employed (26%) compared to the focus group participants (17%). Focus group participants were also poorer; 70% had an annual salary of $20,000 or less compared to 37% of survey respondents. Insurance coverage was similar with seventy-one percent of survey respondents and 71% of focus group participants reporting that they had health insurance; public insurance was the type of insurance most often indicated by both groups. As discussed earlier, the lower reported income among the survey respondents as compared to the median income of the selected communities may be due in part to the criteria used to select the sample.

Hypertension, asthma, diabetes and hearing and vision problems were the health conditions most often faced by survey respondents or their household members. Survey respondents utilized the health care services that were available; almost 9 out of 10 survey respondents (88.8%) indicated that they had used a health care provider in the past two years. Going for a regular medical check-up was one of the major reasons for seeing a health care provider which indicates an interest in preventative care. Other reasons for seeking care included medical emergencies, needing a medical test and not feeling well. Survey respondents sought care from multiple different types of facilities; private offices; hospital clinics and community health centers were most often utilized.

A greater proportion of focus group participants reported that they sought care outside of their community of residence. Quicker provision of services was a reason given by both focus group participants and survey respondents for seeking care at health care facilities located elsewhere. However, focus group participants also stressed the quality of care received and better treatment by providers and staff. Survey respondents were more likely to seek care outside of the community because they needed specialty care

or were assigned a doctor in another neighborhood. For both groups, the majority travelled 30-60 minutes to receive care outside of their community and most used public transportation to obtain care. Focus group participants discussed problems with Access-A-Ride including long waiting times, prohibitive costs and non-direct routes. Interestingly, 85% of survey respondents indicated that it was most convenient to obtain care near to where they lived and those (82.8%) that sought care in the community indicated that it took 30 minutes or less and 47% said they could walk to the health care facility. Nearness to the facility was also the top reason given by focus group participants for seeking care in their community. This underscores the fact that survey respondents would be willing to obtain care in their community if service delivery was improved. For both groups, participants with illnesses, disabilities or high risk conditions were more likely to seek care in their community of residence.

Although survey respondents indicated that they utilized the emergency room for health conditions like asthma and hypertension which can become acute enough to require urgent attention, focus group participants were more likely to cite immediate emergencies as a reason for seeking care. Among the survey respondents, emergency room use was higher for African-Americans and those with public insurance. In this sample, the reported amount of emergency room is lower than might have been expected based on previous research findings. For example, as part of *The Brooklyn Health Care Improvement Project* (2012), North Central Brooklyn residents were surveyed about their emergency room use and 43% reported using the emergency room in non-emergency situations because it was convenient and their primary care provider was unavailable. A United Hospital Fund analysis of *Statewide Planning and Research Cooperative System-SPARCS* data from 2008 showed higher rates of ER use in Bushwick and Williamsburg (57 per 100 residents), Central Brooklyn (52 per 100 residents) and East New York and New Lots (51 per 100 residents) compared to the city rate of 36 per 100 residents (UHF, 2011). The fact that respondents in the current sample were less likely to use the emergency room could be a result of the fact that the survey was administered during the day time hours and may not have included respondents whose long work hours may be more associated with higher rates of emergency room use. In addition, as this was a convenience sample, individuals who participated may have been more interested in health care and more vested in linking to health care services in their communities.

Both survey respondents and focus group participants found that access to dental care and mental health services was hampered by inadequate or no health insurance. Survey respondents also indicated that access to basic care (doctors, nurses, pediatricians, etc.) and midwife/OB/GYN services was a problem along with access to dental care. *The Brooklyn Health Care Improvement Project* (2012) also noted the lack of access to quality primary care services.

Survey respondents and focus group participants gave similar responses in discussing barriers to health care. Problems with insurance (having no insurance, insurance which does not cover needed services, providers not accepting insurance); long waiting times to obtain an appointment; long waiting times at appointments; language and communication issues; costs of care; poor treatment by providers and staff and the hours that care is provided were challenges mentioned. There was also concordance among survey respondents and focus group participants in discussing problems in obtaining needed medications including high costs, having no health insurance and problems with their health plan.

