North Country Hospital

Community Health Needs Assessment

2021 Report

North Country Hospital
Where caring runs deep.

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Section 1: Background and Introduction

Introduction

Between March-June 2021, North Country Hospital (NCH) conducted a Community Health Needs Assessment (CHNA). This CHNA is a part of NCH's strategic initiative and is also in compliance with the Patient Protection and Affordable Care Act (ACA 501(r) (3)). The 2021 CHNA is a part of an ongoing effort by NCH to assess the needs and priorities of the communities it serves. Previous CHNA's were conducted by NCH in 2012, 2015, and 2018.

Following data collection and analysis, NCH has identified the top two Priority Health Needs raised by community members across four categories. In response to these identified needs, an Implementation Plan was created to identify and document strategies to help meet the health care needs of community members.

Included in this report is a description of data collection methodologies, data analyses, identification of priorities, and an Implementation Plan to address these priorities.

Availability of the CHNA and Implementation Strategy

Upon completion of the entire CHNA process, the documents comprising the NCH CHNA Report and Implementation Strategy will be made widely available in an easily downloadable format on the NCH website at www.northcountryhospital.org. A hard copy will also be available by calling NCH Administration at 802-334-3203 and requesting a copy. This information will be available to community members without the need to have special hardware or software, without payment or fee, or without the requirement of creating an account or being required to provide personally identifiable information. NCH's previous CHNA documents, completed in 2012, 2015 and 2018, as well as the related Implementation Strategy documents will continue to be available on the NCH website or at no charge to interested community members who are encouraged to contact NCH administration at the above telephone number to request a copy.

CHNA Design & Implementation Consultants at the University of Vermont, Larner College of Medicine, Graduate Public Health Programs

Dr. Jan Carney	Professor of Medicine, Associate Dean for Public Health and Health Policy
Dr. Kelsey Gleason	Assistant Professor of Medicine
Dr. Thomas Delaney	Associate Professor of Pediatrics
Dr. Vicki Hart	Assistant Professor of Medicine
Caitlin Jenkins	Program Manager, MPH Program, Larner College of Medicine

NCH Core CHNA Team

Megan Marquissee	Care Continuum Manager VT Blueprint for Health Program Manager
Mary Hoadley	Director of The Wellness Center and Employee Wellness
Bobby Jo Rivard	Executive Assistant for Medical Group Operations
Wendy Franklin	Director of Communications & Foundation

Development of the CHNA Advisory Team

An advisory team was recruited to promote collaborative efforts with key stakeholders who lead organizations/agencies in our community. The core CHNA team included strong advocates for wellness who can connect to diverse populations and are prepared to discuss and take action on the healthcare needs in our region.

CHNA Advisory Team members included:

John Castle	Superintendent, North Country Supervisory Union
Lila Bennett	Executive Director, Journey to Recovery Community Center
Noreen Shapiro-Barry	Northeast Kingdom Human Services (Sr. Dept Director, Schools)
Meg Burmeister	Executive Director, Northeast Kingdom Council on Aging
Karen Budde	Northeast Kingdom Council on Aging, RSVP Volunteer and Wellness Coordinator
Michelle Faust	Executive Director, Northeast Kingdom Learning Services

Role of the CHNA Advisory Team

The primary role of the CHNA Advisory Team was to play a participatory process in engaging the community in the Community Health Needs Assessment. CHNA Advisory Team members played an integral role in distributing the quantitative survey, recruiting participants in Focus Group Discussions and Town Halls, and creating awareness for the Community Health Needs Assessment within the community.

Advisory Team Members will also play a critical role in the final implementation plan and actions, using each other's expertise to achieve goals of community health improvement.

Health status profile

Prior to data collection, publicly available data was used to gain a preliminary understanding of the health status profile of Orleans and northern Essex Counties, the region served by North Country Hospital. This data review provided background and contextual information on which the data collection methodologies were based. Review of data from the Vermont Department of Health and the Robert Wood Johnson Foundation (RWJF) indicated both chronic and acute health care issues in these counties may be related to underlying health care and health behavior needs in the community. The presence of specific concerns related to social and community needs (e.g. unemployment), health care needs (e.g. specialty care), health behaviors (e.g. smoking and drinking), and treatment and heath care services (e.g. health care access) were reported to be high in the NCH catchment area.[1] [2] Health Rankings from the RWJF were used to support these findings.[3] This background served to structure the quantitative and qualitative data collection methodologies and major indicator groups used in this CHNA.

[1] Healthy Vermonters 2020 - Quick Reference (Orleans County)
https://www.healthvermont.gov/sites/default/files/documents/pdf/HV2020_OrleansCounty.pdf
[2] Healthy Vermonters 2020 - Quick Reference (Essex County)
https://www.healthvermont.gov/sites/default/files/documents/pdf/HV2020_EssexCounty.pdf
[3] Robert Wood Johnson Foundation Health Rankings: Vermont.
https://www.countyhealthrankings.org/app/vermont/2020/overview

Section 2: Quantitative Data Collection

Quantitative Data Collection: Methodology

A brief (5 minute) electronic survey was developed to clearly and accurately assess the needs of the community with close collaboration between the UVM Larner College of Medicine and NCH teams. Using publicly available data from the Vermont Department of Health and RWJF, current and historical health data were reviewed during the creation of the survey to better understand the background health status measures of the community.

The final survey collected data on 4 main health status indicator groups:

1. Social and Community Needs
2. Health Care Needs
3. Health Behavior Needs
4. Treatment and Health Care Service Needs

Within each indicator group, participants were asked to identify the two most important health care needs, as perceived by the respondent. Data on basic demographics of respondents was also collected. No identifying information was collected as part of this study.

