THE NEW YORK ACADEMY OF MEDICINE

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# Preventing Chronic Disease: Community Perspectives

## New York City Population Health Improvement Program

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P H I P
Population Health Improvement Program

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# INTRODUCTION

In January 2015, the New York City Population Health Improvement Program (NYC PHIP) was launched as a collaboration between the Fund for Public Health in New York, the New York City Department of Health and Mental Hygiene (NYC DOHMH), the United Hospital Fund (UHF), and The New York Academy of Medicine (the Academy). The NYC PHIP, one of 11 such bodies around the state, is funded by the State Department of Health and tasked with aligning various health reform activities to support population health and to promote the Triple Aim of better care, lower health care costs and better health outcomes for New Yorkers.

Objectives for the first two program years include promotion of increased multi-sector investment in interventions that prevent disease and improve health equity in NYC; specifically by (1) developing a PHIP Steering Committee to promote engagement in and support for population health interventions; (2) engaging the community in advancing the city's strategic health agenda; and (3) generating recommendations and analyses that inform stakeholders about actions they can take to support population health improvement. This report focuses on approaches to prevent chronic disease across NYC, particularly in those communities identified as experiencing the greatest burden. The findings are intended to provide the PHIP Steering Committee and the Designing a Strong and Healthy NYC Workgroup with community member perspectives, in order to inform physical activity and healthy eating program development and implementation.

# METHODS

Findings presented in this report are based on data from five focus groups, specifically addressing the topic of chronic disease prevention, convened in NYC between September 2015 and January 2016 (N=69). The Academy partnered with the NYC DOHMH to select a priority neighborhood in each borough. These were: Jamaica, Queens; Port Richmond, Staten Island; Cypress Hills, Brooklyn; Lower East Side, Manhattan; and Soundview, Bronx (see focus group implementation details in Figure 1). The Academy then conducted outreach to community organizations in each neighborhood, requesting that they host a group and recruit participants. Focus groups included twelve to fifteen participants, ages 18 years or older.

**FIGURE 1.**

| BOROUGH | NEIGHBORHOOD | COMMUNITY-BASED PARTNER | DATE OF GROUP | NUMBER OF PARTICIPANTS |
|---|---|---|---|---|
| MANHATTAN | Lower East Side | Two Bridges Neighborhood Council | October 4, 2015 | 13 |
| STATEN ISLAND | Port Richmond | Richmond Senior Services | September 29, 2015 | 15 |
| BRONX | Soundview | Mt. Zion CME Church | September 25, 2015 | 15 |
| QUEENS | Jamaica | Jamaica YMCA | January 19, 2016 | 12 |
| BROOKLYN | Cypress Hills | Cypress Hills Local Development Corporation (Spanish Language) | September 28, 2015 | 14 |

Focus groups were facilitated by two Academy staff and lasted approximately 90 minutes. A semi-structured guide was used to facilitate the groups (see Appendix) and covered topics pertaining to prevention of chronic disease, including participant perspectives on availability and affordability of healthy food, places to be physically active, and recommendations to make healthy activities more accessible. Participants were also asked to complete a brief questionnaire to gather basic sociodemographic and health information. Four of the focus groups were conducted in English; one was conducted in Spanish by bilingual Academy staff members, using translated materials. Focus groups were audio recorded and English groups were professionally transcribed. The recording of the Spanish language group was summarized with literal translations of relevant passages. Transcripts and summaries were managed and coded using NVivo, a software package for qualitative data analysis. A coding scheme (with definitions) was developed that included pre-identified and emergent themes. All transcripts were coded and analyzed using an iterative process that allowed for identification of salient findings.[1]

## Characteristics of Focus Groups Participants

As shown in Table 1, there was significant variability in participant ages, though the majority were 55 and older. Three quarters of the participants were African American or Latino. Approximately half (54%) reported that they were not working or unable to work due to disability; 68% reported that they sometimes or always had concerns about paying for food or housing in the past year. Forty-six percent (46%) of participants reported having high blood pressure, 19% had high cholesterol, and 17% had diabetes.

[1] The project protocol and all instruments were reviewed under expedited procedures and approved by the Academy Institutional Review Board. All participants received an information sheet and were asked to provide verbal consent. Participants were informed that their involvement in the research was completely voluntary and that they could refuse to answer questions or leave the focus group at any time. They were told that their responses would be kept confidential and would be reported in such a way that individuals could not be identified. Brief demographic questionnaires were completed anonymously. All data were stored on password protected drives at The Academy. Participants received a $25 incentive.