There was also a high level of agreement between the open ended responses from the survey and issues raised by participants in the focus groups. For example; both groups viewed costs, insurance problems, hours of service, language and communication issues, negative/poor attitudes on the part of providers, long waiting times to obtain an appointment and at appointments, and lack of information as preventing access to care.

When asked about the health care services that were needed in their community, survey respondents indicated dental care, more health care providers, more clinics, pediatricians, OBY/GYN services, mental health and geriatric services. Survey respondents also indicated that improvements were needed in their community to ensure healthier lifestyles (e.g., access to a greater variety of foods, more pools and parks, parenting classes) and that they wanted help in knowing how to use and locate services. Additionally, they highlighted the need for services for youth (health services, activities for youth), seniors and special populations. Among the focus group respondents, a wide range of needed services were raised by participants. Needed services included changes in service delivery (e.g., better triage in doctor's offices and emergency rooms, one-stop-models of care, 24 hour urgent care, more flexible hours, shorter waiting times); more education for consumers (e.g., prostate, diabetes, hypertension, pregnancy, resources for LGBTQ); improved communication (e.g., trained interpreters; translated documents; American Sign Language); better relationship with health care providers (e.g., more compassionate care; professionalism) and addressing social issues (e.g., poverty, unemployment, low/poor education). Other needs included changes in the structure of facilities (e.g., wheelchair access, brighter lights, and more comfortable chairs for pregnant women), specialty care (e.g., GYN services, urologists, podiatrists, mental health, dental services, and endocrinologists); transportation; the need for support groups; and addressing insurance problems. Thus both groups indicated the need for dental services, mental health services, and OBY/GYN services.

It was evident that there was a high level of agreement about the changes that were needed in the health care system. The need for universal access to care, universal or free/low cost coverage equal treatment, better hours, more services and more available services, education for consumers; professionalism on the part of providers/staff and a focus on the social factors which impact health were raised by both groups.

Among a subset of survey respondents who indicated that they had a particular illness or disability, satisfaction with care was high among those who received care in their community. Health care service delivery for children was also rated highly by some survey respondents.

Finally, it is important to note that the residents of North and Central Brooklyn are not a monolithic group and that this needs to be taken into account in making recommendations for practice and policy. Specific health care conditions, access to care, barriers to care, use of facilities outside of the community and emergency room use differed by zip code. These differences are described more in-depth in the survey findings section of the report (see pages 36-86). Similarly, differences were also found among the individuals who participated in the focus groups; these are discussed more fully in the focus group findings section of the report (see pages 86- 125).

The high level of concordance between the survey responses and focus groups themes lends strength to the perspective that there are clear issues regarding health status, health access and service delivery in North and Central Brooklyn that need to be addressed. In addition, similar themes were echoed in two listening sessions conducted with over 40 community residents, health care providers and an elected official to present the preliminary findings and to obtain feedback on whether the results aligned with their own perception of the health care needs in the community.

Attendees at these sessions were not surprised at the key concerns raised by survey respondents and focus group sessions and indicated that care in the community was preferred but that there was a gap between the type of care desired and the type of care received, that it was important to address the social determinants of health care and that it was critical to improve the quality and delivery of services in North and Central Brooklyn.

Finally, many of the issues raised in *The Need for Caring Study* were similar to the findings of two previous studies-- *The Primary Health Care Initiative Community Health Assessment* (2008) and *The Brooklyn Health Care Improvement Project* (2012). A

decided preference for health care services in the community, concerns about lack of access to specialty care, lack of dental care, long waits to obtain appointments, long waits in waiting rooms, the cost of health care/lack of insurance, difficulty navigating the health care system, inadequate communication and poor relationships with health care providers and the need for better coordination of care were all issues raised in *The Primary Health Care Initiative Community Health Assessment* (2008). *The Brooklyn Health Care Initiative Project* (2012) underscored the need for improved patient access to care, increased coordination of care, improved relationships with health care providers, funding for preventive services, and patient education and empowerment. Taken together, the current study as well as the previous studies provides clear and compelling evidence that there is an urgent need to utilize consumer perspectives to inform changes in the health care delivery system of North and Central Brooklyn.