Quantitative Survey Results: Demographics

A total of 449 participants responded to the quantitative survey. The majority of survey respondents were female (83.7%), white (91.1%), and between the ages of 45-64 (45.2%). 52.8% of survey respondents reported an education level of college or higher, while 40% of respondents reported a yearly household income above $75,000. A full summary table of the participant demographics can be found in Appendix A.

Quantitative Survey Results: Information Preferences

To better understand how to reach community members and disseminate health-related information, respondents were asked to identify their preferred sources for receiving information. The vast majority of respondents identified **Internet/Online** (76%) as their preferred method for receiving information, while **Health Care Offices/Hospitals/Health Care Providers** were also identified as an important information hub (62%).

Quantitative Survey Results: Health Indicators

Survey respondents were asked to identify their perceptions of the most important and second most important health priorities in their community within the identified four main categories: Social and Community Needs, Health Care Needs, Health Behavior Needs, Treatment and Health Care Service Needs. A full summary of these findings, disaggregated by major demographic indicator (age, income level, education level) can be found in Appendix B.

Social and Community Priority Needs

The most important social and community need identified by survey respondents was **Affordable Housing** (36%), while **Employment** (finding or keeping work) was identified as the second most important social and community need (29.2%).

Those with an annual household income less than $75,000 were more likely to cite **affordable housing** as a priority as compared to those with a higher income (41% vs 31%) (figure 1), while high-income respondents were more likely to identify **employment** as a top priority (35% vs 27%) (figure 2).

Similarly, younger respondents aged 18-44 were more likely to cite **affordable housing** as a priority (42%) compared with respondents aged 45-64 (34%) and 65 or older (35%) (figure 1).

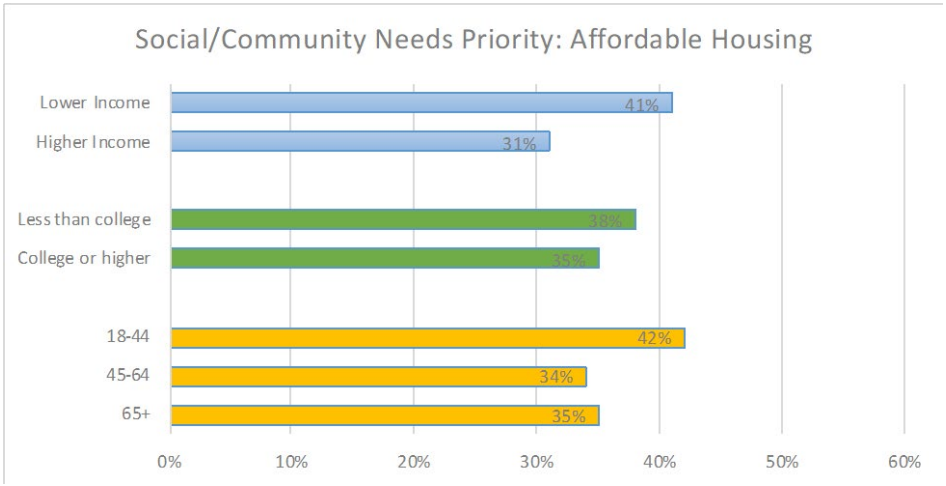


Figure 1: Social and Community Priority Need #1

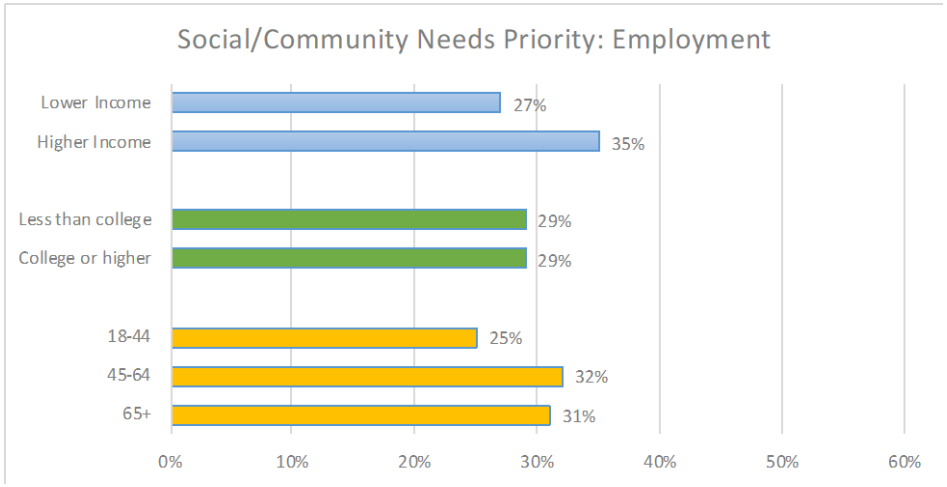


Figure 2: Social and Community Priority Need #2

Health Care Needs

The majority (39.3%) of survey respondents identified **regular medical care** (primary care) as the most important health care need in their community, followed closely by **mental health services** (38.6%).

Interestingly, younger respondents aged 18-44 were more than twice as likely to identify **mental health services** as a priority compared to those age 65+ (50% vs 23%) (figure 4). Instead, those 65+ were the most likely to identify the need **for regular medical care** (primary care) as a priority (56%) (figure 3). This highlights a discrepancy in the perceived health care needs between age groups in this community.

Respondents reporting a higher income were more likely to cite **mental health services** as the greatest health care need compared to those with a low income (44% vs 33%) (figure 4). A similar trend was observed in education status, whereby those with a high education were more likely to cite **mental health services as a priority** (41%), as compared to those who reported a lower education level (36%) (figure 4).