## TABLE 1. FOCUS GROUP PARTICIPANT CHARACTERISTICS

| | N | % |
|---|---|---|
| **AGE** | | |
| 18 – 35 | 4 | 6% |
| 36 – 45 | 10 | 15% |
| 46 – 55 | 14 | 20% |
| 56 – 64 | 14 | 20% |
| 65 and older | 23 | 33% |
| Missing | 4 | 6% |
| **EDUCATION** | | |
| Some/Did not attend HS | 15 | 22% |
| HS grad/techincal + vocational training | 20 | 29% |
| Some College but no degree | 14 | 20% |
| Associates/Bachelor/Advanced degree | 19 | 28% |
| Missing | 1 | 1% |
| **GENDER** | | |
| Female | 42 | 61% |
| Male | 22 | 32% |
| Missing | 5 | 7% |
| **RACE/ETHNICITY*** | | |
| Black/African American | 28 | 41% |
| Hispanic/Latino | 23 | 33% |
| White | 19 | 28% |
| Other | 17 | 25% |
| Missing | 5 | 7% |
| **WORK STATUS** | | |
| Employed full time | 7 | 10% |
| Employed part time | 8 | 12% |
| Not working | 30 | 44% |
| Unable to work – disability | 7 | 10% |
| Retired | 13 | 19% |
| Student | 2 | 3% |
| Missing | 2 | 3% |

(continued on P7)

| | | |
|---|---|---|
| **MAIN LANGUAGE SPOKEN AT HOME** | | |
| English | 52 | 75% |
| Spanish/Spanish and English | 12 | 17% |
| Missing | 5 | 7% |
| **HEALTH INSURANCE*** | | |
| Medicaid | 28 | 41% |
| Medicare | 26 | 38% |
| Private/Commercial insurance | 12 | 17% |
| Other | 9 | 13% |
| Uninsured | 8 | 12% |
| Do not know | 1 | 1% |
| **HAD CONCERNS RELATED TO PAYMENT FOR FOOD OR HOUSING IN PAST YEAR** | | |
| Always | 24 | 35% |
| Sometimes | 23 | 33% |
| Rarely | 7 | 10% |
| Never | 11 | 16% |
| Missing | 4 | 6% |
| **CURRENT HEALTH CONCERNS*** | | |
| High blood pressure | 32 | 46% |
| Arthritis | 18 | 26% |
| Depression or anxiety | 14 | 20% |
| High cholesterol | 13 | 19% |
| Diabetes | 12 | 17% |
| Chronic pain | 10 | 15% |
| **SOURCE OF USUAL HEALTH CARE*** | | |
| Doctor's Office | 39 | 57% |
| Hospital–based clinic | 11 | 10% |
| Community/family health center | 10 | 15% |
| Emergency room/Urgent care | 8 | 12% |
| No usual location of health cae | 9 | 13% |

**Multiple responses permitted*

# FINDINGS

The following sections present study findings focused on participants' perceptions related to accessibility and affordability of healthy food, as well as opportunities for physical activity within their neighborhoods. In conducting the focus groups, and in this report, we attempted to concentrate primarily on recommendations and solutions relevant to these topics. However, participants—who generally lived in low-income communities—were eager to report on persistent barriers to healthy eating and physical activity, and the most common concerns related to these factors are also included here. Although there was variability by neighborhood, these included the high price of healthy foods, limited access to fresh produce, and inadequately maintained parks and streets.

## Barriers to Chronic Disease Prevention in Low Income Communities

### Barriers to Healthy Eating

Participants in most focus groups noted limited access to affordable healthy food. Other than Cypress Hills, where small grocery stores (known as *conocos*) were reported to offer a consistent supply of fresh produce at low prices, participants complained of poor quality and/or high prices, with the latter particularly problematic in gentrifying neighborhoods. In addition, participants reported that a number of local food outlets did not accept Special Supplemental Nutrition Program (SNAP) benefits.

> *When you now go to the supermarket to get certain things, you find that all sugary cereals are cheap, dirt cheap. You can get them for a song. You turn around and you want to get something that's bran or you want to get whole grain items or even tofu, which I'm finding difficult to get around here, throw your hands up and just dig very deep in your pocket.* (Queens)

> *I think that's another problem also is that (there are) a lot of food stamps in this area. When it comes down to paying cash for things, this one we have a problem. So, we got to have more [merchants] take food stamps.* (Manhattan)

Although a number of participants described traveling to other neighborhoods for grocery shopping when local access was inadequate, participants living in Staten Island and the Lower East Side of Manhattan reported that the public transportation serving their neighborhoods was inadequate and exacerbated food access issues—particularly for individuals who, due to age or disability, were unable to carry bags of groceries on public transit. Because travel from these neighborhoods was difficult, participants purchased food at nearby markets, despite higher prices and less variety.