The next section of the report presents recommendations.

VIII. RECOMMENDATIONS

The survey and focus group findings from the CHNA highlight the critical need for improved access to health care services and changes needed in the health care system in many communities in North and Central Brooklyn. The following recommendations, which are derived from an analysis of the information gathered from the 722 community residents living in 15 North and Central Brooklyn communities who participated in either the survey or focus groups, are categorized into four categories, which mimic the original goal of the CHNA, namely to uncover residents' perceptions and concerns regarding:

- Health Care Quality
- Access to Care
- Utilization Patterns and Barriers
- System Changes to Improve Primary Care Delivery

Many of the recommendations fall under multiple categories, as noted below. Since the survey and focus groups targeted low-income residents of North and Central Brooklyn, the ensuing recommendations may not be representative of or applicable to the entire population of this region. Nonetheless, these recommendations highlight useful and meaningful ways to improve residents' access to health services and alter the health care delivery system in a manner that improves health outcomes.

Health Care Quality

- Conduct an air quality study to identify triggers in ambient air in Brownsville (11212), Cypress Hills (11208), Bushwick (11237) and Bedford Stuyvesant (11221), which showed the highest prevalence of asthma. Medical care alone cannot ameliorate this condition.
- Consider the basic needs of patients who are waiting for care. Certain health conditions (e.g. diabetes, pregnancy) may make it difficult for consumers to endure long waits at an appointment without food or beverages.
- Improve screening questions to be more inclusive of the needs of diverse populations, including people with disabilities and people who identify as LGBT, and target outreach to. This will provide for better accurate information gathering, hence improving more earnest consumer disclosures and sharing during medical visits.
- Increase the cultural and linguistic competency of health care providers, staff and administrators by providing ongoing staff development and training on communication skills, the needs of special populations and the importance of being sensitive to their unique needs and the importance of patient-centered care.
- Implement customer service training for all levels of health care staff to improve interactions with clients. Many of the participants noted differential treatment by staff by demographic characteristics (e.g. health insurance status, socio-economic status, immigration, race/ethnicity, language, sexual identity).
- Improve the accessibility and readability of essential medical/health care information in written materials, including but not limited to materials that discuss how to choose a health care provider, what insurance covers or does not cover, and out of pocket costs versus covered costs.
- Collaborate with community or health plan enrollers to work with consumers regarding changes in health care coverage to ensure that consumers maintain coverage for their health care services.
- Provide funding to train and educate patient advocates to support consumers by helping them navigate health care facilities and educate them on service availability.

Access to Care

- Increase OB/GYN practitioners in Prospect Heights (11238) and Bedford Stuyvesant (11233).
- Increase pediatrician providers in Bedford-Stuyvesant (11221).
- Extend primary care hours to evenings and weekends to better accommodate the schedules of patients.
- Increase awareness of and access to low cost health services and public health insurance.

- Financially support outreach and education efforts by grass roots community based organizations to promote community resources/services and provide education/assistance that will help facilitate appropriate referrals.
- Increase access to translation and interpretation services and work with consumers to develop delivery systems that will better meet consumer needs.

Health Care Quality & Access to Care

- Establish centralized referral services or information centers where consumers can obtain information on existing health care resources in their community. In addition, increase consumer awareness of grass roots community based organizations which can assist them with meeting their health care needs.
- Increase peer support groups for residents and make residents aware that such groups are available, particularly for special populations.