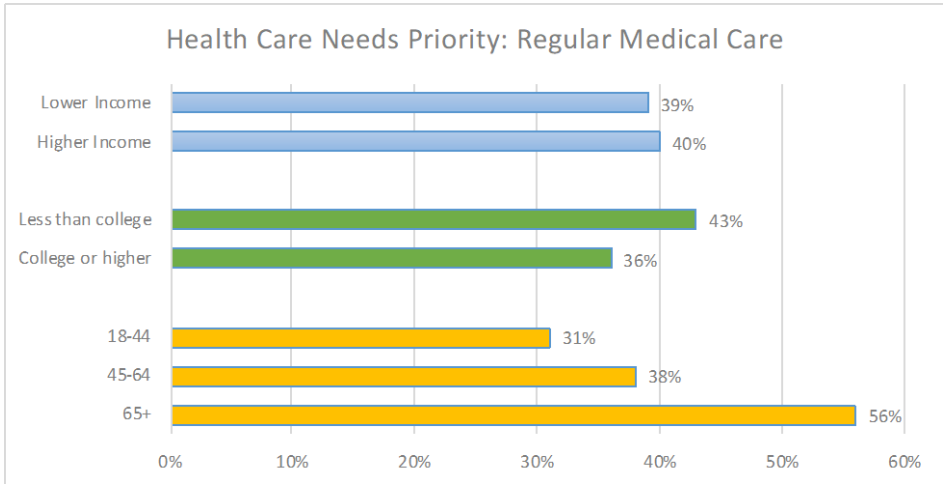


Figure 3: Health Care Priority Need #1

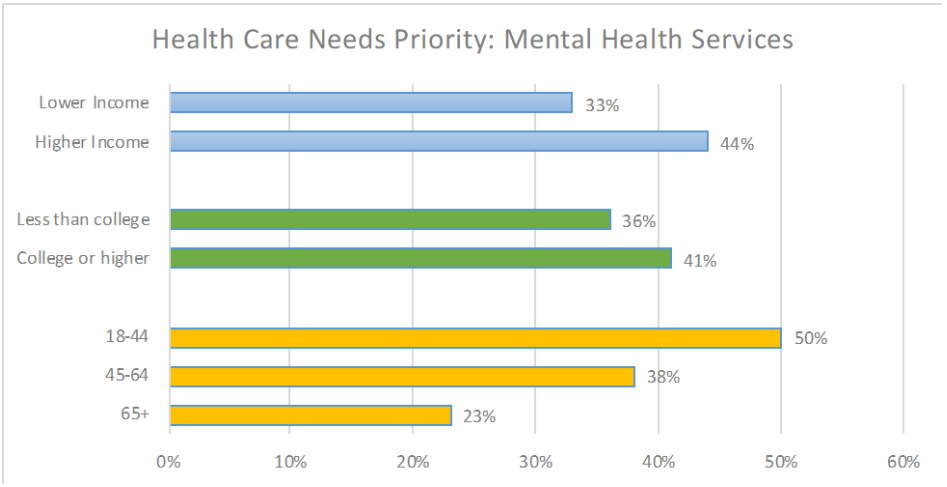


Figure 4: Health Care Priority Need #2

Health Behavior Priority Needs

The use of **illegal drugs or prescription drugs taken in a way not recommended by a doctor** was identified by 48.8% of respondents as the most important health behavior need in the community. **Stress, anxiety, or depression** were also identified as a health behavior need by 31.3% of respondents.

This finding is particularly important to those with a lower education level, with 57% of low education respondents identifying **illegal drugs or prescription drugs taken in a way not recommended by a doctor**, as compared to 41% of respondents with a high education (figure 5). Those with a high education as compared to a low education were more likely to report **stress, anxiety, or depression** as the primary health behavior need in the community (37% vs. 25%) (figure 6).

Similarly, older respondents, aged 65+, were more likely to report **illegal drugs or prescription drugs taken in a way not recommended by a doctor** as an issue compared to respondents aged 18-44 (52% vs 45%) (figure 5).