> *I don't go to Trader Joe's because I have to take two buses, and you wait for one bus. It doesn't come. So – or and as the weather's getting colder, you don't want to stand on a bus, so you just go to your local neighborhood.* (Staten Island)

### Barriers to Physical Activity

Walking was the preferred physical activity for many focus group participants: barriers to physical activity, therefore, focused primarily on concerns related to walking, both on sidewalks and in parks. Participants explained how poor maintenance resulted in underutilization of certain parks—or areas within parks. Low use created opportunities for increased drug activity and assaults, which perpetuated and exacerbated the underuse. Inadequate maintenance of sidewalks was also described, including disrepair (sometimes resulting from construction) and insufficient snow and ice removal in the winter months.

> *They're building up a lot of our parks, but a lot of those parks, they have [become] old. They have been forgotten about. The swings and stuff are rusty. And nobody even wants to go over there because a lot of illegal activities go on in the park.* (Bronx)

> *Most of the people will shovel the walk, or my neighbors have blowers. But still, if there's some snow on the sidewalk, it just doesn't melt, freezes, and as more snow comes on, it gets very slippery. I think that's one big thing. A lot of people like me who do walk find it not a good thing to do. So I stay inside and sit in front of that box that you were just talking about.* (Staten Island)

## Promising Practices and Solutions

Participants described a number of governmental and community–based programs that supported healthy eating and physical activity. They advocated for continuation, expansion, and/or replication of these noted successes, as well as increased advertising and dissemination of information so that available programs and services were fully utilized.

### Community Based Activities

In response to questions about existing community programs that promote healthy eating and physical activity, participants described a broad array of ongoing activities. These included programs that addressed the food environment within neighborhoods and/or institutions, as well as activities focused on individual knowledge, attitudes, skills and behaviors, such as school–based cooking and nutrition classes, and exercise classes in senior centers, churches, schools and workplaces. Comments regarding these successful programs include:

> *Everything happens in my daughter's school. There is a nutrition program on Thursdays and the parent coordinator brings a nutritionist to teach us, and we also cook with everyone.* (Brooklyn)

> *I would say, at my job, we do have a little exercise because we take a break at 11:30 and 3:30. So for 15 minutes, we can go up to the seventh floor, and they have a trainer and everybody brings their weights. It's about 50 people in the classroom setting. And you see them with their weights and their water, and they're doing stretching and they're doing exercise for 15 minutes.* (Bronx)

> *I come here … to the [senior] center where there are activities. I like yoga a lot. There's yoga or cardio, there are other activities in the chair also. (Brooklyn)*

To build on the strengths of existing programs, participants suggested offering more educational opportunities focused on cooking and physical activity. Holding classes in local churches and schools was recommended, as these are well–utilized and familiar institutions where community members can easily come together.

*Cooking classes. Because a lot of people, especially as you get older, it's so much easier to pick up the package prepared already cooked, and then there's more salt, there's more sugar. There's more god–knows–what chemicals in it. … But if you had cooking classes so that people could see, you can take fairly simple ingredients and put them together, and have a halfway decent meal that would be a useful thing for people to know.* (Staten Island)

*I was thinking that maybe there should be more groups to really explain nutrition and what people are really eating, because not everybody—we read labels, but not everybody does.* (Staten Island)

*In the churches there are large spaces that are always vacant and open … it could be any church. It's close to your house, part of the community and there's space to exercise and it's not in use all day and could be used.* (Brooklyn)

*Schools are where our children spend the majority of their day. It would be interesting if some schools implemented programs so kids eat more fresh vegetables that aren't from the can.* (Brooklyn)

*You got to bring stuff to a lot of [the] disabled people that live in this community; a lot of senior citizens. And you got to bring it to the people, more closer to the people where they would get there. Why they can't have one [farmers market nearby]?* (Manhattan)

One participant from Queens, explained the value of providing opportunities for food demonstrations where individuals can sample new foods. She noted that individuals on a fixed budget are unlikely to purchase costly, unfamiliar foods:

*Why would you spend $6.00 on a package of something that you've never eaten before? And then you might not like it and you wasted your money.*

### Food Assistance

A number of participants were enrolled in food assistance programs and described the benefits thereof. Several received Health Bucks, which extended the funds they had available to buy fresh fruits and vegetables from local farmers markets. Assistance through SNAP and SNAP for Women, Infants, and Children (WIC) facilitated improved access to fresh fruits and vegetables, more generally.