System Changes to Improve Primary Care Delivery

- Develop a system of care among a coordinated network of health care and social service providers, residents and community based organizations to address various barriers such as; the lack of cultural and linguistic competent information and resources available to community residents; the need for provider resource sharing to address long waiting time for and at appointments; the need for extended office hours/days to also address gaps in care/services and emergency room overuse.
- Develop a process to engage community residents (“community advisory board”) to work on some of the community level utilization barriers, such as over-use of emergency rooms. Residents can help in various ways such as the development of messaging at the community level that will encourage use of alternative services and conducting outreach to encourage residents to use primary care and other services. African Americans and persons insured by Medicaid need special focus as they had the highest rates of emergency room use. Communities to pay special attention to are: Bedford Stuyvesant (11221 and 11216), Brownsville/East Flatbush (11212). Funding resources will be needed to engage residents.
- Explore improving or developing health care access and care coordination by linking community pharmaceutical services and hospital care electronic systems.
- Explore improving or developing better electronic systems between community pharmaceutical services and hospitals, which may improve medication compliance.

Access to Care & Utilization Patterns and Barriers

- Focus attention on particular illnesses and communities in order to target services where they are most needed. Our findings indicate that the following health conditions were prevalent and often the reason cited for emergency room visits: Asthma, diabetes, and hypertension. These illnesses were particularly prevalent in the following areas: Bushwick (11237) and Brownsville/East Flatbush (11212), Cypress Hills (11208) and Bedford Stuyvesant (11221). When comprehensive, continuous care is available these conditions can be treated on an outpatient basis.
- Increase the availability of quality dental care services in North and Central Brooklyn. Priority should be given to communities reporting greatest problems in accessing dental care; which are: Bedford Stuyvesant (11221), Bedford Stuyvesant/Ft. Greene (11205), Williamsburg (11206) and Cypress Hills (11208). Many residents travel outside of the borough for such services.
- Increase access to specialty health care services in the community. Participants indicated that they had to travel outside of their community to see specialists.
- Develop working relationship with Access-A-Ride to address consumer concerns with its transportation procedures, costs, and timeliness to increase utilization and access to appointments, particularly for senior citizens and people living with disabilities.

Access to Care, Utilization Patterns and Barriers & System Changes Necessary to Improve Primary Care Delivery

- Develop a coordinated campaign to outreach to and work with primary care practitioners, health clinics and managed care plans to encourage and increase the number of providers who accept public health insurance. While this coordinated campaign should cover North and Central Brooklyn, targeted focus should be on Bedford Stuyvesant (11216 and 11221) and Brownsville/East Flatbush (11212). Similar campaigns have been utilized in the past and can serve as a model - such as the measles epidemic campaign, borough-wide Child Health Plus promotion by facilitated enrollment agencies, and the borough-wide HIV outreach and referral case management campaign. With the introduction of the Affordable Care Act's increase in primary care reimbursement, receptivity to this campaign may be greater.
- Modify the design of health care facilities to make them more accessible, "user friendly" and comfortable. For example, improve wheelchair access, the level of lighting, the font of printed materials, and the comfort of seats in waiting rooms and clinics for pregnant women.
- Extend urgent care center hours in North and Central Brooklyn to offset emergency room use. According to our analysis, participants utilized emergency rooms for immediate problems and when health care offices were closed. Extending hours may have to address the issue of emergency room overuse.

- Use evidence based strategies to help redesign systems for patient scheduling and patient flow to reduce waiting times for and at appointments. For example, technology can be used to help patients schedule their appointments using the internet.
- Increase access to dental and mental health services. Participants indicated that this was a major gap in the current service delivery system in North and Central Brooklyn. One stop care models where these services are added to current facilities, renting space near current facilities, using mobile vans and referrals to training programs in dentistry and clinical and counseling psychology programs/clinics which offer services with reduced and sliding scale fees can be used to address these needs.
- Provide funding to train and educate patient advocates to support consumers by helping them navigate health care facilities and educate them on service availability.

Many of the recommendations from this CHNA are analogous to those made in the New York City Health and Hospital Corporation's Primary Care Initiative Community Health Assessment Final Report, released in 2008, which highlights the barriers residents living in underserved areas of New York City face when seeking primary health care. Similarly, many of the recommendations regarding accessibility; outreach and education strategies; and collaboration with community groups in the CHNA were also presented in the BHIP's study. The overlap between these recommendations symbolizes the urgency for required changes in the health care system. Implementing these recommendations will likely not only improve health outcomes for residents of North and Central Brooklyn but also reduce healthcare costs overall.