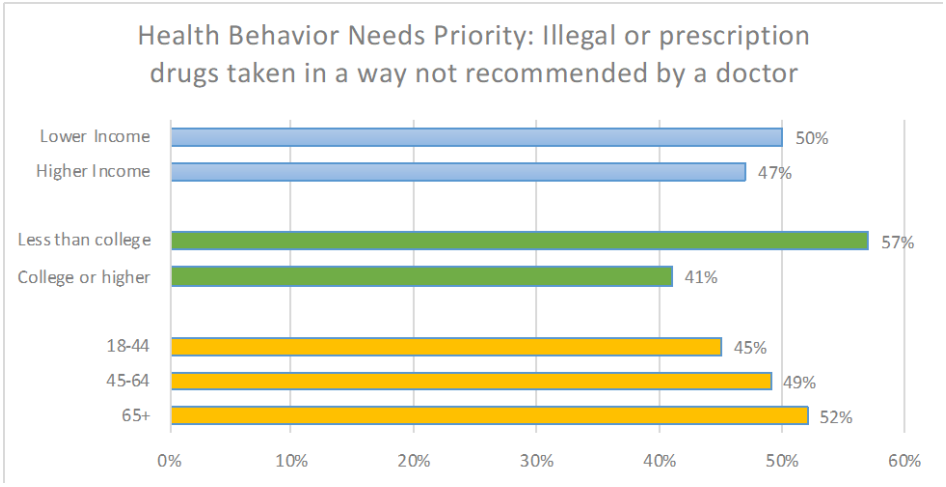


Figure 5: Health Behavior Priority Need #1

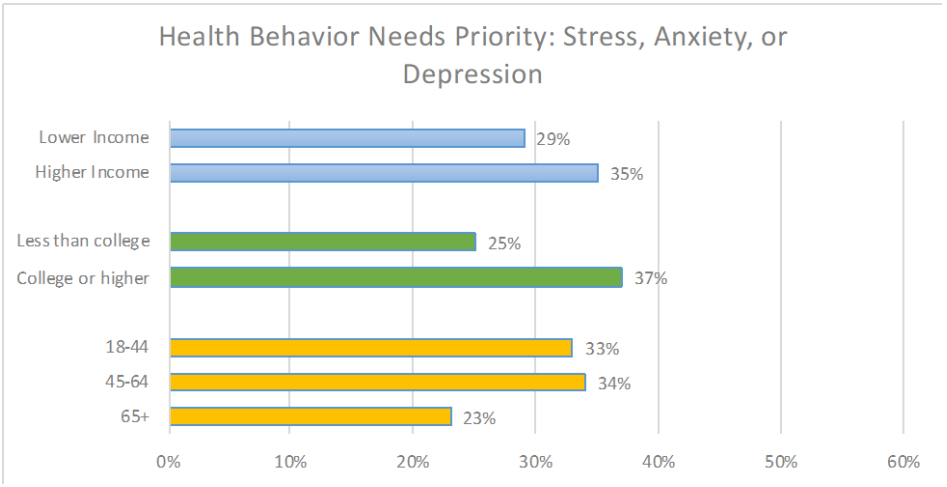


Figure 6: Health Behavior Priority Need #2

Treatment & Health Care Services

The need for both an **urgent care/walk-in clinic** and **emergency mental health services** were identified as treatment and health care services, with 36.5% and 35.1% of respondents identifying these areas as priorities, respectively.

Those respondents with a high education were more likely to report **emergency mental health services** as a need as compared to those with lower education (41% vs 30%) (figure 8). This need was most identified by those aged 18-44 (44%) as compared to those aged 45-64 (32%) or 65+ (29%) (figure 8). Conversely, the youngest respondents were less likely to report **urgent care/walk in clinics** as a major need (30%) as compared to the middle (40%) or oldest (37%) age groups (figure 7).

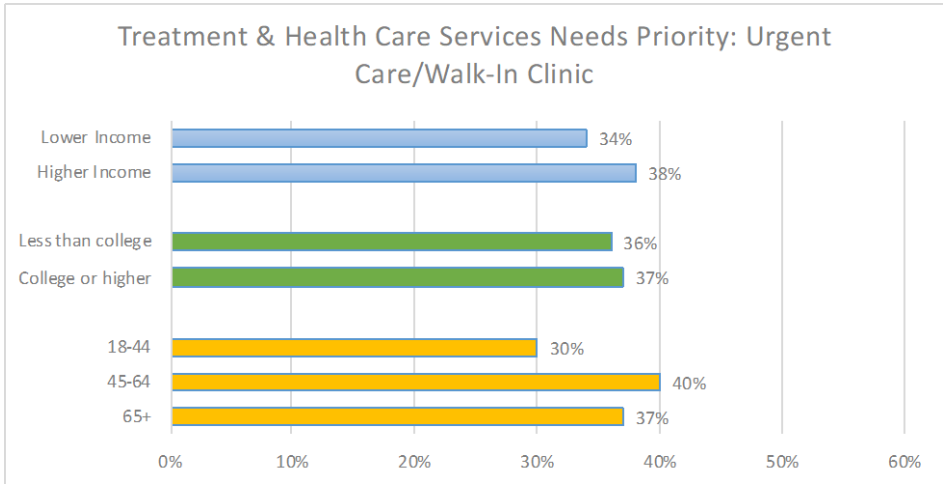


Figure 7: Treatment and Health Care Services Priority Need #1

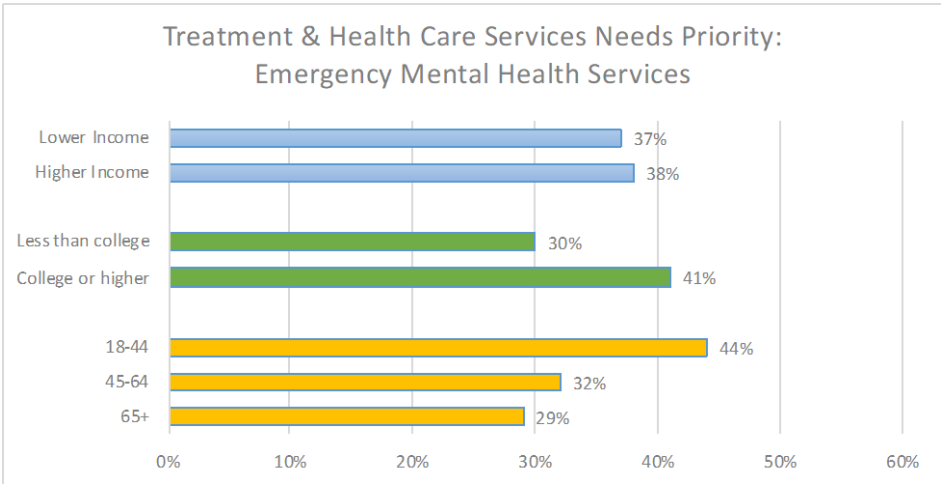


Figure 8: Treatment and Health Care Services Priority Need #2

Section 3: Qualitative Data Collection

Qualitative Data Collection: Methodology

Focus Group Discussions (FGDs) and Town Halls were designed to gather qualitative data from the community served by North Country Hospital. Due to the COVID-19 pandemic, all FGDs and Town Hall meetings were conducted remotely using Zoom.