> *Three months' supply of [WIC] checks for each one of those children. And each one of those months, they get $10 for fruits and vegetables. And when they go to the supermarket, they can pick up bananas, oranges, apples, whatever. So the WIC program is really good.* (Bronx)

> *The markets that we have here in the community that you all mentioned a moment ago they have another benefit. If we go and listen to a workshop they will teach you how to cook in a healthy way. They will give you a coupon for $2.* (Brooklyn)

### Bicycle Lanes and Bike Share Programs

Focus group participants supported the development of bicycle lanes and NYC's bike share program. Those in Staten Island and the Bronx reported that improved bicycle access had not yet reached their neighborhoods and recommended expansion of lane and bike share, consistent with the changes evident in Manhattan.

> *We need something like that where we could have bikes so we could depend on riding your bike, especially up in this area because you see a lot in Manhattan and even in Brooklyn, they encourage you to become a bike rider. But I don't see the encouragement up here to become a bike rider. (Bronx)*

> *But even more bike runs or bike paths. That they are clearly marked so people won't be killed out here trying to do a bike path. (Queens)*

### Getting the Word Out

Although participants most commonly advocated for the expansion of services, they also noted that even when community activities and services are available, many potentially interested community members are unaware of them. They suggested advertising health-related events and information more broadly and in locations where people are most likely to see them.

> *A lot of places out here will do things. The only bad thing is they don't get the word out enough to where people can actually attend. So they need some kind of better public announcement system or something to get these things out. Or some kind of hotline where they can make some calls and let people know or whatever. (Queens)*

> *Put your signs into areas like the stores that people go in every day. Because a lot of people go to stop one here, stop one there. Put your information where people really go at; in front of the train station, on the liquor store. You have to put information where people basically go in order to get that. (Manhattan)*

# DISCUSSION AND RECOMMENDATIONS

Focus groups findings indicate that although barriers to physical activity and healthy eating persist in neighborhoods that experience high burdens of chronic disease, a number of programs and services are available and may successfully improve health, if offered and utilized at an appropriate scale. In addition, the findings indicate some variability across neighborhoods, suggesting that one size does not fit all and that programming should be selected and/or tailored to match the needs and realities of specific communities. These results are consistent with those described in the Academy's *City Voices* reports, which included a significantly larger sample, including *Physical Activity: New Yorkers on the Move*. Considering barriers and successful practices described, as well as suggestions from community members, the primary focus group recommendations are as follows:

- Improved access to affordable healthy food, including fresh produce, in all neighborhoods. Food assistance programs, including Health Bucks, SNAP, and WIC, facilitate affordability for low–income populations and should be accepted at more food outlets.
- Support and expansion of community programs that address the food environment within neighborhoods and/or institutions, as well as activities focused on individual knowledge, attitudes, skills and behaviors, such as school–based cooking and nutrition classes, and exercise classes in senior centers, churches, schools and workplaces.
- Ongoing maintenance and repair of parks and sidewalk so community members feel comfortable and safe walking for exercise and recreation. Walking is a regular form of physical activity for many focus group participants; barriers to walking should be eliminated.
- Promotion of bike riding in all neighborhoods through the delineation of bike lanes and expansion of NYC's bike share program.
- Dissemination of information on existing programs more broadly, and through venues with the greatest reach, such as subway stations.

# APPENDIX

# THE NEW YORK ACADEMY OF MEDICINE
# PUBLIC HEALTH IMPROVEMENT PROGRAM
## Focus Group Guide: Preventing Chronic Disease

*Welcome and thank you for participating in this focus group. Today we are interested in talking with you about being active and eating a healthy diet, both of which are important to preventing and managing obesity, diabetes, and heart disease as well as other common chronic diseases. We have done a lot of talking with community members across the city, about the challenges people face in getting enough exercise and eating healthy foods. We would now like to hear from you about ways to address these challenges, and about your approaches–and recommendations–for staying healthy.*

*We work at The New York Academy of Medicine and are conducting this focus group in partnership with the New York City Department of Health. Your thoughts will inform ongoing discussions between organizations and institutions in New York City that work on addressing key risk factors for chronic disease, including improving opportunities for being physically active and eating healthy foods.*

1. To begin, can you tell us a little bit about the neighborhood you live in and how long you have lived there?
    a. What would you tell someone visiting for the first time?