IX. ENDNOTES

[1] Medicaid Redesign Team: Health Systems Redesign: Brooklyn Work Group (2011). At the Brink of Transformation: Restructuring the Healthcare Delivery System in Brooklyn. Available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/brooklyn_mrt_final_report

[2] The time and costs to complete the project exceeded our estimates due to an overly ambitious timeframe for the project, delayed receipt of funding, work disruptions caused by Hurricane Sandy, and the loss of one co-lead partner during the finalization of the report.

[3] The Office of the Governor (2011). *Governor Cuomo Issues Executive Order Creating Medicaid Redesign Team*. [Press Release] Available at: http://www.governor.ny.gov/press/01052011medicaid

[4] Brooklyn Healthcare Working Group (2011). *Creating a Vision for Brooklyn's Health Care System: A report of the Brooklyn Healthcare Working Group.* Available at: http://www.nysenate.gov/files/pdfs/Creating%20a%20Vision%20for%20Brooklyns%20Health%20Care%20System%20A%20Report%20of%20the%20Brooklyn%20Healthcare%20Working%20Group.doc

[5] Medicaid Redesign Team: Health Systems Redesign: Brooklyn Work Group (2011). At the Brink of Transformation: Restructuring the Healthcare Delivery System in Brooklyn. Available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/brooklyn_mrt_final_report

[6] The Save Our Safety Net –Campaign (SOS-C), a coalition of community and labor, was organized in 2006 when an official State Commission was appointed by the then-Governor Pataki to perform a review for hospital closings. SOS-C organized a campaign to ensure that if hospitals were to be closed, they would not be closed in low-income, community-based, immigrant and communities of color. www.soscny.wordpress.com

[7] National Institute for Clinical Excellence (2005) *Health Needs Assessment: A Practical Guide.* London

[8] Wallerstein, N., & Duran, B. (2010). Community-Based Participatory Research Contributions to Intervention Research: The Intersection of Science and Practice to Improve Health Equity. *American Journal of Public Health.* 100-S1. S40-546.

[9] Viswanathan, M. Ammerman, A. Eng, E, et al. (2004 Aug.) Community-Based Participatory Research: Assessing the Evidence: Summary. In. *AHRQ Evidence Report Summaries. Rockville (MD); Agency for Healthcare Research and Quality.* 1998-2005. 99.

[10] Parrill, R. Kennedy, B.R., (2011). Partnerships for Health in the African American Community: Moving Toward Community-Based Participatory Research. *Journal of Cultural Diversity.* 18(4), 150-154.

[11] Parrill, R. Kennedy, B.R., (2011). Partnerships for Health in the African American Community: Moving Toward Community-Based Participatory Research. *Journal of Cultural Diversity.* 18(4), 150-154.

[12] Medicaid Redesign Team: Health Systems Redesign: Brooklyn Work Group (2011). At the Brink of Transformation: Restructuring the Healthcare Delivery System in Brooklyn. Available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/brooklyn_mrt_final_report

[13] Medicaid Redesign Team: Health Systems Redesign: Brooklyn Work Group (2011). At the Brink of Transformation: Restructuring the Healthcare Delivery System in Brooklyn. Available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/brooklyn_mrt_final_report

[14] Lee Rivers Mobley, et al. (2012) The Effects of Safety Net Hospital Closures And Conversions on Patient Travel Distance to Hospital Services. *Health Services Research.* 47.1pt1 129-150.

[15] Lee Rivers Mobley, et al. (2012) The Effects of Safety Net Hospital Closures And Conversions on Patient Travel Distance to Hospital Services. *Health Services Research.* 47.1pt1 129-150.