Focus Group Discussions

A total of 4 FGDs were planned with local organizations to assess the specific needs of the community as perceived by those serving the community. The following groups were selected and approached by the NCH team:

- Journey to Recovery Community Center (JTRC)
- Northeast Kingdom Council on Aging (NEKCOA)
- Northeast Kingdom Learning Services (NEKLS)
- Local business owners

A focus group discussion guide was created to assess the health care needs and priorities of the community while promoting discussion amongst participants. The FGD guide assessed the four main indicator groups in this study (social and community needs, health care needs, health behavior needs, treatment and health care service needs) and can be found in Appendix C.

Town Halls

Town Halls were organized to provide the opportunity for community members to contribute to the conversation around health care needs and priorities within their community. A total of four Town Halls were organized, representing community members from the areas of:

- Barton/Orleans/Glover
- Jay/Westfield/Troy
- Island Pond/Morgan/Charleston/Holland
- Newport/Newport Town/Derby/Derby Line

Town Halls were designed to facilitate and promote discussion amongst community members and were intentionally structured to let the community guide the discussion as guided by the four main indicator groups used in this study: Social and Community Needs, Health Care Needs, Health Behavior Needs, Treatment and Health Care Service Needs.

Qualitative Data Collection: FGD Findings

A total of four Town Halls were held remotely over Zoom. Community groups confirmed their intended involvement, but participation was limited. Low participation was reported to be caused by work conflicts and the increase in workload due to the COVID-19 pandemic. The remote nature of these FGDs was also a contributing factor.

Of the four Town Halls scheduled, meaningful data are only available from the Town Hall with the Journey to Recovery Center (JTRC) due to the limited number of participants at other meetings.

The primary findings from this focus group discussion with JTRC staff highlight specific health related priorities in the community, as perceived by FGD participants:

1. *Generally speaking, poor health (especially mental health) is driven by hardship (especially financial hardship).*
    a. Financial hardship primarily manifests as housing insecurity and difficulty obtaining child care.
2. *Mental health issues often involve substance use.*
    a. Substance use/abuse is normalized in the community.
    b. Some healthcare providers (especially older ones) lack empathy of people with drug issues.
    c. Mental health staff are quick to identify drug/alcohol issues, but gloss over the mental health issues that create the drug/alcohol issues.
3. *Accessing primary care isn't a major issue, but the current mental health system of care falls short.*
    a. There aren't enough mental health-oriented facilities, providers, and support staff.
    b. There are barriers to *entry*, such as unmanageable amounts of paperwork for the patient and lack of transportation.
    c. There are barriers to *continuity of care*, such as a lack of intermediate mental health facilities. (i.e., facilities that do long-term mental health support outside of an acute crisis.)
4. *Patients (especially children) do not get sufficient education*
    a. The lack of education is primarily evident through vaping and food quality.

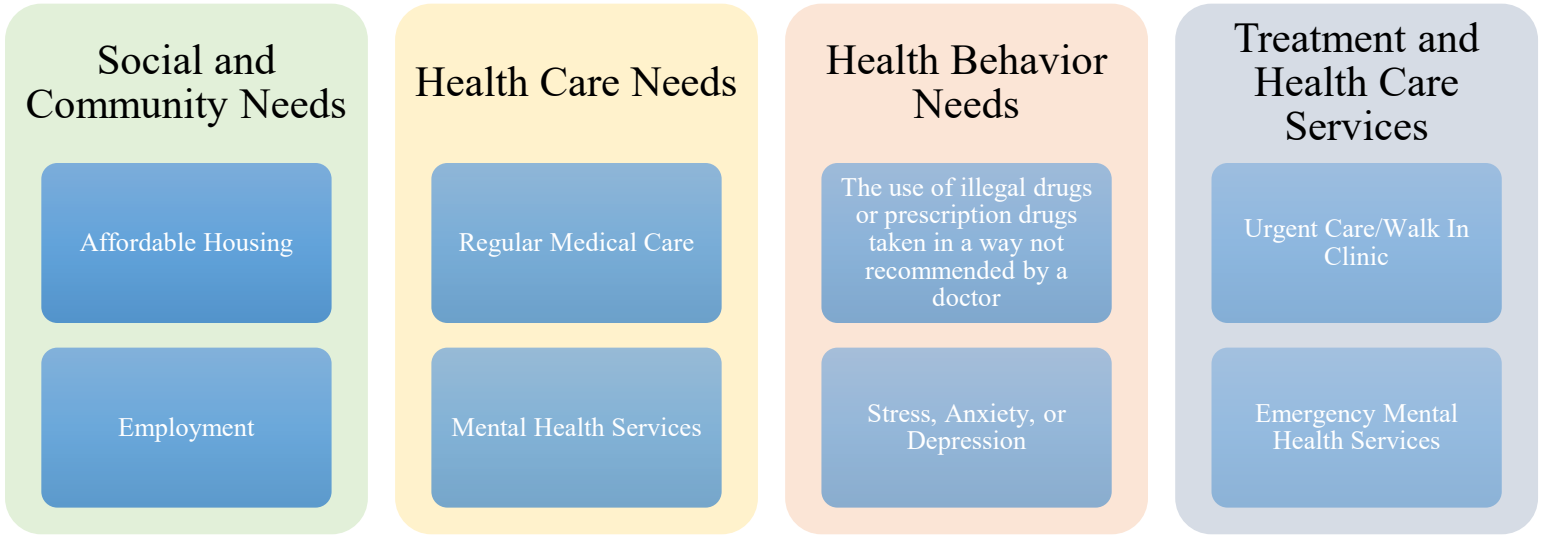
Qualitative Data Collection: Town Hall Findings

A total of four Town Halls were held remotely over Zoom, during times that were determined to be convenient for participation of community members. Participation in these Town Halls was minimal due to the remote online nature of the meetings. The lack of participants did not allow for thorough or meaningful data collection, and no findings from the Town Halls are reported here.