*Now I'd like to focus specifically on how physical activity can be increased among people in this community. As you may know, recommendations are that adults should be physically active (including walking quickly) for 150 minutes each week, which would equal 30 minutes, 5 days a week.*

2. We're interested in the ways your neighborhood may make being physically active easy and what could be improved.
    a. What types of exercise do you and your neighbors engage in?
    b. What aspects of your neighborhood make physical activity inviting and accessible?
    c. What are barriers in your neighborhood to being physically active?

3. What kind of activities do you think can be implemented to increase physical activity among residents in your community?
    a. What would be most appealing to you?
    b. Where should these activities take place – what kind of setting?
    c. What about settings we do not usually think of when we think of health–For example local businesses, NYCHA, employers, and faith based organizations?
    d. What kinds of activities do you think can be implemented without much money or organizational effort?

4. Exercising may take time and money that some residents don't have. What would make it easier for people with these constraints to be more physically active? Why?

5. Is there any group of people who you think would particularly benefit from increasing their level of physical activity? Why? (If needed, prompt: This might include specific age groups or genders, or other groups like working parents or people living with disabilities).
    a. Is there a specific approach that should be used to engage those people?
    b. [If needed] Who do you think would be likely to participate in programs to increase physical activity? Least likely? Why?

*I'd like to change topics here and talk about healthy food choices in this community, including what's available and what's needed.*

6. To start, what are the places you shop for food? Why?
    a. Is healthy food available–and affordable–there?

7. We are interested in ways that your neighborhood encourages healthy eating and what could be improved.
    a. Where in your neighborhood are healthy foods accessible?
    b. What are barriers to healthy eating?

8. What kind of activities should be implemented to promote a healthy diet among residents in your community?
    a. What would be most appealing to you?
    b. Where should these activities be held—what kind of setting?
    c. What about settings we do not usually think of when we think of health, such as local businesses, NYCHA, employers, and faith based organizations?
    d. What kinds of activities do you think can be implemented quickly, with little cost or organizational effort?

9. Buying and preparing healthy food can take time and money some community members do not have. What would make it easier for people with these constraints—and their families—to eat healthy?

    a. Cooking healthy food at home is one way to eat well. What makes it easy for you to cook healthy food at home?
    b. What would help you cook at home more often (prompt: more convenient grocery stores, more quality fresh food, more affordable produce)?

10. Is there any group of people who you think would particularly benefit from efforts to improve opportunities for healthy eating? Why? (If needed, prompt: This might include specific age groups or genders, or other groups like working parents or people living with disabilities).
    a. Is there a specific approach that should be used to engage those people?
    b. [If needed] Who do you think would be most likely to participate in programs to promote a healthy diet? Least likely? Why?
    c. [If needed] Who in your community has the most access to healthy food? The least? Why?

*I'd like to change topics a bit here, and ask some more general questions.*

11. Many say that you can improve the health of people in a community by working in other sectors like education, housing, sanitation, transportation, etc. In what ways can these sectors contribute to healthy eating and exercise in your communities?
    a. How effective do you think this kind of an approach can be in improving health? Why?
    b. How important to you is this approach as compared to an approach that focuses directly on health through activities like health education or the role of doctors or hospitals?

12. Who are the most trusted and respected voices in your neighborhood (these may be individuals or institutions)? What role can they play in improving the health of your neighborhood?

13. In general, do you think it is more important for health dollars to be spent to prevent illness or to treat people who are already ill? Why?

14. Do you have any other comments or recommendations regarding healthy eating and physical activity in this community? Anything we should have asked but didn't?

*Thank you for participating!*

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The New York Academy of Medicine advances solutions that promote the health and well-being of people in cities worldwide.

Established in 1847, The New York Academy of Medicine continues to address the health challenges facing New York City and the world's rapidly growing urban populations. We accomplish this through our Institute for Urban Health, home of interdisciplinary research, evaluation, policy and program initiatives; our world class historical medical library and its public programming in history, the humanities and the arts; and our Fellows program, a network of more than 2,000 experts elected by their peers from across the professions affecting health. Our current priorities are healthy aging, disease prevention, and eliminating health disparities.

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