[16] Richman, BD. (2007). Antitrust and Nonprofit Hospital Mergers: A Return to Basics. *University of Pennsylvania Law*

[17] Hartocolis, Anemona "The Decline of St. Vincent's Hospital. *The New York Times.* February 10, 2010 *http://www.nytimes.com/2010/02/03/nyregion/03vincents.html?pagewanted=all&_r=0*

[18] Santora, Marc "St. Mary's Hospital in Brooklyn Is to Close After Years of Losses. *The New York Times.* June 4, 2005. http://www.travel.nytimes.com/2005/06/04/nyregion/04hospital.html

[19] New York Medicaid Redesign Health System Redesign Brooklyn Work Group (2011). Power Point presentation by Rick Cook, NYS Department of Health. Available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/2011-07 28_brooklyn_work_group_presentation.ppt

[20] New York Medicaid Redesign Health System Redesign Brooklyn Work Group (2011). Power Point presentation by Rick Cook, NYS Department of Health. Available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/2011-07 28_brooklyn_work_group_presentation.ppt

[21] Center for Study of Brooklyn http://www.brooklyn.cuny.edu/pub/departments/csb/

[22] New York Medicaid Redesign Health System Redesign Brooklyn Work Group (2011). Power Point presentation by Rick Cook, NYS Department of Health. Available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/2011-07 28_brooklyn_work_group_presentation.ppt

[23] Wong, G., & Fyfe, D. (2012) Brooklyn Healthcare Improvement Project. Final Report: Making the Connection to Care in Northern and Central Brooklyn. *SUNY Downstate Medical Center*.

Twelve of the zip codes in both studies overlapped: 11206, 11237, 11217, 11238, 11216, 11213, 11226, 11212, 11207, 11208, 11233, and 11221. The B-HIP study also covered 11210 and 11227. The Need for Caring also covered: 11222, 11211, 11205, and 11201. http://www.downstate.edu/bhip/pdf/B-HIP-Final-Report.pdf

[24] Wong, G., & Fyfe, D. (2012) Brooklyn Healthcare Improvement Project. Final Report: Making the Connection to Care in Northern and Central Brooklyn. *SUNY Downstate Medical Center*. 5.

[25] Wong, G., & Fyfe, D. (2012) Brooklyn Healthcare Improvement Project. Final Report: Making the Connection to Care in Northern and Central Brooklyn. *SUNY Downstate Medical Center*.

[26] Wong, G., & Fyfe, D. (2012) Brooklyn Healthcare Improvement Project. Final Report: Making the Connection to Care in Northern and Central Brooklyn. *SUNY Downstate Medical Center*. 7.

[27] Wong, G., & Fyfe, D. (2012) Brooklyn Healthcare Improvement Project. Final Report: Making the Connection to Care in Northern and Central Brooklyn. *SUNY Downstate Medical Center*.

[28] U.S. Department of Health and Human Services. Health Professional Shortage Areas. Available at: http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/designationcriteria.html

[29] U.S. Department of Health and Human Services. Health Professional Shortage Areas. Available at: http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/designationcriteria.html

[30] Medicaid Redesign Team: Health Systems Redesign: Brooklyn Work Group (2011). At the Brink of Transformation: Restructuring the Healthcare Delivery System in Brooklyn. Available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/brooklyn_mrt_final_report. 76.

[31] Lager, Nancy, Green, Donna, Kim, Victor and Deborah Zahn. (2006) A Primary Care Capacity Shortage in New York City & The Potential Impact of Hospital Closures. *Primary Care Development Corporation and the New York City Health and Hospitals Corporation*.

[32] Rosenbaum, S., Shin, P., & Perez Whittington, R. (2006) Laying the Foundation: Health System Reform in New York State and the Primary Care Imperative. *CHCANYS; PCDC; and NYS Area Health Education Center System.*

[33] Health & Hospitals Corporation. (2008) Primary Care Initiative Community Health Assessment: Final Report. Available at: http://council.nyc.gov/downloads/pdf/PCI%20Final%20Report.pdf

[34] Health and Hospitals Corporation. (2008) Primary Care Initiative Community Health Assessment: Final Report. Available at: http://council.nyc.gov/downloads/pdf/PCI%20Final%20Report.pdf

[35] Health and Hospitals Corporation. (2008) Primary Care Initiative Community Health Assessment: Final Report. Available at: http://council.nyc.gov/downloads/pdf/PCI%20Final%20Report.pdf

[36] Wong, G., & Fyfe, D. (2012) Brooklyn Healthcare Improvement Project. Final Report: Making the Connection to Care in Northern and Central Brooklyn. *SUNY Downstate Medical Center*.