Section 4: Key Findings

Summary of Key Findings & Priority Areas for Implementation Strategy

The following have been identified as health need priorities in the communities served by North Country Hospital and are recommended as focus areas for the 2021 NCH CHNA Implementation Strategy:



Related Concerns that Affect the Health of the Community

The results of the quantitative survey provide a clear picture of the needs and priorities of the community served by NCH. Additional concerns emerged through this process that impact the identified Priority Areas. These include:

- The perceived association between mental health and substance abuse
- Financial hardship and the trickle down impacts (child care, transportation, etc.)
- Limited employment opportunities
- Barriers to care caused by the above challenges

Limitations of this CHNA

The primary limitation of this research was the remote nature of the assessment due to the COVID-19 pandemic. Social distancing practices and guidelines required the Focus Group and Town Hall discussions to be held remotely over Zoom. As a result, the Focus Groups had limited participation and Town Halls had no meaningful participation. These qualitative data collection methods are meant to engage community members in a conversation; potential participants may not have felt comfortable engaging in a discussion remotely.

The COVID-19 pandemic has also created unique primary and secondary health implications in the community served by North Country Hospital. The primary objective of this CHNA was to assess the health needs of the community in general, and the findings presented in this report are not specific to the COVID-19 pandemic. However, it is not possible to differentiate between health issues in the community that are related to or exacerbated by the pandemic from those that would have existed had the pandemic not occurred. This limitation was minimized by using clear language in the qualitative and quantitative data collection methods that encouraged participants to think outside of the pandemic.

Regarding the findings from the survey, it is important to acknowledge that there are differences between the people who participated in these aspects of the CHNA and the demographic profile of the community served by NCH. Despite efforts to make the survey as accessible as possible for all community members, the sample obtained using the survey was disproportionately female and had higher educational attainment and incomes than are typically seen in Orleans and Essex counties. This limitation is commonly encountered when community-based samples are used in projects similar to this CHNA; future needs assessments might benefit from adopting additional strategies to increase population representation in survey samples.

Section 5: Discussion

The results of the 2021 CHNA provide a clear picture of the community's perceived health related needs and priorities. Community participants agreed relatively strongly with one another on the top needs and priorities related to health in their community.

Though eight priorities have been indicated as the top needs of the community and are recommended for the focus of the implementation strategy, it is important to understand the relationship between the identified priorities. For example, it is likely that the need for increased mental health services is closely related to the use of illegal drugs or prescription drugs taken in a way not recommended by a doctor; both of which were cited as community needs by survey respondents. As such, the recommended process for the implementation strategy includes a holistic approach, rather than a strictly linear process.

Section 6: Implementation Strategy Process

Findings from this CHNA were used to inform the 2021 Implementation Strategy. This report outlines eight key priority needs within four health indicator categories; the 2021 Implementation Strategy builds upon these findings and provides actionable recommendations and strategies targeted within each identified priority need. The 2021 Implementation Plan was created jointly by the NCH Core CHNA Team, the CHNA Advisory Board, and the CHNA Design and Implementation Consultants at the UVM Larner College of Medicine. This collaborative effort put forth a plan that outlines current strategies in place at NCH, evidence from the literature on best practices, identified strategies, and indicators to measure progress. This clear and concise action plan provides well-defined guidance to build upon the successes of NCH to better the health of the community it serves.

Appendix A: Demographics Table

Age		**N**	**%**
	18-44	145	32.3
	45-64	203	45.2
	65+	92	20.5
	Prefer not to say	9	2.0
Gender		**N**	**%**
	Female	376	83.7
	Male	60	13.4
	Prefer not to say	11	2.4
Do you identify as Transgender?		**N**	**%**
	No	439	97.8
	Yes	2	0.4
	Prefer not to say	8	1.8
Race		**N**	**%**
	White	409	91.1
	African American	3	0.7
	American Indian/Alaskan Native	4	0.9
	Multiple Race	4	0.9
	Native Hawaiian or other Pacific Islander	2	0.4
	Other (write in)	4	0.9
	Prefer not to answer	23	5.1
Ethnicity		**N**	**%**
	Hispanic, Latino/a/x, Spanish	5	1.1
	Non-Hispanic, Latino/a/x, Spanish	390	86.9
	Prefer not to answer	52	11.6
Highest level of education completed		**N**	**%**
	Low education (less than a college education)	212	47.2
	High education (college graduate or higher)	222	49.4
	Prefer not to answer	15	3.3
Household yearly income		**N**	**%**
	Low income (less than $75,000)	198	44.1
	High income (more than $75,000)	179	39.9
	I'd rather not say	70	15.6

Appendix B: Primary findings disaggregated by major demographic indicators

Social and Community Health Needs					
Income					
		Lower Income	**Higher Income**	**Prefer not to say**	**TOTAL**
Affordable Housing	N	78	54	28	160
	%	41.3%	30.5%	41.2%	36.9%
Discrimination in the community	N	6	3	0	9
	%	3.2%	1.7%	0.0%	2.1%
Employment (finding or keeping work)	N	50	62	14	126
	%	26.5%	35.0%	20.6%	29.0%
Food Access and Affordability	N	31	18	17	66
	%	16.4%	10.2%	25.0%	15.2%
Internet where I live	N	15	30	5	50
	%	7.9%	16.9%	7.4%	11.5%
Transportation to and from health care appointments	N	9	10	4	23
	%	4.8%	5.6%	5.9%	5.3%
TOTAL	N	189	177	68	434
	%	100.0%	100.0%	100.0%	100.0%
Education					
		Less than college	**More than college**	**Prefer not to say**	**TOTAL**
Affordable Housing	N	78	76	6	160
	%	38.0%	35.3%	40.0%	36.8%
Discrimination in the community	N	6	3	0	9
	%	2.9%	1.4%	0.0%	2.1%
Employment (finding or keeping work)	N	59	63	5	127
	%	28.8%	29.3%	33.3%	29.2%
Food Access and Affordability	N	33	33	0	66
	%	16.1%	15.3%	0.0%	15.2%
Internet where I live	N	16	31	3	50
	%	7.8%	14.4%	20.0%	11.5%
Transportation to and from health care appointments	N	13	9	1	23
	%	6.3%	4.2%	6.7%	5.3%
TOTAL	N	205	215	15	435
	%	100.0%	100.0%	100.0%	100.0%

Age

		18-44	45-64	65+	Prefer not to say	TOTAL
Affordable Housing	N	61	67	29	3	160
	%	42.1%	34.0%	34.5%	33.3%	36.8%
Discrimination in the community	N	3	3	3	0	9
	%	2.1%	1.5%	3.6%	0.0%	2.1%
Employment (finding or keeping work)	N	36	62	26	3	127
	%	24.8%	31.5%	31.0%	33.3%	29.2%
Food Access and Affordability	N	19	31	15	1	66
	%	13.1%	15.7%	17.9%	11.1%	15.2%
Internet where I live	N	18	23	8	1	50
	%	12.4%	11.7%	9.5%	11.1%	11.5%
Transportation to and from health care appointments	N	8	11	3	1	23
	%	5.5%	5.6%	3.6%	11.1%	5.3%
TOTAL	N	145	197	84	9	435
	%	100.0%	100.0%	100.0%	100.0%	100.0%

Health Care Needs

Income

		Lower Income	Higher Income	Prefer not to say	TOTAL
Dental Care	N	14	6	7	27
	%	7.4%	3.4%	10.3%	6.2%
Mental Health Services	N	62	78	28	168
	%	32.8%	44.1%	41.2%	38.7%
Preventive Care (vaccines for children and adults, cancer screening, etc.)	N	9	11	4	24
	%	4.8%	6.2%	5.9%	5.5%
Regular medical care (primary care)	N	74	70	26	170
	%	39.2%	39.5%	38.2%	39.2%
Treatment for alcohol and drug misuse	N	28	11	3	42
	%	14.8%	6.2%	4.4%	9.7%
Vision Care	N	2	1	0	3
	%	1.1%	0.6%	0.0%	0.7%
TOTAL	N	189	177	68	434
	%	100.0%	100.0%	100.0%	100.0%

Education					
		Less than college	**More than college**	**Prefer not to say**	**TOTAL**
Dental Care	N	15	10	2	27
	%	7.3%	4.7%	13.3%	6.2%
Mental Health Services	N	74	89	5	168
	%	36.1%	41.4%	33.3%	38.6%
Preventive Care (vaccines for children and adults, cancer screening, etc.)	N	5	18	1	24
	%	2.4%	8.4%	6.7%	5.5%
Regular medical care (primary care)	N	89	77	5	171
	%	43.4%	35.8%	33.3%	39.3%
Treatment for alcohol and drug misuse	N	21	20	1	42
	%	10.2%	9.3%	6.7%	9.7%
Vision Care	N	1	1	1	3
	%	0.5%	0.5%	6.7%	0.7%
TOTAL	N	205	215	15	435
	%	100.0%	100.0%	100.0%	100.0%

Age						
		18-44	**45-64**	**65+**	**Prefer not to say**	**TOTAL**
Dental Care	N	6	14	7	0	27
	%	4.1%	7.1%	8.3%	0.0%	6.2%
Mental Health Services	N	72	74	19	3	168
	%	49.7%	37.6%	22.6%	33.3%	38.6%
Preventive Care (vaccines for children and adults, cancer screening, etc.)	N	8	14	1	1	24
	%	5.5%	7.1%	1.2%	11.1%	5.5%
Regular medical care (primary care)	N	45	75	47	4	171
	%	31.0%	38.1%	56.0%	44.4%	39.3%
Treatment for alcohol and drug misuse	N	13	19	9	1	42
	%	9.0%	9.6%	10.7%	11.1%	9.7%
Vision Care	N	1	1	1	0	3
	%	0.7%	0.5%	1.2%	0.0%	0.7%
TOTAL	N	145	197	84	9	435
	%	100.0%	100.0%	100.0%	100.0%	100.0%

Health Behavior Needs					
Income					
		Lower Income	**Higher Income**	**Prefer not to say**	**TOTAL**
Alcohol Use	N	11	14	4	29
	%	5.9%	8.0%	5.9%	6.7%
Illegal drugs or prescription drugs taken in a way not recommended by a doctor	N	93	83	35	211
	%	49.5%	47.2%	51.5%	48.8%
Social Isolation or Loneliness	N	22	11	8	41
	%	11.7%	6.3%	11.8%	9.5%
Stress, Anxiety, or Depression	N	54	62	19	135
	%	28.7%	35.2%	27.9%	31.3%
Tobacco Use, including vaping	N	8	6	2	16
	%	4.3%	3.4%	2.9%	3.7%
TOTAL	N	188	176	68	432
	%	100.0%	100.0%	100.0%	100.0%
Education					
		Less than college	**More than college**	**Prefer not to say**	**TOTAL**
Alcohol Use	N	11	17	1	29
	%	5.4%	7.9%	6.7%	6.7%
Illegal drugs or prescription drugs taken in a way not recommended by a doctor	N	115	88	8	211
	%	56.7%	41.1%	53.3%	48.8%
Social Isolation or Loneliness	N	16	23	2	41
	%	7.9%	10.7%	13.3%	9.5%
Stress, Anxiety, or Depression	N	51	80	4	135
	%	25.1%	37.4%	26.7%	31.3%
Tobacco Use, including vaping	N	10	6	0	16
	%	4.9%	2.8%	0.0%	3.7%
TOTAL	N	203	214	15	432
	%	100.0%	100.0%	100.0%	100.0%