[37] Center for Brooklyn study

[38] Wong, G., & Fyfe, D. (2012) Brooklyn Healthcare Improvement Project. Final Report: Making the Connection to Care in Northern and Central Brooklyn. *SUNY Downstate Medical Center*.

[39] Commission on the Public's Health System. (2008) CPHS Child Health Initiatives survey *Voices from the Community.* CPHS. Available at: http://www.cphsnyc.org/cphs/reports/december_2008-_voices_from_the_c/

[40] Health and Hospitals Corporation. (2008) Primary Care Initiative Community Health Assessment: Final Report. Available at: http://council.nyc.gov/downloads/pdf/PCI%20Final%20Report.pdf

[41] Wong, G., & Fyfe, D. (2012) Brooklyn Healthcare Improvement Project. Final Report: Making the Connection to Care in Northern and Central Brooklyn. *SUNY Downstate Medical Center*.

[42] Giuliano AR, Mokuau R, Hughes N, et al. (2000) Participation of minorities in cancer research: the influence of structural, cultural, and linguistic factors. *Ann Epidemiol.* 10(8 Suppl):522-534. and Wendler D, Kington R, Madans J, et al. Are racial and ethnic minorities less willing to participate in health research? (2006) *PLoS Med.* 3(2):e19.

[43] Nyguen GT, et al. Surveying Linguistically Challenged Southeast Asian American Population Use of a Community-Partnered Methodology. *Journal of Health Care for the Poor and Underserved.* (August 2011) Vol.22:3 pp. 1101-1114. and Moreno J. Lessons learned a half-century of experimenting on humans.(1999) *Humanist.* 59:9-15.

[44] Patel V, Rajpathat S, Karasz. (2012) Bangladeshi Immigrants in New York City: A Community-Based Health Needs Assessment Of A Hard To Reach Population. *Journal of Immigrant And Minority Health.* 14.5:767-773. and Martinez IL, Carter-Pokras O. (2006) Addressing Health Issues and Barriers to Health in a Heterogeneous Latino Community. *Journal of Healthcare for the Poor and Underserved.* 17(4):899-909.

[45] Nyguen GT, et al. Surveying Linguistically Challenged Southeast Asian American Population Use of a Community-Partnered Methodology. *Journal of Health Care for the Poor and Underserved.* (August 2011) Vol.22:3 pp. 1101-1114. and Moreno J. Lessons learned a half-century of experimenting on humans.(1999) *Humanist.* 59:9-15.

[46] Schulz A, Parker EA, Israel, BA, et al. (1998) Conducting a participatory community-based survey for a community health intervention on Detroit's East Side. J *Public Health Manag Pract.* 4:10-24.

[47] Commission on the Public's Health System. (2008) CPHS Child Health Initiatives survey *Voices from the Community.* CPHS. Available at: http://www.cphsnyc.org/cphs/reports/december_2008-_voices_from_the_c/

[48] Health and Hospitals Corporation. (2008) Primary Care Initiative Community Health Assessment: Final Report. Available at: http://council.nyc.gov/downloads/pdf/PCI%20Final%20Report.pdf

[49] Quotations in italics are respondents' answers to *The Need for Caring* open-ended survey questions.

[50] Wong, G., & Fyfe, D. (2012) Brooklyn Healthcare Improvement Project. Final Report: Making the Connection to Care in Northern and Central Brooklyn. *SUNY Downstate Medical Center*.

[51] Wong, G., & Fyfe, D. (2012) Brooklyn Healthcare Improvement Project. Final Report: Making the Connection to Care in Northern and Central Brooklyn. *SUNY Downstate Medical Center*.