Age						
		18-44	**45-64**	**65+**	**Prefer not to say**	**TOTAL**
Alcohol Use	N	9	13	7	0	29
	%	6.2%	6.6%	8.5%	0.0%	6.7%
Illegal drugs or prescription drugs taken in a way not recommended by a doctor	N	65	96	43	7	211
	%	44.8%	49.0%	52.4%	77.8%	48.8%
Social Isolation or Loneliness	N	15	13	12	1	41
	%	10.3%	6.6%	14.6%	11.1%	9.5%
Stress, Anxiety, or Depression	N	48	67	19	1	135
	%	33.1%	34.2%	23.2%	11.1%	31.3%
Tobacco Use, including vaping	N	8	7	1	0	16
	%	5.5%	3.6%	1.2%	0.0%	3.7%
TOTAL	N	145	196	82	9	432
	%	100.0%	100.0%	100.0%	100.0%	100.0%

Treatment and Health Care Services Needs					
Income					
		Lower Income	**Higher Income**	**Prefer not to say**	**TOTAL**
Cancer care	N	17	14	7	38
	%	9.0%	8.0%	10.3%	8.8%
Chronic Care for diabetes, high blood pressure, heart disease	N	21	18	12	51
	%	11.1%	10.2%	17.6%	11.8%
Emergency dental care	N	3	3	3	9
	%	1.6%	1.7%	4.4%	2.1%
Emergency mental health services	N	69	67	16	152
	%	36.5%	38.1%	23.5%	35.1%
Specialty care for dermatology, ophthalmology, etc.	N	15	7	3	25
	%	7.9%	4.0%	4.4%	5.8%
Urgent Care/Walk-in Clinic	N	64	67	27	158
	%	33.9%	38.1%	39.7%	36.5%
TOTAL	N	189	176	68	433
	%	100.0%	100.0%	100.0%	100.0%
Education					
		Less than college	**More than college**	**Prefer not to say**	**TOTAL**
Cancer care	N	24	12	2	38
	%	11.8%	5.6%	13.3%	8.8%
Chronic Care for diabetes, high blood pressure, heart disease	N	25	23	3	51
	%	12.3%	10.7%	20.0%	11.8%
Emergency dental care	N	6	2	1	9
	%	2.9%	0.9%	6.7%	2.1%
Emergency mental health services	N	61	87	4	152
	%	29.9%	40.7%	26.7%	35.1%
Specialty care for dermatology, ophthalmology, etc.	N	14	10	1	25
	%	6.9%	4.7%	6.7%	5.8%
Urgent Care/Walk-in Clinic	N	74	80	4	158
	%	36.3%	37.4%	26.7%	36.5%
TOTAL	N	204	214	15	433
	%	100.0%	100.0%	100.0%	100.0%

Age						
		18-44	**45-64**	**65+**	**Prefer not to say**	**TOTAL**
Cancer care	N	11	18	7	2	38
	%	7.6%	9.2%	8.4%	22.2%	8.8%
Chronic Care for diabetes, high blood pressure, heart disease	N	18	20	12	1	51
	%	12.4%	10.2%	14.5%	11.1%	11.8%
Emergency dental care	N	3	6	0	0	9
	%	2.1%	3.1%	0.0%	0.0%	2.1%
Emergency mental health services	N	64	62	24	2	152
	%	44.1%	31.6%	28.9%	22.2%	35.1%
Specialty care for dermatology, ophthalmology, etc.	N	5	11	9	0	25
	%	3.4%	5.6%	10.8%	0.0%	5.8%
Urgent Care/Walk-in Clinic	N	44	79	31	4	158
	%	30.3%	40.3%	37.3%	44.4%	36.5%
TOTAL	N	145	196	83	9	433
	%	100.0%	100.0%	100.0%	100.0%	100.0%

Appendix C: Focus Group Discussion Guide

1. In the past 3 years, what social and community needs have emerged as priorities? These can be things like affordable housing, food access, discrimination, employment, and everything in between.

2. Now let's think about health care needs in a more specific way – the places that you actually go for your health care needs. This includes the doctor's office for regular or preventive care, but also places like the dentist or eye doctor, or drug and alcohol treatment.

3. I now want to talk about Health Behaviors in your community, and what kind of health behavior needs are priorities in your communities. By 'health behaviors', I mean people's actions that influence health. These are things like tobacco or alcohol use, but can also include eating habits, illegal drugs.

4. Now that we've covered health care needs and health behaviors, I'd like to discuss your community's priorities for treatment and health care services. What is lacking in your community, or what needs to be improved? This includes health care services like walk in clinics and emergency services, but also places that offer specialty care or care for chronic conditions.

5. Finally, I'd like you to share your thoughts on your preferences to receiving health information. This includes messaging around health care, public health, social services and other community health services. What is the best way to reach you and your community with health-related information?

6. Is there anything we didn't talk about today that you would like to discuss?